CBT in DHAT Syndrome and Co-Morbid Conditions

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Abstract- Dhat syndrome is a condition in which the male patients suffer from premature ejaculation or impotence, and believe that they are passing semen in their urine. The prevalence rate is varying between 40-66% among Indian population. The patients with Dhat syndrome are experiencing the overlapping symptoms of other disorders such as depression, anxiety, and mood, and it can be hypothesized that they would respond to CBT and symptoms would be diminished. The effectiveness of CBT in the intervention of psychosexual dysfunction has been proved. **Methodology:** Aim of the study was to investigate the efficacy of cognitive behaviour therapy (CBT) in Dhat syndrome and co-morbid conditions. Pre-post research design was used to study the efficacy of Cognitive Behaviour Therapy. Three outward male patients who diagnosed with Dhat syndrome were selected for the sample from GEMS Health Care, Hyderabad. The intervention was included with psycho-education, supportive psychotherapy and cognitive behaviour therapy with a duration of 4 months in 18 sessions and inform consents were taken from the patients. The cognitive behaviour therapy was compiled with activity scheduling, cognitive restructuring (thought challenging, role playing, positive statements, and behavioural rehearsal and relaxation therapy (JPMR). BDI-II, HAM-A and IIEF were used for pre-post assessment.
Result: In CASE-1 on BDI-II he improved 71%, on HAM-A 47%, and on IIEF 61.2%. In CASE-2 on BDI-II he improved 53.8%, on HAM-A 57%, and on IIEF 69%. In CASE-3 on BDI-II he improved 73%, on HAM-A 42%, and on IIEF 61%. This study concluded that CBT techniques are very effective Dhat syndrome and co-morbid conditions.

Index Terms- Dhat syndrome, Case studies, Cognitive Behaviour Bherapy and Supportive Psychotherapy.

I. INTRODUCTION

Dhat is believed to be a precious body fluid in many cultures and its loss can have harmful consequences to the body. This belief is carried forward over generations by different members of the society, which may be a key, authoritative elder member of the family or society or a traditional healer. The individuals do not understand the complex anatomy and physiology of penis and believe that the blood that is collected in the cavernous spaces during erection gets converted into semen and thus, they are losing blood and energy with each sexual activity (Prakash & Meena 2008; Salam, et al., 2012). In India, sexuality is considered as taboo and sexual matters are generally not discussed in the families. The tabooed nature of sex and discussions related to it in social & cultural context make it difficult for them to have discussions with peer groups, which prevents normalization of the experience of semen loss (Ranjith & Mohan, 2006). Dhat syndrome is a culture-bound neurotic disorder seen in the Indian subcontinent (Chadda & Ahuja, 1990). There are various co-morbid conditions of Dhat Syndrome in which depression is the most common disorder. Dhat Syndrome is a way of expressing depression or anxiety among Indian population. In India, prevalence rate of Dhat Syndrome is varying between 40-66% (Sinha, & Singh, 2013). Dhat syndrome is also found in many South East Asian countries with different names and is characterized by semen loss resulting in a range of mood and anxiety related disorders. Loss of semen can be explained through masturbation, nocturnal emission, through urine and accompanying psychiatric symptoms are usually fatigability, weakness, anxiety, feelings of guilt, insomnia, inferiority, loss of appetite, weight loss, anxiety and sexual dysfunction. The effectiveness of CBT in the intervention of psychosexual dysfunction has been proved (Mohar, & Beutler, 1990, Munjack et al. 1984) because the patients with Dhat syndrome are experiencing the overlapping symptoms of other disorders such as depression (Dobson, 1989; Shapiro, et al. 1994), anxiety (Chambless & Gills, 1993; Borkovec & Ruscio, 2001), and mood, and it can be hypothesized that they would respond to CBT and symptoms would be diminished (Salman, et al., 2012). CBT also appears to be most relevant intervention in view of faulty beliefs and misconceptions about the origin of their symptoms and sexual functioning (Salam, et al., 2012). CBT deals with distinct illness behaviour shown by the patients in Dhat syndrome. A recent study reveals that psychosexual issues, supportive psychotherapy, reassurance, and family intervention is helpful in reducing the distress level of the patient with dhat syndrome and also found that rapid improvement in the depressive symptoms over a period of two weeks which also suggests that the depression was reactionary or secondary (Sinha, & Singh, 2013). A study revealed that 64 % of Dhat patients had no improvement with anti-depressants and dropped out from therapy (Singh 1985). Salam, Sharma & Prakash (2012) developed CBT module consisted of sex education, cognitive restructuring, relaxation training, imaginal desensitization, masturbatory training, Kegel's exercises, 'start-stop technique' and 'squeeze technique' for and found that feasibility of CBT module in clinical setting is suitable for application within busy clinical settings. Though combined modality of treatment (pharmacotherapy and psychotherapy) considered to be the best modality of treatment in resolving the Dhat syndrome as well as the associated co-morbidities (Bhatia, Bohra, & Malik 1989). Considering these factors, present study is an attempt to find the effectiveness of CBT in the patients with Dhat syndrome and co-morbid conditions.

