ORIGINAL ARTICLE
pISSN 0976 3325 | eISSN 2229 6816
Open Access Article
www.njcmindia.org

Dhat Syndrome: Delay in Seeking Psychiatric Help, Cultural Myths and Co-Morbid Depression

Shakeel M Ansari[1], Shakila Mulla[2]

Financial Support: None declared
Conflict of Interest: None declared
Copy Right: The Journal retains the copyrights of this article. However, reproduction of this article in the part or total in any form is permissible with due acknowledgement of the source.

How to cite this article:
Ansari SM, Mulla S. Dhat Syndrome: Delay in Seeking Psychiatric Help, Cultural Myths and Co-Morbid Depression. Natl J Community Med 2017; 8(7):416-420.

Author's Affiliation:
[1]Assistant Professor, Dept of Psychiatry; [2]Associate Professor, Dept of Community Medicine, Jhalawar Medical College, Jhalawar

Correspondence
Dr. Shakila Mulla
shakil_77@rediffmail.com

Date of Submission: 20-06-17
Date of Acceptance: 28-07-17
Date of Publication: 31-07-17

ABSTRACT

Introduction: Dhat syndrome is widely reported in India. Existing myths exaggerate this problem. Hence current study was conducted to assess role of myths in the course of dhat syndrome. Delay in seeking psychiatric help was also assessed and its association with co-morbid depression was analysed.

Material and method: Analytical cross-sectional study was carried out on 100 dhat syndrome cases visiting Psychiatry OPD in a tertiary care centre. Study tools included Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Hamilton Depression Rating Scale and Questionnaire regarding 'myths and misconceptions about sex'.

Results: The mean age of Dhat syndrome cases was 23.35 years. Mean observed delay in seeking psychiatric help was 8.06 months. 98% had previous consultations prior visiting a psychiatrist. Significant delay was observed in cases who previously visited quacks or Indigenous medical practitioners. These previous consultations reinforced various myths among cases. Prevalence of depression in dhat syndrome was 43%. Delay in seeking psychiatric help was significantly associated with depression.

Conclusion: Non-psychiatric consultations escalate myths related to dhat syndrome and contribute to delay in seeking psychiatric help. This delay needs to be curtailed by community awareness, as it worsens the outcome in the form of co-morbid depression.

Key words: Dhat syndrome, Delay in Psychiatric help, Co-morbid depression, Cultural myths

INTRODUCTION

Dhat syndrome, a culture bound syndrome (CBS) has been found to be prevalent in different regions of the world.[1] It is seen in Indian subcontinent, but it is prevalent in other cultures also.[2] In India, common CBS is Dhat Syndrome.[3]

Research has yielded estimates of dhat syndrome prevalence to be 64% in men attending psychiatric clinics in India.[4] It is characterized by complaints of loss of semen.[5] Reported associated symptoms are weakness, anxiety, sadness of mood and guilt feeling.[6, 7, 8]

Delay in seeking psychiatric help in dhat syndrome is least studied aspect. Hence current study was conducted keeping objectives to find out extent of delay in psychiatric help, various myths and co-morbid depression.

MATERIAL AND METHODS

It is an Analytical Cross-sectional study carried out at a tertiary care Government teaching hospital situated at District Jhalawar in southern Rajasthan. Study subjects were cases of Dhat syndrome visiting psychiatry OPD. Patient profile in the study area was mixed, covering both rural and urban populations. Inclusion criteria for the study was age group of 18-65 years cases diagnosed by qualified psychiatrist as per DSM V (Diagnostic and Sta-

tistical Manual of Mental Disorders, Fifth Edition)[4]. Cases with medical and/or surgical illness and those who were not willing to participate were excluded from this study.

Sample size was calculated based on the prevalence of depression in dhat syndrome[7]. According to the formula[9], sample size worked out as 96.04. It was rounded up to 100. Written informed consent was taken from each patient. Ethical approval was obtained from the Institutional Ethics Committee. Study period was February and March 2017; the period required to include desired sample size. With the help of predesigned, pretested proforma, preliminary data regarding socio-demographic profile were noted. Details of clinical examination were entered in clinical datasheet. Patients were diagnosed as per DSM-V criteria for comorbid depression and severity of depression was assessed using Hamilton Depression Rating Scale (HAMD-17)[10]. Separate Questionnaire regarding 'myths and misconceptions about sex' was developed to know various myths among patients.

