Culture Bound Syndromes Reconsidered

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Culture Bound Syndromes[1] are mental disorders that are limited to particular cultural settings. At the heart of the complex discussions around CBSs is a tension between universals and particulars. At one end of the spectrum are those who argue that we already have, or could in principle generate, a psychiatric nosology that would account for all forms of mental and behavioral illness, for all people, at all times and places. At the other end are those who argue that the criteria for mental health and illness are historically and culturally emergent and variable, so that the dream of a universal psychiatric nosology cannot be achieved, and might even be regarded as repressive. If CBSs could be shown to exist, then they would powerfully bolster the latter argument.

The term "culture bound syndrome" was coined by the psychiatrist Pow Meng Yap, a British-trained psychiatrist who worked in Hong Kong and is perhaps best known as the editor of the classic textbook *Comparative psychiatry: a theoretical framework* (1974). Yap defined CBSs as "psychogenic reactions that are in fact non-volitional, elementary biopsychological reactions, sensitive to culturally specific stimuli, and moulded pathoplastically by distinct belief systems related to illness or disorder" (*ibid.* 74). The DSM IV Text Revision defined them as

> recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations (First & Pinkus 2002: 1998).

Here the authors are trying to make a subtilr and rather difficult distinction. On the one hand are cultural inflections of universal disease entities, on the other hand specific, localized, CBSs that cannot be easily mapped onto standard psychiatric nosology. The authors acknowledge that "the major DSM-IV" categories are culturally inflected, but CBSs point to something else: the possibility that some forms of mental illness or aberrant behavior might escape the net of conventional psychiatric nosology entirely. This raises a number of questions that go straight to the issues that divide psychiatrists and anthropologists. Do psychiatric nosological categories like psychosis, schizophrenia, borderline personality disorder etc. reflect universal forms of mental illness, or are they contingent historical constructs? Are they natural kinds, or purely theoretical entities?

Most psychiatrists espouse a position that we can label "naturalist" since (with a few interesting exceptions) its adherents tend to believe that mental disorders are forms of "brain disease" whose causes can ultimately be traced to biological or genetic factors. Psychosis, schizophrenia and the rest are thus "the same" diseases wherever they are found, even though they might be named, understood, and treated differently in different cultures. Many anthropologists tend by contrast to espouse a position that we can label "culturalism" since, for them, many if not most of the etiological categories of Psychiatry are particular products of "Western" (Euro-American) culture, and one should not assume that they are universal.

The nosological issues raised by the CBSs quickly ramify into the fields of etiology, epidemiology, and ultimately therapy. For example, the existence of CBS would lend weight to the hy-

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pothesis that some (many?) mental disorders are caused by particular cultural environments, or specific forms of life. In other words, their existence would be a powerful argument for the (at least partially) sociocultural etiology of mental illness.

The tension between universalist and particularist explanations in psychiatry is an old one (see KIRMAYER 2007). The stage was set by Kraepelin and Bleuler's foundational - thoroughly "naturalist" - studies of schizophrenia, which have powerfully shaped psychiatric nosology to the present day. Bleuler's classical study described "basic notions" of schizophrenia which "have not been improved on since," including "specific and illogical" association of ideas, speech that is "chaotic and difficult to understand," and disturbances in affect such that the schizophrenic "exhibits emotions inappropriate to the ideas he expresses." Other features include lack of adequate ego boundaries and inability to distinguish between the real and the unreal (WHITE & GILIALAND 1975, cited in KARP 1985). According to Kirmayer,

> The neo-Kraepelinians of DSM-III in 1980 introduced operationally defined discrete diagnostic categories in place of dimensional or narrative descriptions of psychiatric disorders (Wilson 1993). With this new nosology and the accompanying technology of highly structured diagnostic interviews, comparative psychiatry followed the rest of the discipline, abandoning in-depth ethnographically informed studies in favor of research organized around discrete diagnostic categories (2007: 7).