II. METHODOLOGY

Aim of the study was to investigate the efficacy of cognitive behaviour therapy (CBT) in Dhat syndrome and co-morbid conditions. A case study method was used to for the present study. The sample consisted of three male patients from GEMS, Hyderabad, Telangana, who were diagnosed as Dhat syndrome (WHO, 1993) with co-morbid conditions. All of the three consented patients were single and were in the age range of 20 to 25years. Two of the patients had consulted faith healers before consulting GEMS Health Care. Pre-post research design was used to study the efficacy of Cognitive Behaviour Therapy. Three patients were assessed using Beck Depression Inventory (BDI-II) developed by Beck in 1990; Hamilton Rating Scale for Anxiety (HAM-A) developed by Hamilton 1959 and International index of erectile function (IIEF) developed by Rosen et al in 1997 and also by clinical interview and observation. BDI-II, HAM-A and IIEF were used for pre-post assessment of intervention. Informed consents were taken from the patients'. The patients were undergone for therapies such as psycho-education, supportive psychotherapy and cognitive behaviour therapy for 4 months in 18 sessions at GEMS Health Care, Hyderabad. The cognitive behaviour therapy was compiled with activity scheduling, cognitive restructuring (thought challenging, role playing, positive statements, and behavioural rehearsal and relaxation therapy (JPMR).

CASE NO-1

Mr. "V" a 21 yr old male brought by his mother with the complaints of decreased sleep and appetite, weakness/lack of energy, loss of interest in pleasurable activities, decreased self confidence, disturbed activity of daily living, hopelessness, worthlessness, crying spell/death wishes since 4 years. Onset was insidious, course was continuous and progress was deteriorating. Mr. "V" was a Muslim, Male, educated up to 5th standard, working as a knitting worker, belonged to the low SES, and resided at urban Hyderabad.

In brief history, Mr. "V" started masturbating from the age of 13 years, due to curiosity and initially he was practiced once in a week. At the age of 14 years he watched a porn movie with his colleague and he enjoyed the movie. Gradually his interest towards watching such kind of movies was increased and the act of masturbation was also increased up to 6 to 10 times in a weak. During the age of 15yeras he heard that masturbation is injuries to health and is prohibited in Islam. He scared and started trying to control the masturbatory activity, but he used to fail to control himself; due to this failure he started feeling guilty about his interest in watching porn movies and masturbatory activities but still he was fine till the age of 17yrs. Subsequently he started believing that his physical strength and appearance was deteriorating due to these activities which also increased his guiltiness. Finally he used to believe that all his conditions were due to his masturbatory activity and he had no control over that and even he did not want to marry as he started to believe that he had no capacity to make a sexual relationship. In medical history, he visited many traditional faith-healers (hakim) and hospitals and also took medicine for the same, but no improvement was found and he had no record of medicines and any prescriptions. In family history, Mr. "V" belonged to a nuclear family and he was fourth child among seven siblings. His father's attitude toward him was critical and he was more attached with his mother. Interpersonal relationship between family members are cordial, and attitude towards his illness was supportive except his father.

Mr. "V" was born with a full-term normal delivery at home and no prenatal, natal and postnatal complications were reported by mother. His developmental milestones were reported to be normal. Mr. "V" started his schooling at Etha district (U.P) from the age of 6 years and used to perform average in studies till 5th class. At the age of 13year he started learning "zarikam" with one of his friend and after three years he was working independently. He used to maintain healthy relationship with his co-workers and supervisor. Mr. "V" was premorbidly responsible and an active person; but sensitive towards criticism and used to be anxious in a stressful situations. He was religious and has good moral standards and he never been interested towards any type of substance abuse and also never had been any conflict with siblings or peers. On MSE he was looking older than his age, appears short, lean and thin, sitting in a reclined manner, maintained eye to eye contact partially, whenever enquired about his personal matters, he used to keep his hands on mouth, speech tone and intensity was low and productivity was decreased. He had below average cognitive and intellectual functioning, preoccupation with sex, ideas of hopelessness, guilt and suicidal ideation were found in content of thought, mood was irritable and affect was anxious, judgement was poor and had grade-II level of insight.