Statistical Analysis: Data were entered in Microsoft excel sheet and were analyzed using the Statistical Package for Social Sciences, version 20 (SPSS V20.0). For quantitative data, mean, standard deviation, and standard error were calculated. ANOVA test was applied to find out impact level of previous consultations on continuous dependent variable i.e. Delay in psychiatric help. To these results, further a Post Hoc (Tukey) test was applied for multiple comparisons. Student *t* test was performed to find out association between delay in psychiatric help and presence of co-morbid depression. For qualitative data, percentages were calculated. A p value of <0.05 is deemed significant, <0.01 as highly significant and <0.0001 as very highly significant.

RESULTS

One of the striking finding in this study was that prevalence of Dhat syndrome in study area was observed to be quite high as it required only two months to recruit the sample size of 100. Socio-demographic distribution of the study sample is shown in Table 1.

The mean age of Dhat syndrome cases was 23.35 years with Standard deviation of 7.17. Major complaints presented by Dhat syndrome cases were semen discharge (100%), weakness (100%), anxiety (81%), anorexia (73%), constipation (53%), guilt (51%), low mood (49%), burning micturition (38%), palpitation (35%) and blackout (27%).

Majority of them (94%) gained knowledge of sex from friends, relatives or raw literature. Duration of the current illness was recorded to assess delay in psychiatric help. This delay in psychiatric help ranged from 2 months to 36 months with mean delay 8.06 months and standard deviation 6.25.

Table 1: Socio-demographic details of Dhat syndrome cases

Variable	Distribution
Religion	
Hindu	66
Muslim	29
Christian	2
Other (Sikh and Jain)	3
Education	
Illiterate	5
Primary	8
Secondary	23
Higher Secondary	42
Graduation	20
Post Graduation	2
Occupation	
Unemployed including students	41
Daily wage earner	13
Self employed	26
Government service	9
Private service	11
Region	
Rural	62
Urban	38
Socio-Economic Class*	
Upper class	3
Upper middle class	7
Middle class	15
Lower middle class	46
Lower class	29
Marital Status	
Married	30
Un-married	45
Separated	21
Divorced and Widower	4
Type of Family	
Nuclear	21
Nuclear Extended	32
Joint	47

*as per Revised Modified BG Prasad scale 2016

Table 2: Analysis of Variance showing impact of previous consultations on delay in psychiatric help

Previous Consultation	N	Delay (Mean±SD)	'p' Value
Friend	22	6.86±2.800	0.001*
Relative/ Elderly	12	4.25±1.357	
Quack	21	12.19±7.639	
Allopathic practitioner	11	4.64±1.027	
Indigenous medical practitioners†	22	10.23±7.483	
Paramedical staff‡	10	6.50±7.230	
No previous consultation	2	3.50±0.707	
Total	100	8.06±6.254	

* Highly Significant, † Ayurvedic, Homeopathic or Unani Doctors; ‡Including Nurse and Pharmacist

Table 3: Post Hoc (Tukey) Test for multiple comparisons between two groups of previous consultation

(I) Previous consultation	(J) Previous consultation	Mean Difference (I-J)	Standard Error	p value
Friend	Relative/Elderly	2.614	2.041	0.859
	Quack	-5.327*	1.735	0.043*
	Allopathic practitioner	2.227	2.101	0.938
	Indigenous medical practitioner	-3.364	1.715	0.446
	Paramedical staff	0.364	2.170	1.000
	No previous consultation	3.364	4.201	0.984
Relative/Elderly	Quack	-7.940*	2.059	0.004*
	Allopathic practitioner	-0.386	2.375	1.000
	Indigenous medical practitioner	-5.977	2.041	0.063
	Paramedical staff	-2.250	2.436	0.968
	No previous consultation	0.750	4.345	1.000
Quack	Allopathic practitioner	7.554*	2.117	0.010*
	Indigenous medical practitioner	1.963	1.735	0.917
	Paramedical staff	5.690	2.186	0.137
	No previous consultation	8.690	4.210	0.382
Allopathic practitioner	Indigenous medical practitioner	-5.591	2.101	0.120
	Paramedical staff	-1.864	2.486	0.989
	No previous consultation	1.136	4.373	1.000
Indigenous medical practitioner	Paramedical staff	3.727	2.170	0.606
	No previous consultation	6.727	4.201	0.682
Paramedical staff	No previous consultation	3.000	4.406	0.993

*The mean difference is significant at the 0.05 level.