When faced with the alleged existence of a CBS, the naturalist tends to classify it in terms of the standard nosology, arguing that the disorder is indeed a token of a universal type, merely labeled and weighted differently. SUMATIPHALA *et al.* put this explicitly when they wrote that "clusters of illnesses across cultures have similar symptoms but are called by different names" (2004: 201). Yap himself came to think of CBSs as "culture-bound variations of universal clinical prototypes" rather than as independent disease entities (JILEK & JILEK 1985: 205). In their attempt to develop "an international classification of psychiatric disorders that will be more culture-free than either the current DSM-III or ICD-9," ultra-naturalists PRINCE and TCHENG-LAROCHE re-defined CBSs as

> a collection of signs and symptoms (excluding notions of cause) which is restricted to a limited number of cultures primarily by reason of certain of their psychosocial features. In this definition, notions of etiology and illness labels are excluded because these are highly variable and change over time. On the other hand, collections of signs and symptoms (*i. e.* syndromes), insofar as they are reasonably complete descriptions of nature, remain constant over time and are verifiable by all investigators . . . the meaning of illness, both for individuals and for cultures, is an important area of study in its own right but such meanings should not be confused with syndrome descriptions or used as criteria for an international disease classification (1987: 3).

Their strategy is to preserve the universality of psychiatric nosology by limiting the definition of the syndrome to "signs and symptoms," while ruling hermeneutical questions of meaning out of court. In this way, Prince and Tcheng-Laroche hope to develop and defend a nosology uncontaminated by history, culture, or meaning. For them, the CBS must describe an ontologically stable set of symptoms, rather than a culturally variable experience, even though this leaves unclarified the question where, exactly, those symptoms are located. In other words, they define the CBS as culturally motivated error. Less coherent is the assertion by SUMATIPHALA *et al.* that although, on the one hand, "cultures do influence psychopathology," still, "the individual's disorder can be and will be influenced by other factors such as personality traits, peer and family support available to the individual, and alternative explanations of the experience" (2004: 208). It is difficult to know what to make of this. Evidently, neither "alternative explanations of the experience" nor "peer and family support" belong to the realm of "culture," which seems to be conceptualized here as a set of ideas existing in the head of abstract "individuals": a thoroughly unacceptable definition at many levels. Confusion grows when they conclude that CBSs "transcend cultural boundaries, and such variations should be seen in the cultural context" – what in the world might this mean? In the end, they propose a teleological model: the classical CBS *dhat* syndrome (discussed below at length) is associated with pre-industrial societies and will disappear with the triumph of psychiatry.

Margaret LOCK has argued that such extreme

forms of naturalism are motivated by a "sterile drive towards universal order and control" (1987: 41). And in any case, conventional psychiatric diagnosis and epidemiology are, in the anthropologist's view, methodologically flawed. Although both disciplines rely on self-reporting of symptoms and experiences, patients' languages are not necessarily commensurable with psychiatric language (KINZIE & MANSON 1987), and in any case patients may for cultural reasons be reluctant to describe and discuss their internal states, a reluctance that itself is pathologized by psychiatry as "Alexithymia" (KIRMAYER 1987). Moreover, class and gender differences between therapist and patient might have distorting effects (see the numerous articles cited at LEE 1996: 26).

But such problems are nothing compared to the elephant in the room: namely, the culturalists' suspicion that psychiatric nosology does not accurately represent that which it claims to represent, *i. e.* that it has no scientific validity because its language and theories differ so radically from the language and theories of "patients" (even the category of "patient" is highly suspect) from non-European cultures. Cross-cultural psychiatric epidemiologists are exquisitely aware of the problem, and they regularly seek to improve the validity of their instruments by making their questionnaires ever longer, but even this may impose notions of time that are quite alien to those in non-Western countries who respond to the questionnaire. The International Pilot study for Schizophrenia was instrumental in "realizing" (solidifying, reifying) the term "schizophrenia" as a universally applicable category, but when one looks closely at how the study was conducted (*e. g.* KROLL 1988), the entire edifice begins to look very shaky. As KIRMAYER puts it, "the diagnostic categories of psychiatry bury the traces of their origins in European and American cultural history and become self-confirming 'culture-free' commodities ready for export" (2007: 8).

Good anthropologists pursue a very concrete methodology in their research and this methodology, called "participant observation," is radically different from the box-ticking questionnaires of standard psychiatric epidemiology. Anthropologists master a local language and spend years living with other people, participating in their activities and observing their lives in intimate and detailed ways, with the goal of internalizing how those "others" experience and understand the world. Those anthropologists who are interested in psychology and psychiatry pay special attention to how mental states are talked about and experienced, to the ways in which certain forms of behavior are characterized as pathological, and to how people respond to them. In contrast to the self-reporting questionnaires and laboratory experiments of the psychologists and psychiatrists, one can only characterize the methodology of the anthropologist as radically empirical; nevertheless, dedicated naturalists see nothing that they would dignify with the adjective "scientific," because such participant observation is not particularly good at producing numbers, which the naturalists confuse with "facts."