Mr. "V" was assessed using Beck Depression Inventory (BDI-II) developed by Beck, 1990; Hamilton Rating Scale for Anxiety (HAM-A) developed by Hamilton, 1959; International index of erectile function (IIEF) developed by Rosen et al in 1997; Thematic Apprehension Test (TAT) developed by Bellak 1993; Millon Clinical Multiaxial Inventory (MCMI-III) developed by Millon et al., 1994. In test findings, he scored 31 on BDI which indicated presence of severe level of depression; score on HAM-A 15 indicated present level of anxiety was not at clinical level; scored 31 on IIEF indicated moderate level of erectile dysfunction. TAT results showed that he had predominant need for sex, aggression, dominance and affection, major presses as sexual desire, lust and love. He had main conflict with need for sex and inferiority and to overcome from this conflict he used to utilize wishful thinking. On MCMI-III the results showed that it was a valid profile and his approach toward testing was frank and self revealing. He comes under Depressive, schizoid and avoidant Clinical personality trend means he had worthless self image, and characteristically warm, tender and non competitive, timidly avoids social tension and interpersonal conflicts. On severe personality pattern he comes under schizotypal and borderline group which indicated, he have estranged self-image and tendency toward himself as forlorn with repetitive thoughts of life's emptiness and meaninglessness. On clinical syndrome scale, elevated score was found on anxiety scale which indicated, patient might be having estranged self-image and tendency toward himself as forlorn with repetitive thoughts of life's emptiness and meaninglessness. On clinical syndrome scale, elevated score was found on anxiety scale and severe clinical syndrome scale, elevated score were found on Major depression and Thought Disorder, which indicated that he

have major depression. *Mr. "V" diagnosed as* "Severe Depression with Dhat syndrome"

CASE NO -2

Mr. "R" a 25 yr old male came with the complaints of repetitive thoughts related to sex, palpitation, nocturnal emission, masturbation, disturbed sleep, frequent headaches, increased irritability and difficulty in concentrating at work which are increased since last 6 months. Eventually the repetitive thoughts started interfering in his social and occupational functioning. Total duration of illness was 5 yrs, onset was insidious, course continuous and progress was deteriorating. Mr. "R" was a single, Hindu, male, educated up to post graduation, working as a private tutor, belonged to middle socioeconomic background came to GEMS Health Care at Hyderabad. In brief history, at the age of 20years, Mr. "R" was noticed nocturnal emission with the frequency of once in a weak and gradually it increased. He used to feel shame as the family members were also noticed it and he was suggested for masturbation for the same by his close friend. He was aware of that these practices are not good for health but could not be controlled by himself and he used to masturbate 2-3 times in a day and he maintained well till the age of 23 years. After that he noticed that semen was discharging during urination and he had pain whenever he masturbated and due to this he stopped these practices but he had a feeling of loss of energy and strength in his body. Meanwhile, he had two failed attempts of sexual intercourse with his girlfriend and he became socially isolated and preoccupied with worry for his condition. Thereafter his erection was decreased even for his imaginative thinking of sexual content and due this he started getting palpitation and other bodily sensations which lead him to thought of dying. He has a family history of bipolar mood disorder. Mr. "R" belonged to a joint family which consisted of grandmother, mother- father, elder brother's family, and his twin brothers. His father was retired as a teacher and after that he started running his own tuition classes. His mother was educated up to 7^{th} standard and was a house wife and his elder sister got married and living with her family. Elder brother educated up to 10^{th} standard and was married. He had a monozygotic twin younger brother who is doing Hotel Management with part time job. Mr. "R" reported that his parents are very supportive and he was attached to his mother. He was an obedient and disciplined child to his family and he did not have any conflict with his family members. F/H/S/O mental illness was present in his elder sister.

Birth and developmental history was not elicited due to unavailable of the informants. He was being interested in academics since his childhood and an average student in the class. After his post graduation he started to work as a part time for his further studies. He completed his B.Ed. (Bachelor of Education) and was trying for Teacher Eligibility Test.

Premorbily he was quiet, ambitious, obedient and disciplined since his childhood. He was enthusiastic and optimistic and he wanted to become a good teacher. He used to respect others and had a healthy family and social relationships. His attitude to self and others was positive and had good moral values. He did not have any specific interests or hobbies and had few friends. On MSE, he was appeared older than his age, has lean and thin body built, eye to eye contact was partially maintained, rapport was easily established easily, speech was spontaneous with increased speed and productivity. Non-adaptive movements like blinking and twitching of the shoulders were observed in psycho motor activities. He has average cognitive and intellectual functioning, mood was "anxious" and affect was congruent, circumstantialities in stream of thought, feelings of guilt, inferiority and ruminations related to past experiences in content of thought. His judgement was intact and insight was in at intellectual level.