Table 4: Various myths among patients pertaining to Dhat syndrome and Reasons for semen loss

Myth	Prevalence(%)	Source of Myth
Semen		
Vital fluid for health	98	Quacks, Relatives, Friends
Many blood drops make one drop of semen	45	Indigenous doctors, Quacks, Relatives, Friends
Semen loss due to Nightfall	86	Indigenous doctors, Quacks, Friends
Sexual Activity		
Excessive indulgence in sex	12	Elderly/ Relatives, Friends
Multiple sex partners	9	Quacks, Elderly/ Relatives, Friends
Masturbation	93	Quacks, Friends, Indigenous doctors
Slight trauma during sex	5	Quacks, Friends
Sex Organs		
Bending of Penis	7	Friends
Length of Penis	87	Quacks, Friends
Weakness of 'nerves'	78	Quacks, Friends, Indigenous and Allopathic doctors
Body structure		
Lean and thin body	83	Quacks, Elderly, Friends, Paramedics, Indigenous doctors
Heat in the body	45	Quacks, Elderly, Paramedics, Indigenous doctors
Eating heat producing foods	78	Indigenous doctors, Quacks, Elderly Friends, Relatives
Season Summer season	69	Quacks, Elderly, Friends, Relatives

Table 5: Association between delay in psychiatric help and depression in dhat syndrome

Depression	n	Mean delay in psychiatric help	Standard Deviation
Yes	43	10.19	7.513
No	57	6.46	4.552

t = 3.076, Degree of freedom= 98, p <0.0001 (Very highly significant)

Details of previous consultations and various myths explained by them for Dhat syndrome were also recorded. Except for two cases, remaining all 98 cases had consulted their friends, relatives, elderly people or medical/paramedical personnel for their problem before seeking psychiatric help. 38% of study cases had more than one previous consultation. For statistical analysis, the first consultation was considered so as to correlate its impact on psychiatric delay. To know role of previous consultations in delay for seeking psychiatric help, mean duration of delay for each category of previous consultation was calculated and compared statistically (Table 2).

Mean delay in psychiatric help between groups and within groups was found statistically highly significant. Maximum delay was observed in cases who previously visited either quacks or Indigenous medical practitioners. Multiple comparisons were done using Post Hoc (Tukey) test to the above data. Significant difference in mean was ob-

served between friends and quacks; relatives and quacks; Allopathic practitioners and quacks (Table 3).

Various myths regarding Dhat syndrome and sexual activities were prevailing among cases of Dhat syndrome. All previous consultations solidified and/or instilled these myths. All observed myths are grouped in Table 4.

Each case had more than one myth related to Dhat syndrome. Most common myths were 'semen is vital fluid for health, semen loss due to nightfall, masturbation, short penis, weakness of nerves, lean body and eating heat producing foods'. Mostly the source of myth observed was quacks, indigenous practitioners or friends.

Depression was found in 43 cases making the prevalence of depression in Dhat syndrome 43%. Among cases of depression when assessed in detail using HAM-D rating scale it was found that most of cases that scored high in feeling of guilt item of HAM-D scale were those who had myths regarding masturbation. Also scores were high in items like hypochondriasis, general somatic symptoms, somatic gastro-intestinal and genital symptoms among all cases of depression. Student *t* test was performed to compare whether mean delay in psychiatric help (months) differs between group of cases having depression and cases not having depression (Table 5). Mean delay in psychiatric help was significantly high in cases of dhat syndrome having depression.

DISCUSSION

Dhat syndrome is a very common culture bound sex neurosis, widely prevalent in India. Though the origin of this condition is deeply rooted to the overvalued role of semen as a vital substance of the human body; sexual awareness and improved literacy rates have still not been able to convince the general population of its non organic nature.[11] The prevalence rate is varying between 40-66% among Indian population.[12] Prevalence of Dhat syndrome in study area also seems to be very high.