Some have claimed that the debate between naturalists and culturalists is over (*e. g.* PATEL 2010: 1), but such rhetoric is misleading. Its continuing relevance is illustrated by the controversy regarding DSM-V. Shortly before it was published, Thomas Insel, head of the US National Institute for Mental Health (the primary funder of research in the field) repudiated it, justifying his actions with the argument that that the DSM concerned itself only with symptoms, whereas he was interested "causation," *i. e.* neuropsychiatry.[2] Meanwhile the Association of Clinical Psychologists of the UK rejected DSM V on quite the opposite grounds; namely, that it had too much neuropsychology and not enough social causation. In short, the community of psychiatrists and psychologists is not even close to agreement about the etiology of mental disorders.

Ultimately, the opposition between extreme forms of naturalism and culturalism has stymied useful discussions of psychiatric nosology in general, and CBSs in particular. A good example is the debate between Simons and Kenny regarding Latah, a "classical" CBS in which the affected person screams, curses, dances, laughs uncontrollably, and often mimics the words or actions of those around him or her. GUARNACCIA & ROGLER summarize the debate nicely, proposing a kind of compromise:

> Simons privileged psychobiological explanation; Kenny privileged cultural meaning. Simons disaggregated latah into its symptoms, de-emphasized the sociocultural context, privileged the

> startle reflex as the predominant symptom, and then diminished the identity of latah as a culturally specific category. Kenny, in contrast, so focused on the cultural uniqueness of the latah experience that comparisons with other frames of explanation are difficult. Both writers are skilled at argument, and since there are no external decision-making rules, it is difficult to resolve the issue within their own terms. We believe a more integrative research approach would see the cultural configuration of latah as building on the biology of the startle reflex within its sociocultural context, the purpose being to understand why older women in Malaysia are particularly at risk and how culture leads to the elaboration of this reflex into a cultural syndrome (1999: 1323).

Hahn also emphasizes that anthropology can complement neuroscience, and that

> full explanation requires an opening of the inner sanctum of Biomedicine to anthropological review and a concomitant recognition of pervasive physiological constraint in the workings of culture. Humans are bound by their cultures, but not rigidly. Culture is not the only binding principle; body, mind, society and the broader environment also bind. An exploration of culture-bound syndromes thus reaches the range of human disciplinary approaches and the variety of forms of suffering (1985: 165).

Debates around CBS have become tiresome. They return over and over to the same polarities: universals *vs.* particulars, biology *vs.* society; in short, nature *vs.* culture. But even without reading Latour, the best scientists on both sides of the debate know that in our attempts to understand the human mind, "nature" and "culture" cannot be so easily separated, and that mental health and illness involve a mix of biological and social causation.

Recent research has shown that our experiences leave physical (neurological) traces in our brains: why should this surprise anyone? After all, we are embodied beings. But a correlation is not a cause, and a neurological change has no inherent meaning. As Lock puts it, a

> paradox arises: without interpretation there can be no research, no attempts at explanation, and no therapy. In biomedicine all of these activities are believed to rest upon scientific control achieved by the decontextualization of the basic units of analysis, the symptoms and signs. But decontextualized signs carry no meaning and cannot be interpreted (1987: 38).

The rejection of CBSs

I have suggested some of the reasons why CBSs ought to be important and indeed attractive to those interested in theorizing the social and cultural causes of mental disorders. I have also summarized some of the contributions to the literature on CBSs by those who wish to define them in such as way as to preserve the universality of psychiatric nosology. But what is most prominent in this discussion is the thoroughgoing rejection of the concept, for example in the DSM-V, which still relegates anomalous CBSs to an appendix, but renames them as "Cultural Concepts of Distress." Indeed, all three words in the term "Culture Bound Syndrome" have been rejected by authors from all sides of the debate: "culture" is rejected by its erstwhile champions, the anthropologists; "bound" is rejected by nearly everyone, because so many ostensible CBSs can be found outside the cultures to which they putatively belong; and "syndrome" is rejected, either because the symptoms are not indigenously classified as a "disease," or because ostensible CBSs can often be more accurately understood as something other than illnesses. Let us take these objections one at a time.