Mr. "R" was assessed using Brief Psychiatric Rating Scale (BPRS) developed by Overall & Gorham 1962, Ventura, et al., 1993; Human Figure Drawing Test (HFDT) developed by Mitchel, Richard, & Roland; 1993; Neo- Five factor inventory (NEO-FFI) developed by Costa, & McCrae, 1991; Sentence Completion Test (SCT) developed by Sack & Levy 1950, and Thematic Apperception Test (TAT). In test findings, on BPRS he scored high on anxiety, depression, guilt and hostility and distractibility. HFDT findings indicated the absence of cognitive impairment and organicity but qualitative finding suggested presence of anxiety, uncertainity, insecurity and timidity. Profile figure of the drawing suggested aggressive tendencies, evasiveness, paranoia, oppositional tendencies and intelligence in the patient. On NEO—FFI suggested he was very warm and affectionate towards others, enjoys large and noisy crowds or parties also seen as being forceful and dominant, preferring to be a group leader rather than a follower and has high level of energy. However, low scores on openness, tends to be conventional in behaviour, conservative in outlook and his emotional responses are somewhat muted. Low scores on agreeableness scale suggested he might be having narcissistic, antisocial, and paranoid personality traits. Low scores on conscientiousness scale indicated that he was not applying his moral values on self and tends to be hedonistic, as more interested in sex related matters. On SCT he obtained high scores in the area of self- concept, which suggested feeling of guilt and inferiority. The TAT stories revealed the predominant needs of love, affection, sex and acceptance. The feelings and emotions reflected in the story are love, guilt, hostility and sadness and as a result of ongoing stress, the patient was showing significant conflict with opposite sex individuals and to cope with these conflicts, he was using intellectualization, rationalization and fantasy. The Rorschach Inkblot Test revealed that the patient had significant coping deficits which might resulted in poor interpersonal relationship, thinking by inducing distortions to reality and decision making capacity but there may be an underlying need for social attachment. His personality type was ambient and his self image was negative. His emotional display was inconsistent, sometimes well controlled on the other hand impulsive. He had a chronic vulnerability to become disorganized under stress and the failures might induce depressive feelings and no findings related to impair reality testing were found. Mr. "R" was diagnosed "Anxiety with Dhat syndrome".

CASE NO – 3

Mr. "S" a 20 year old male came with the complaints of loss of energy, fatigability, poor self confidence and self esteem, suicidal ideation, disturb sleep since 2 years. Onset was insidious, course was continuous and progress was deteriorating. Mr. "S" was single, Muslim, was pursuing graduation, belonged

to middle SES of urban area came to GEMS Health Care at Hyderabad. In brief history, he was fine till the age of 17 years and he never used to masturbate as he strongly believed that masturbation spoils the person sexual life and also reduce the physical appearance. At the age of 18yrs once he saw a porn movie on a mobile and had nocturnal emission and it was gradually increased to three to four times in a week which made him to feel shame about it guilty about his behaviour. Since the age of 19yrs he started noticing that semen was discharging during urination and due to this started to believe that his physical strength was reducing. He consulted a faith healer and started taking Ayurvedic medicine for the same. As a result of this semen discharge was reduced but his feeling of helpless, hopelessness and worthlessness was increased significantly.

In family history, he is the younger child to his family and he has one elder brother and two elder sisters and all are married and settled. His father and brother both run their own business and mother was a house wife. He was more attached with brother and depended on brother for his all needs and demands. His father's attitude toward him was critical and other family members were supportive towards him and had sympathy for his physical condition. Birth and developmental history was not elicited due to unavailability of informants. He gained admission in school at the age of 5 years and he was average student in his class since his childhood. He used to participate in extracurricular activities. In premorbidly, Mr. "S" was well adjusted in premorbidly as he had good friend circle and he maintained healthy relationship with friends and peer group. He was a responsible and sensible person for his family and had good moral values. On MSE he was well kempt & tidy, dishevelled, wearing dull colour T- shirt and jeans, has lean and thin body built, looking older than his age, eye to eye contact was maintained partially, rapport was easily established easily, and psychomotor activity was decreased. In speech tone and intensity was low, productivity was decreased, coherent and answered when asked question. Orientation and memory was intact, abstract thinking was at functional level and has average level of intellectual functioning. No abnormalities were elicited in stream, form and possession of thought. Feeling of inferiority, guilt, helplessness and hopelessness was found in content of thought and mood was depressed and congruent. No perceptual disturbances were elicited. Judgement was intact and insight was at grade-V.

Mr. "S" was assessed using Eysenck's Digit Span Series Test (EDSST) developed by Wechsler, 1955; Thematic Apperception Test (TAT); and MCMI-III. In test findings, on EDSST his obtained score was 5 in digit forward and 4 in digit backward which indicated that his attention was easily aroused and sustained. The TAT stories revealed that there was conflict with maternal authority and unwilling submission to it. Patient had a strong superego and most acts are seen clearly as 'crime' and 'punishment'. The society was seen as a means to apprehend 'perpetrators' and nobody could escape from societal punishment. Passivity appeared on 12M that was ego syntonic and indicated that he wanted to receive aid and comfort. There was a clear suicidal ideation as appears on cards 3BM and 14, it could be corroborated with his history. On 3BM there was a combination of intra-aggression and a very strong superego indicated suicidal ideation. On 14 there was a conflict between an active denial of depressive feelings and suicidal tendencies. However, his story on 14 also pointed towards aesthetic interests, which might be helpful for therapeutic purposes. On MCMI-III, the Profile was valid and his clinical personality pattern was Depressive, Schizoid, and Avoidant which means he might be having worthless self image, and characteristically warm, tender and non-competitive, timidly avoids social tension and interpersonal conflicts. On severe personality pattern, he was Schizotypal and Borderline which indicates he might be having estranged self-image and tendency toward himself as forlorn with repetitive thoughts of life's emptiness and meaninglessness. Among the severe clinical syndromes, he obtained the highest scores on **Scale CC (Major Depression)** which indicated that he was usually incapable of functioning in a normal environment because he was severely depressed, and expressing a dread of the future, suicidal ideation, and a sense of hopeless resignation and had problems of concentration and feelings of worthlessness or guilt. Mr. "S" was diagnosed as "Severe Depression with Dhat Syndrome".