The notion of "culture" has been widely rejected by anthropologists even though they were, for many decades, its most vociferous advocates. Use of the culture concept is often said to be a form of "othering," where putative differences are emphasized in order to create a hierarchical distinction between self and other, which then serves as a form of power. CBSs are said to amount in many cases to little more than lists of exotic oddities, "cabinets of curiosities" for curious Orientalists. Although sympathetic to the idea of CBSs, Kleinman observed that in practice, they were "defined in terms of the degree to which they [struck] observers as odd or incomprehensible" (in Karp 1985: 223), and this observation was strongly confirmed by Bathia & Malik (1991).

Certainly it is true that anthropology and cultural psychiatry run the risk of exoticization, which for ethical as well as intellectual reasons should be carefully avoided. Nevertheless, such comparative disciplines are epistemologically de-

pendent precisely upon difference or "otherness," since it provides them with their data as well as their questions, and indeed it determines (at least in part) their methods. For a scholar interested in cultural comparison to be embarrassed by difference is like a biologist being embarrassed by organic matter. The solution is not to ignore it, but rather to open one's eyes and see the "difference within." In the case of CBSs, this means to recognize the CBSs within "western culture," and that is one reason why I have provided a list of them below. But in any case, and despite all the familiar problems with the term "culture," it appears to be a concept that we cannot do without. For the notion of the culture-bound syndrome, it boils down to the idea that particular ways of socializing children, incorporating values, learning (largely through mimesis) how to inhabit a gendered body, along with a hundred other inter-dependent processes, generate particular ideas regarding mental health and disease, and categories for naming mental disorders. That, to me, is what the idea of the CBS is all about.

Anthropologists used to think of "cultures" as monolithic, well-defined units. But cultures have no clear boundaries: ideas and practices move between and among them with such regularity and speed that the very idea of autonomous "cultures" has come to seem absurd. This is true of CBSs as well. LEE for example has shown (1996) how anorexia nervosa, usually regarded as a paradigmatically "western" CBS, spread through multiple cultural milieus, mostly by means of popular media. She points out the problems of attributing the disorder to single causes (*e. g.* "fat phobia") when in fact the causes are usually much more complex. She shows how key concepts changed over time (*e. g.* "fatness" was sometimes been valued, in Europe as well as in Asia). Tellingly, she relates the case of an Ethiopian woman who, after experiencing torture, was hospitalized with other women and appropriated their symptoms and attitudes. Likewise in their discussion of *koro*, another "classical" CBS in which people are overpowered by the fear that their sex organs are retracting and will disappear, JILEK & JILEK-AALL (1985) list a number of cases where *koro*-like phenomena are found outside of the culture with which it is traditionally associated (China). They argue that a political context of intense inter-ethnic strife played a decisive role in the dramatic outbreaks that they documented in Singapore, Thailand and India. In a similar vein, KARP (1985) argues that several "classical" CBSs are best regarded not as pathological "syndromes," but rather as rule-bound, conventionalized, performative commentaries; forms of "theater" dramatizing relations between self and society. The same can be said of another classic CBS, "arctic hysteria," which was shown by KIRMAYER (2007) to be a form of protest against colonial exploitation and sexual abuse rather than a pathological "syndrome."If we filter out those forms of behavior labeled "CBSs" solely on account of their "otherness," if we acknowledge that similar (perhaps sometimes even identical) CBSs are found in many cultures, and if we recognize the difference between pathology and protest, then we will drastically reduce the number of CBSs. But this does not mean that we should reject the concept altogether. Moreover if, after all these revisions, we can still identify CBSs, defined as forms of "mental suffering" that do not fit in conventional psychiatric nosologies, are found in a limited number of sociocultural environments, are locally recognized and/or named, and for which indigenous theories and therapies exist, then we will have taken an important step toward clarifying the relationship between "culture" and mental illness. That is precisely what I intend to do now, by focusing on another "classical" CBS, the so-called *dhat* syndrome.