III. THERAPUTIC PROCESS

Session 1 to 3 (Common for all)

Initial intervention sessions were same for all three cases and in mid sessions some cognitive and behavioural strategies were changed according to their symptoms. The therapeutic process was done with psycho-education, supportive psychotherapy and cognitive behaviour therapy with in one session per a week, with the duration of 45 minutes and the overall intervention has been completed within 18 sessions in a period of four months at Gems Health Care, Hyderabad. The cognitive behaviour therapy was compiled with activity scheduling, cognitive restructuring (thought challenging, covert conditioning, role playing, positive statements, and behavioural rehearsal and relaxation therapy (JPMR).

Psycho-education: The patients were provided the information regarding nature, cause, course and prognosis of the disease. In initial session, informal conversation including what they likes, dislikes, interests and hobbies were discussed to make rapport with the patients. After successfully establishing rapport the patients were psycho-educated about the nature, course, prognosis and management, non-pharmacological approach based on their requirements. They were also informed the need and course of the current psychotherapeutic treatment and their active participation for the same.

In second session, sex education was given to them in a very lemon language and common examples were used to convince them regarding the production of semen and its utility. During session they were persistently motivated about asking the questions regarding the sex and the proper information was provided to them and it was found that they had lot of misconceptions and myths regarding the sexuality. In the next session was also dominated with sex education in which they were taught about human reproductive system by using drawing, pictures and posters related to the subject.

Supportive Psychotherapy: Supportive psychotherapy was used as adjuncts to re-educative or reconstructive psychotherapy. Aim of this therapy was to bring the patient to an emotional equilibrium as rapidly as possible, with amelioration (to make

better or easier) of symptoms, so that they can function at a level to approximating their norms. It was an effort to make strengthen existing defenses as well as enhancing better mechanisms of control. Supportive psychotherapy techniques were widely practiced not only for hospitalized or chronically ill psychiatric patients, but also, on a relatively short-term basis, for patients in acute crisis situations (Conte, 1994). It has also been found effective for patients with medical illnesses to help them develop more effective coping mechanisms, thereby providing a more favourable long-term course of illness (Conte, 1994).

Cognitive Behaviour Therapy:

CASE-1: Sessions 4 to 16

Mr. "V" has moderate to severe level of depression therefore initially supportive psychotherapy, cognitive strategies and other behavioural techniques were introduced. Initially he was motivated and assured that he will fine and would gain his strength, if he participates in collaborative way. He was advised for morning walk in early in the morning. Meanwhile his mother was involved in a session and provided the therapeutic process and asked her to help the patient to overcome from his problem. She was provided his activity scheduling regarding his food habits and timings and explained to monitor for his betterment.

His negative automatic thoughts and cognitive errors were identified:

1) "I lost all my energy, strength and appearance" because no one is looking to me or interacting with me- black & white thinking
2) "I made a big mistake and god must punish me"- must statement.

During the sessions also targeted his underlying core beliefs and application of pure cognitive techniques to reconstruct his wrong cognition about self, others as well as world. After convincing the patient that his underlying beliefs were maladaptive by proving some examples, he was suggested to write sentences consisting positive and motivating words, such as "I am a young and attractive man", "my family and friends are carrying to me" and some positive statements were also taught to him.

In these sessions his dysfunctional automatic thoughts were identified and challenged by some questions such as "What is the evidence that your thought is true"?, "What will be the effect continuing to think this way"?, "What are the best outcome, worst outcome, and most realistic outcome"?, "What is the likelihood that this will happen"?.

During thought challenging he was motivated and supported with simple conversation which might not hurt him at any point. Initially he used so many defences but gradually his defences were decreased and he started accepting them and even at a point he admitted that he was wrong. In between the sessions, the behavioural techniques were introduced and he was motivated to go for working again, for watching movies or interact with his friends. His mother was reported that initially he was not motivated in maintaining the thought diary and activity scheduling but gradually he started maintaining all instruction which were given by the therapist and she was also happy that he started conversing with his family members. She reported that he used to discuss regarding therapy sessions and weekly activities. Behavioural rehearsals and role-playing techniques for used to improve his communication skills and advised to start the conversation with female co-workers and he was very comfortable to communication with female co-worker as well as other females. He was realized that his prejudiced behaviour was wrong regarding a neighbourhood lady as he found that she was good in nature after started to talk with her.