Dhat Syndrome

Jadhav (2004) provides a useful summary of the literature on *dhat* syndrome, with is pervasively reported in South Asia: prevalence rates of 11.7 % in India to 30% in Pakistan are reported. Common symptoms include weakness, fatigue, palpitations and sleeplessness.

Most significantly, patients attribute these symptoms to a white discharge in their urine (which they claim is a "vital substance"-semen). Losing such a vital substance thus generates anxiety and dysphoria. The condition has no known organic aetiology. Medical literature commonly refers to *dhāt* as a sex neurosis of the Indian subcontinent that is widely regarded as a culture-bound syndrome, and it continues to be extensively reported despite a prediction that the syndrome

will "become less common with increasing literacy and progress in sex knowledge."

According to classical Ayurvedic theory, semen is the most precious and refined substance in the body, whose loss is believed to result in catastrophic consequences (EL HAMAD, SCARCELLA & PEZZOLI 2009). *Dhat* Syndrome has to do with the belief that semen is escaping from the body—be it through sexual intercourse, masturbation, nocturnal emissions, or simply in the flow of urine—and that this semen loss results in mental and physical weakness and listlessness, along with a host of related health problems. It is said by Indian psychiatrists to be most common in sexually inexperienced young males and is associated with premature ejaculation, weakness and other physical problems. In an outpatient clinic in India, it was the most frequently observed of the CBSs, with a figure of 76.7 % (BHATIA 1999). Research in India and Sri Lanka suggests that loss of semen is most commonly perceived to occur via urine during sleep, and is commonly associated with masturbation and excessive heterosexual intercourse. The commonly reported symptoms are anxiety about sexual performance and depression, and difficulty with marital relationships.

Like most of the other "classical" CBSs, the *dhat* syndrome is controversial, and some have called its very existence into question. One of the "pregnant" critiques is by SUSHRUT JADHAV (2004), cited above. In the same essay, he writes that (a) "*dhat* is an imprecise and misleading term" that is (b) based on a "false theoretical premise based on exoticizing 'other' cultures;" and that (c) "concerns about semen regulation are equally pervasive in Euro-American societies." Let us take up these points one at a time.

First, Jadhav claims that "*dhat* is an imprecise and misleading term." What he seems to mean is that *dhat* does not correspond to the word for "sperm" or "semen" in Ayurvedic texts. This however is a minor point, whereas to me it seems crystal clear that there is in South Asia a coherent set of beliefs, practices, and symptoms relating to semen loss and the weakness believed to result from it. The sheer number and wide provenance of examples here is overwhelming: similar disorders have been named and analyzed by the classical Ayurvedic writers Sushruta and Charaka. Stories from Hindu mythology support the associated ideas as well (*e. g.* GOLDMAN 1978). As JOSEPH ALTER has exhaustively shown (1992, 2011), the writings of Gandhi and the practices of Indian wrestlers and bodybuilders are thoroughly consistent with the belief that male strength and vitality depends on a rich and healthy supply of semen; and that this supply is threatened by nocturnal emissions, by simple outflow through the urine, and by sexual activity whether heterosexual, homosexual, or onanistic. According to Sumatipala *et al.*, anxieties regarding semen loss are not confined to India, having been reported from Sri Lanka and other parts of the subcontinent as well. Fear of semen loss and resulting problems is so strong that cures are advertised by *vaids* and *hakims* everywhere—on walls, on television, in newspapers and on roadside hoardings.

In brief, we clearly have a theory of the relationship between semen and male health that is echoed in classical medicine, religion, politics of the Gandhian as well as the Hindu Nationalist sort, and a variety of cultural practices such as wrestling. But why refer to these concerns as a "syndrome"? Is what we call "*dhat* syndrome" not just a particular understanding of sexuality, of living in a male body? Is it not ethnocentric to medicalise and pathologise it, simply because it is exotic and unfamiliar? Such doubts are clearly implied by the second of Jadhav's criticisms, which we should take very seriously indeed. There is little doubt that the original descriptions of many of the "classical" CBSs are associated with racist language and pseudo-evolutionary thinking, along with the "exoticizing" or "othering" of culturally distinctive ways of being. Indeed, the definition in DSM-IV is followed by a list of classical CBSs that remind me of nothing so much as the cabinet of Dr. Caligari. This is what led SUMATIPALA et al to argue that the very term CBS is "a relic of an imperialist Eurocentric heritage" (2004:208), and KIRMAYER (2007: 13) to argue that racist and chauvinistic attitudes lie behind the "discovery" and naming several classical CBSs, some of which are still found in the canonical list. Today, the racist, colonialist, and broadly "social evolutionist" assumptions of some early discussions of CBSs seem indefensible to us. They are exemplified in the words of MALHOTRA and WIG's seminal study:

> It seems that the Oriental culture condemns all

> types of orgasms because they involve semen loss (Wise 1840, Carstairs 1961, Koestler 1961). In comparison the Judeo-Christian cultures of the eighteenth and nineteenth centuries in Europe considered most types of sexual activities outside marriage as sinful.
>
> The susceptible Oriental individual reacts to the belief system of semen loss. He seeks medical intervention for the symptom complex of the Dhat syndrome. We have demonstrated that lower socioeconomic background and illiteracy are contributing factors in the concept of semen loss. We expect that, with increasing literacy, progress in sex research will influence the Oriental culture and result in a reduced incidence of Dhat syndrome (1975: 527).

As recently as 1988 an Indian psychiatrist could write, evidently without irony, that CBSs are defined as such precisely because they are not found in the West.[3] In my view, the problem lies in taking heterosexual, white, middle-class, North Atlantic ways of inhabiting a male body as the norm, and pathologizing other ways that deviate from it. This is the psychiatrists' version of the idea that "everyone has an accent except me." An obvious solution to this problem is to recognize that Europeans and Americans, too, have their CBSs, and this is precisely what Hacking (1998) did in his book on fugue, the "mad travellers' disease." Hughes, too, provides a list of conditions that have been analyzed as "Western" CBSs: "obesity (and its contraries, anorexia nervosa and bulimia), adolescent turmoil and rebellion, premenstrual tension syndrome (PMS), chronic fatigue syndrome, multiple personality disorder" and others (1998: 419). We can add hysteria with its well-documented changes over time (Atwell 2007), and also the "Type A Behaviour Pattern" in its relation to heart disease, so brilliantly analysed by Helman (1987). Hughes points out that in the task force for DSM IV included western CBSs in a list at the end of the book, but that the editors deleted it (1998: 415). But to return to Jadhav's critique: it became clear during my research that large numbers of young Indian men suffered in ways there were more or less precisely equivalent to what is meant by the term "*dhat* syndrome." To deny their suffering by claiming that it is an orientalist construction strikes me as indefensible.

A third critique has to do with the idea of a syndrome being "culture bound"—that is, being limited to a particular culture. Jadhav assembles quite a bit of evidence showing that in many cultures, semen is thought of as a vital body fluid, that its loss is a waste of the vital male essence, and indeed that "[a]lmost every conceivable form of physical and mental illness was once attributed to seminal loss, mainly by masturbation" (280). He goes on to report that *The Lancet*

> carried an editorial in 1840 on the physical debility, mental impairment and moral degradation caused by seminal loss. Physicians believed that virtuous young men absorbed the spermatic fluid which enriched the blood and vita used the brain. Thus, there was consensual validation between the patient's and the doctor's view of such problems, quite like the one now between the traditional village healer and the native Indian. (*ibid.*)

Many authors have persuasively shown that the idea that loss of semen results in health problems is found in many cultures, especially the English-speaking world during the Victorian period. Whole generations of boys and young men were educated about the evils of masturbation in the school, in the church, and at home, and this was regarded as both a moral problem and a medical one. In short, "concerns about semen regulation are equally pervasive in Euro-American societies" and "distress over semen loss or retention is neither specific nor unique to South Asia" (Jadhav 2004: 2). But although it seems true that forms of mental distress very similar to *dhat* syndrome existed or previously existed at other times and places, this is no reason to question its existence in contemporary South Asia.

The Ethnographic Evidence

In 2009 and 2010 I conducted research on sellers of herbal medicine on the streets of Kolkata and Delhi, and in the rural backwaters of U. P.: Muslim doctors, performers hawking various medicines on the street, nomadic purveyors of Ayurvedic medicine, and slum-dwelling tribal women who surreptitiously sold medicines on the sidewalk. Many of these medicines were meant to improve the quantity and quality of male semen. I interviewed dozens of these "footpath pharmacists," recorded their sales pitches, and observed their interactions with customers, and it didn't take me

long to discover that this entire complex more or less perfectly matched the *dhat* syndrome.