CASE NO-2: Sessions 4 to 6

Mr. "R" has moderate level of anxiety and ruminative thoughts related to sex for that, initially relaxation therapy and supportive psychotherapy were introduced. Once he learned to relax by himself after that cognitive therapy was introduced to change his misconceptions. The cognitive distortions were elicited from his are as follows:

1) "I will be die soon, because my heart is choking"
2) "My sexual life spoiled" I never satisfied a girl"

Relaxation technique was introduced in which he was taught to relax all 15 muscles (feet, calf, knees, Thais, lower abdominal, stomach, chest, wrist, hand, y-shapes, shoulders, neck, jaws, eyes, forehead) one by one. In first session all the procedure regarding relaxation was taught by demonstration. He was instructed to sit on the chair comfortably, close eyes and try to concentrate on breathing and asked to concentrate instructions to follow them. Immediate after each session his subjective feeling was recorded on 10 point scale. Initially he was not able to concentrate and used to open his eyes in between but late he was doing well and good. First three sessions were assisted him with instructions and later he was advised to follow the procedure by himself and also asked to practice it two to three time at home and he became mastery in sixth session.

Middle Sessions: 7 to 16

CBT techniques were used to change his misconceptions and believe. In covert conditioning he was asked to imagine about his girl friend and her sexual appearance which made him to get the erection in first session. He was advised to do the same at home and also asked to practice the masturbation and also asked to relax himself which helps him to get control over ejaculation and also suggested him to maintain in a particular conditions such as, once in day and the practices should be done in peaceful environment.

In the next session he reported that he had a control over his ejaculation. Then the thought stopping technique (Self control Triad) was introduced by therapist. Therapist was introduced an intrusive thought by covert conditioning which was elicited in thought dairy. He asked to raise his Index finger when he gets the intrusive thought, and this thought was distracted by therapist by using "Stop" as a word and he also reported that his thought was stopped immediately. He was asked to practice it by himself when he gets an intrusive thought.

He was also explained the amusement technique (Laughing at his own thought) and asked to practice it. He was asked to fix a particular time to practice these techniques with a order of first deliberately he has to get the thoughts which was disturbing him and then go for thought challenging and then laugh at his own thoughts. He was reported that he was succeeded with his continuous practices.

CASE NO-3:

Mr. "S" has moderate to severe level of depression for that he was provided supportive psychotherapy behavioural strategies and followed by cognitive techniques.

In initial individual sessions, he was expressed that still he need to clarify few questions regarding sexuality and he was provided the information based on his question.

The cognitive distortion was identified such as "Religiously what was happened with me was wrong and god should be punishing me". He was asked proofs for his believe in which he was failed. There after he was explained that his believes are maladaptive by providing suitable examples and also asked him to write some positive self statements as a home work such as "I have done nothing wrong, it is common for every individual in early adult hood". "It happens with all ".

Once again he was explained the process of reproduction semen and body functions. He taught that our body has ability to produce it again and again and the semen discharge has no harmful effects to human beings. Some examples were used to convince him such as "married men do sex every day but they don't become weak".

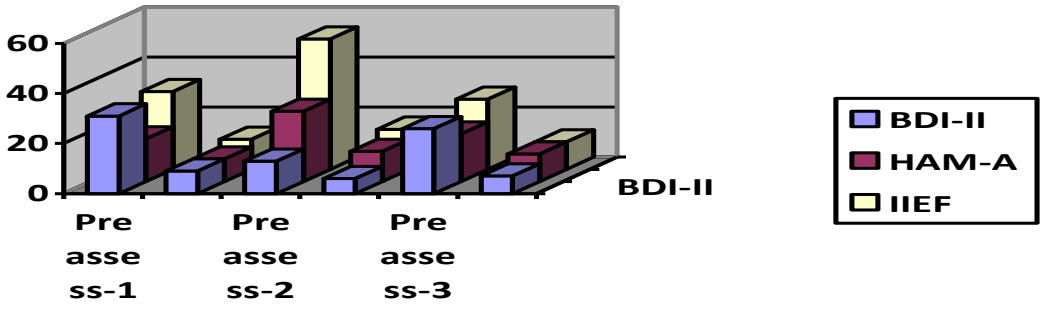
In the next session he reported that at times he was disturbing by his above mentioned maladaptive thoughts for that he was also explained the amusement technique (Laughing at his own thought) and asked to practice it. He was asked to fix a particular time to practice these techniques with a order of first deliberately he has to get the thoughts which was disturbing him and then go for thought challenging and then laugh at his own thoughts.

Terminal session: 17 to 18

The terminal sessions were taken in a group as they were familiar with each other. They have provided to discuss about their therapeutic experiences individually and their present conditions and during discussions others were asked to raise their questions. Therapist was maintained a passive role during these sessions and he used to interrupt only when it was necessary or for any clarification.

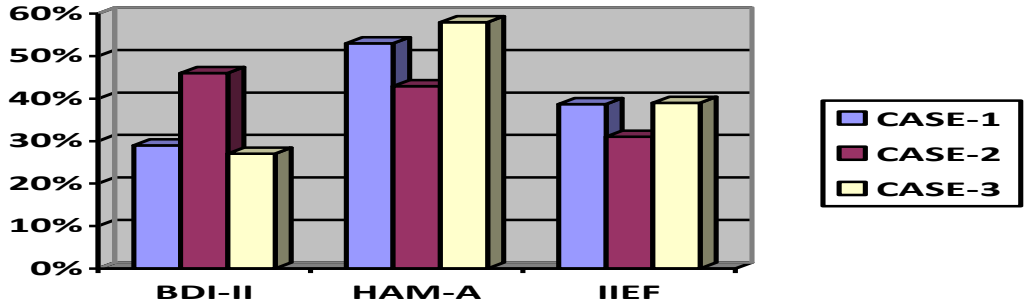
IV. RESULTS

Graph-1: Graphical representation of Pre and Post assessment scores of Case-1, Case-2 and Case-3.



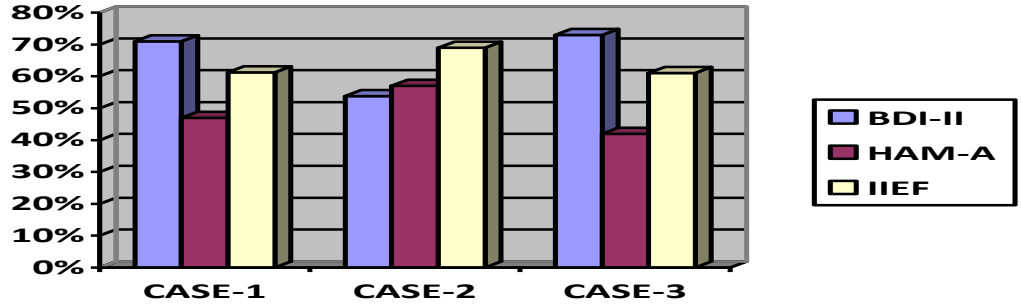
In CASE-1 pre assessment score of BDI-II was 31 and post assessment score was 9; on HAM-A pre assessment score was 17 and post assessment score was 9 and on IIEF pre assessment score was 31 and post assessment score was 12. In CASE-2 pre assessment score of BDI-II was 13 and post assessment score was 6; on HAM-A pre assessment score was 28 and post assessment score was 12 and on IIEF pre assessment score was 52 and post assessment score was 16. In CASE-3 pre assessment score of BDI-II was 26 and post assessment score was 7; on HAM-A pre assessment score was 19 and post assessment score was 11 and on IIEF pre assessment score was 28 and post assessment score was 11.

Graph-2: Graphical representation of reduction in scores of BDI-II, HAM-A and IIEF of Case-1, Case-2 and Case-3.



In CASE-1, his score on BDI-II was reduced to 29%, on HAM-A was reduced to 53%, on IIEF it was reduced to 38.7%. In CASE-2, his score on BDI-II was reduced to 46%, on HAM-A was reduced to 42.9%, on IIEF it was reduced to 31%. In CASE-3, his score on BDI-II was reduced to 27%, on HAM-A was reduced to 58%, on IIEF it was reduced to 39%.

Graph-3: Graphical representation of the improvement in Case-1, Case-2, and Case-3 in relation t BDI-II, HAM-A and IIEF.



In CASE-1 the post assessment score on BDI-II was 9 which shows that his condition was improved to 71%, for CASE-2 it was improved to 53.8% and for CASE-3 it was 73%. The overall decreased scores on BDI-II in all three cases reflect that CBT techniques were useful for the better improvement depression. In CASE-1 the post assessment score on HAM-A was 12 which shows that his condition was improved to 47%, for CASE-2 it was improved to 57% and for CASE-3 it was 42%. On HAM-A in all three cases there was significant reduction on the scores which showed the better improvement in the patient's anxiety level. In CASE-1 the post assessment score on IIEF was 12 which shows that his condition was improved to 61.2%, for CASE-2 it was improved to 69% and for CASE-3 it was 61%. On IIEF in all three cases there was significant reduction on the scores which showed that CBT techniques were very much useful to improve their condition in clients with erectile dysfunction. The overall findings in all three cases suggested that CBT techniques were very effective in clients with Dhat Syndrome related co-morbid conditions.

V. Discussion & Conclusion

Present study was an attempt to find out the efficacy of CBT in Dhat syndrome and co-morbid conditions. Finding reveals that it was an effective intervention technique in Dhat related neurotic disorders such as depression and anxiety and findings also supported that psychological intervention alone was effective in these types of cases.

Masturbation and nocturnal emission perceived as detrimental to mental and physical health in our society. Most of the individuals are depending on suggestions of friends or visits self claimed sex specialists and traditional faith healers. This type of health providers are spreading the misconception and these types of false beliefs and also compel the patients expensive for investigations and drugs which are not only non effective but also hazardous. During assessment process we also noticed that the misconceptions associated with biological or anatomical aspects of sex and sexuality are very difficult to be corrected with the help of pharmacotherapy or psychological counselling. Although, our patients are from different social, economical, cultural and educational background but they found almost same level of depression, anxiety and the erectile dysfunction and it was also revealed that CBT techniques were effective for clients with Dhat Syndrome. This study was concluded that CBT techniques are effective in clients with Dhat Syndrome with co-morbid conditions.