Much of my research focused on so-called "Majmawallas," streetside purveyors of medicine in Kolkata and Delhi. All of them were Muslims, called themselves "Hakims" and claimed to derive much of their knowledge from Yunani medicine, which has come to be strongly associated with Islam although it is originally Greek ("Ionian" >> "Yunani"). Their biggest seller were medications for male sexual problems: erectile dysfunction, premature ejaculation, and semen loss, and when they mentioned semen loss and the problems associated with it, I often heard the young men in the audience whispering to each other, "*dhat*! It's *dhat*!"

Three points are important here: first, that the classical *dhat* syndrome very much informs the standard routines of the Majmawalas; second, that they have a specific and consistent theory of semen; and third, that the young men who stop, listen to them, and purchase their medicines are concerned mostly with potency and erectile issues, and secondarily with semen loss (*dhat*). Here are some brief excerpts from the routine of one man in Kolkata who accompanied his routine with photographs and anatomical charts. He spoke Hindi, since the laborers who made up the majority of his public were Hindi-speakers.

> An uneducated man gets sick, and he starts taking medicine to thicken his *dhaat*…Semen, *dhaat*, is the king of the body. But if it begins to leak out (*nikalnaa*), well, this can be stopped within 3-7 days—how? It can be stopped by taking a medical injection called "penediol." If you take this injection, then within seven days you will be "corked" (*korak lag jaegaa*).
>
> But this won't cure the root (*jaD*) of the sickness. And this root is mostly to be found in young people. I have a special kind of grass; it is called *tiinto* grass. Bring thirty grams of it. Look! I have kept it here in my box. If you go to the big bazaar you will find it. And here are thirty grams of *bar gaach*. It's the grass seed. I have put it in the water—look![4] Do you know what kind of grass this is? If you even touch it, it will coagulate (*murjhaa jaaegaa*). Look, it's Lajjavati—that fellow walking by on the street recognized it![5] It saves a man's honor[6]—listen! If these three things go into a man's body, then—watch carefully!—then a man's *dhaat*, a man's *biij*,[7] a man's semen, will be braked, it will be stopped—just like this [he points to the coagulated mixture].
>
> Listen Babu-ji—you had a dirty thought, and you ruined your clothes. You went to a woman, you joked around, you touched each other, you were affectionate with one another (*pyaar mohabbat kaa baat kiyaa*). Case dismissed! (*mukadma pes decree khatam*!). For such a man, I say, "Get these three things and eat them!"
>
> And I tell him to stop eating raw mangoes for one month. Stop eating them completely, and your semen will stop leaking. Look, you do something and it just oozes (*laafaa laafa*a) out like the water from an egg, like egg white (*diim*). But if you eat this regularly for 45 days, then it will increase (the quantity of the semen) in your body and make it *just like butter*![8]

This Majmawalla went on to articulate a rather complex theory of semen and how to keep it thick and plentiful. Here is another excerpt from a different Majmawalla, Hajji Muhammad from Delhi, who was notable for his interactions with the crowd of onlookers.

> Hajji Muhammad: A well-built man with long mustaches sat one day to urinate. Before and after the piss, a gluey, thick white liquid would come out. What do we call it? dhaat, sapandosh, manii, BDA, *nightfall*. While sleeping the clothes become messy. Can that guy go to a temple, a gurudwara, or a mosque in the morning?
>
> Crowd: "No!"
>
> Hajji Muhammad: Now let me tell you what are the symptoms of a dhaat patient, if there is a biology student here he can challenge if I am wrong! The symptoms: His palms will always be warm and he will feel hotness in the feet. Second, when he sits and stands up he feels pain in the lower back, calf muscles, in the head. He can't sleep well and feels thirsty all the time. Also, if he squats for a long time he will feel darkness in front of the eyes when he gets up. One more thing: if a man has a dhaat problem then don't let him get married!
>
> Crowd: "Why!"
>
> Hajji Muhammad: Why? Because if the girl is from a good family then she will still accommodate but if she is not virtuous then she will kick him in the ass and run away! Even if she stays back, then she will definitely get involved with the neighbors. Right or wrong?
>
> Crowd: "Right!"
>
> You might have hundreds of thousands of ru-

> pees, take your wife for a ride in an airplane, take her to dinner in Pakistan, make golden jewelry, make diamond jewelry for her, but if you do not satisfy her desire (kvaish puurii nahiim karii to) then the revered woman (aurat shariif) will get her pleasure from servants or drivers. Right or wrong?
> Crowd: "Right!"