References

[1] Beck, A. T., Steer, R. A., & Brown, G. K., (1990) Beck Depression Inventory, 2nd Ed., The Psychological Corporation.

[2] Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. Archive of General Psychiatry, 4 (6):561–71.

[3] Bellak, M. D., (1993). The thematic apperception test, The children's apperception test and Senior apperception technique in clinical use 5th Ed./Rev. with the collaboration of Abraham Bhatia, M. S., Bohra, N., & Malik, S. C., (1989). 'Dhat' syndrome-a useful clinical entity. Indian Journal of Dermatology, 34(2):32-41.

[4] Borkovec, T. D., & Ruscio, A. M. (2001). Psychotherapy for generalized anxiety disorder. Journal of Clinical Psychiatry, 62:37–45.

[5] Chambless, D. L., Gillis, M. M. (1993). Cognitive therapy of anxiety disorders. Journal of Consulting Clinical Psychology, 1:248-60

[6] Chadda, R. K., & Ahuja, N., (1990). Dhat syndrome: A sex neurosis of the Indian subcontinent. British Journal of Psychiatry,15(6):577-579.

[7] Conte, H. R., (1994). Review of research in supportive psychotherapy: an update. American Journal of Psychotherapy, 48(4):494-504.

[8] Costa, P. T., McCrae, R. R. (1991). Neo-five- factor inventory (NEO-FFI), Psychological assessment resources, Inc. Florida Avenue. Lutz, FL33549. www.parinc.com.

[9] Dobson, K.S. (1989). A Meta-analysis of the efficacy of cognitive therapy for depression. Journal of Consulting Clinical Psychology, 57:414-9.

[10] Hamilton, M. (1959). The assessment of anxiety scales by rating. Journal of Medical Psychology, 32: 50-55.

[11] Millon, T., Millon, C., Davis, R., Grossman, S., (1994). Millon Clinical Multiaxial Inventory (MCMI-III), Pearson, Psychcorp. WWW.PsychoCorp.com.

[12] Mitchell, J., Richard, T., & Roland, M. A. (1993). Human figure drawing test (HFDT); Western Psychological Services, Los Angeles, California.

[13] Mohr, D. C., Beutler, L. E. (1990). Erectile dysfunction: A review of diagnostic and treatment procedures. Clinical Psychological Rev. 10:123–50

[14] Munjack, D. J., Schlaks, A., Sanchez, V. C., Usigli. R., Zulueta, A., Leonard, M. (1984). Rational emotive therapy in the treatment of erectile dysfunction: An initial study. Journal of Sex and Marital Therapy, 10:170–5.

[15] Overall, J. E., & Gorham, D.R., (1962). The brief psychiatric rating scale. Psychological Reports, 10; 799-812.

[16] Prakash, O., & Meena, K., (2008). Association between Dhat and loss of energy - a possible psychopathology and psychotherapy. Med Hypotheses, 70:898–9.

[17] Ranjith, G., & Mohan. R. (2006). Dhat syndrome as a functional somatic syndrome: Developing a sociosomatic model. Psychiatry, 69:142-50.

[18] Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick. J., Mishra, A., (1997). The international index of erectile function (IIEF): A multidimensional scale for assessment of erectile dysfunction. Urology; 49: 822–30.

[19] Sacks, J. M., & Levy, S. (1950). "The Sentence Completion Test." In Projective Psychology: Clinical Approaches to the Total Personality. Edited by Lawrence Edwin Abt and Leopold Bellak. 357-402, New York: Alfred A. Knopf, Inc.,. Pp. xvii, 485, xiv.

[20] Salam, K. P. A., Sharma, M. P., & Prakash, O. (2012). Development of cognitive-behavioral therapy intervention for patients with Dhat syndrome, Indian Journal of Psychiatry, 54(4):367-374.

[21] Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive behavioral and psycho dynamic-interpersonal psychotherapy. Journal of Consulting Clinical Psychology, 62:522-34.

[22] Singh, G. (1985). Dhat syndrome revisited. Indian Journal of Psychiatry, 11:119–122.

[23] Sinha, K. D., & Singh, Y. P. B. (2013). Dhat syndrome: A review of the world literature. Indian Journal 0f Psychological Medicine, 35: 4: 326-33.

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

[25] Ventura, M. A., Green, M. F., Shaner, A., Liberman, R. P. (1993). Training and quality assurance with the brief psychiatric rating scale: "The drift buster". .International Journal of Methods in Psychiatric Research, 3: 221-244.

[26] Wechsler, D. (1955). Wechsler Adult Performance Intelligence Scale; Manual of Indian adaptation of WAIS- Performance Scale by Prabha Ramalingaswamy, Manasayan, 32, Netaji Subhas Marg, Delhi-110006.

[27] World Health Organization. (1993). International Classification of Diseases and Related Health Problems (ICD-10). Geneva: World Health Organization.

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