Another Majmawala distinguished between various male sexual fluids:

> There is "manii," "majj" and "maddii." "Majji" comes out first in a glue type (chaip) form. It lubricates the nerves of the penis (chiknahat ho jaati hai nali mein). This helps in easy discharge of manii (semen), which is thick (gaadhi), from the penis (nali). The last discharge is maddii, which clears the remnants of manii (semen) in the penis tube (nali). It is important that all three come out.

According to the Majmawala, all of these fluids were "natural" and their presence indicated sexual health. But when *dhat* was discharged with urine it indicated poor health, stemming from improper behavior.

I also conducted research on "traditional ayurvedic pharmacists" (*paaramparik aayurvaidik davaakhaanaawaalaas*), urban nomads speaking a Gujarati dialect, whose tents are a familiar sight throughout northern South Asia, from Pakistan to Bangladesh. Their most popular medicines are for counteracting *dhat* or semen loss, and erectile dysfunction. One of their leaders, a man named Bishambar, told me that *dhat* was caused by heat in the urinary tract, which was in turn caused by excessive sexual activity. He claimed that his medicines would replenish this lost seem, leading to an increase in vigor and strength.

Thus it became clear to me that *dhat* syndrome is alive and well in India, and that it corresponds to my definition of a CBS: it is a form of "mental suffering" that does not fit in conventional psychiatric nosologies, is found in a limited number of sociocultural environments, is locally recognized and/or named, and for which indigenous theories and therapies exist. Others would agree, for example BHATIA & MALIK (1991) who, despite their vehement criticism of how CBSs often served to "otherize" non-Europeans, agree that *dhat* syndrome is prevalent in India.[9]

Conclusion

In order to understand human health and illness, we must consider human beings in all their complexity: not only their material bodies but their intellectual, social, and spiritual aspects as well. That is why it is so deeply mistaken to "explain" mental illness as the naturalists do, in purely organic terms, as a kind of brain disease. Even if one were to agree (and I do not!) that many or most mental disorders were organically caused, still in order to understand their significance and choose the most appropriate response to them, one would necessarily have to see the suffering patient as a complex being, enmeshed in many different relationships, many or most of which are implicated in disorder. One would have to supplement the naturalist approach with the culturalist one. A mental "disease" does not exist outside its social context: it makes itself known in the first place in terms of unusual behavior or symptoms, it is classified in terms of some local etiology and nosology (perhaps even psychiatry), it is treated according to local methods (again, these might include psychiatry), and according to the success or failure of the treatment, the symptoms may be mitigated and the suffering person reintegrated into society. Or not. These acts of diagnosis, classification, and treatment are not mere responses to an external material or biological reality: they are historically and culturally conditioned human ways of making a world. In this sense, all syndromes are "culture-bound."

Notes

1 Compare KROLL's (1988) distinction between "lumpers" and "splitters."

2 Insel's research on communication and social attachment amongst rodents and later, primates, had qualified him for this post. Before resigning to work for Google.com, he slashed funding for research into the social causes of mental illness, in order to focus on neuropsychiatry.

3 AKHTAR 1988. This is a particularly ludicrous example of the genre; he mentions "bhang psychosis" and "keemam [he means kimaam] dependence," even though he evidently doesn't know what it is. Possession is pathologized immediately and without justification. Possession syndrome is associated predominantly with women, and lower classes. Most thorough source is SUMATHIPHALA *et al.*, though the logic is often tortured.

4. Later during my research, I watched as the same substances were mixed in more or less the same way, 1500 kilometers away, in Delhi.
5. When the majmawala asked if anyone in his audience knew what the grass was called, a man walking past on the other side of the street had called out "Lajjavati!"
6. The term *lajjaa* means "honor."
7. literally "seed."
8. Indian butter tends to be quite firm, like refrigerated butter in Europe and America.
9. Compare LOCK's fascinating (1987) discussion of *taijin kyofusho*, regarded by Japanese psychiatrists as a fully-fledged and often-diagnosed CBS.

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