In the current study, overview of socio-demographic details indicate that majority of Dhat syndrome cases were Hindu and educated upto secondary or higher secondary level. As study area is predominated by Hindu population, same was reflected in the distribution of religion. Majority of the cases were students studying in colleges who had completed higher secondary education which reflected in distribution as per education as well as occupation as 'unemployed including students'. Persons residing in rural areas had quite large distribution of dhat syndrome. Large number of cases was from lower and middle socio-economic class, unmarried and belonged to joint families. Lack of awareness and knowledge reflects in various myths and related illnesses like in case of dhat syndrome; this might be the reason for observed socio-demographic distribution in current study. Previous Indian studies found that majority of dhat syndrome cases were married, had secondary education or studying in colleges and were from lower socio-economic group.[6,7]

Mostly young population is affected by dhat syndrome. In different studies, mean age of dhat syndrome varied from 21.6 to 26.69 years.[6,7,8] Observed mean age in the current study was similar to these findings, 23.35 years. Similar clinical presentation was observed in our study as recorded by previous studies.[7,8] It is consistent that all cases complain of semen discharge and weakness. Sandeep Grover et al. recorded mean duration of symptoms of Dhat before the patients presented to psychosexual clinic as 6.78 years.[13] In present study, duration of current episode was considered as period of psychiatric delay. Duration of previous episodes followed by asymptomatic period was not included. This might be the reason why mean delay was 8.06 months and was not that high. Still it is very well understood from the current study that a person suffering from dhat syndrome does not seek immediate psychiatric help and wanders around to various quacks, paramedical or indigenous medical personnel. These previous consultations lead to statistically significant delay in seeking psychiatric help which was observed to be more with quacks and indigenous medical practitioners. One third of study population was found to seek first help from either friends or relatives. This might be the result of hesitation in patient's mind to speak on sexual issues, which is consistent with another clinical study[13]. Noteworthy lack of knowledge was observed in these consultations which resulted in instilling various myths in the minds of patients. Other Indian studies reported that masturbation related myths were most frequent, seminal loss is perceived as wastage of energy and all attributed dhat syndrome to semen loss.[6,7,8] Similarly in the current study, myths pertaining to vitality of semen, nightfall, masturbation and sex organs were most common.

A retrospective study on dhat syndrome reported that among the psychiatric disorders, depressive disorders were the most common.[14] In the current study prevalence of depression was 43%, bit lesser than other studies. One Indian study found depression in all cases (100%) of Dhat syndrome[6], while it was found out in 50% patients in another clinical study.[7] In current study, most of subjects had preoccupation with health, feeling of guilt and psychosomatic complaints. Another study reported

that 50% of cases had guilt feeling.[8] Studies also reported psychosomatic symptoms in cases of dhat syndrome.[7,8]

High mean delay in seeking psychiatric help among cases with co-morbid depression can be concluded as, delay in psychiatric help resulted in worsening of the condition in the form of depression. Thus delay in psychiatric help is associated with depression.

CONCLUSION

Seeking psychiatric help is still not the first choice of dhat syndrome cases. The preferred personnel for consultations like friends, quacks or Indigenous medical practitioners play the role of catalyst in enhancing myths among cases and also contribute to delay in seeking psychiatric help, which results in increased prevalence of depression. This suggests at community level, awareness is required about dhat syndrome so that timely psychiatric help can avoid their progression to major psychiatric morbidity.

REFERENCES

1. Deb KS, Balhara YS. Dhat syndrome: A review of the world literature. Indian J Psychol Med 2013; 35: 326-31
2. Prakash O. Lessons for postgraduate trainees about Dhat syndrome. Indian Journal of Psychiatry. 2007; 49(3): 208-10
3. Vishal Chhabra, MS Bhatia, Ravi Gupta. Cultural bound syndromes in India. Delhi Psychiatry Journal. 2008; 11(1): 15-18
4. American Psychiatric Association. Diagnostic and Statistical manual of Mental disorders. Fifth Edition (DSM-5). CBS Publishers & Distributors; 2013: pg 833
5. Sumathipala A, Siribaddana SH, Bhugra D. Culture bound syndromes: The story of Dhat syndrome. Br J Psychiatry. 2004; 184: 200–9
6. Neena Sanjeev Sawant, Anand Nath. Cultural misconceptions and associated depression in Dhat syndrome. Sri Lanka Journal of Psychiatry. 2012; 3(1): 17-20
7. Manubhai Parmar. Dhat syndrome- A clinical study. International Journal of Pharmaceutical and Medical Research. 2014; 2 (1): 16-22
8. Ashish Pundhir, Rohit Shrivastava, Saurabh Sharma, Prachi Singh, HS Joshi, Vijender Aggarwal. Dhat syndrome assessment using mixed methodology. ASEAN Journal of Psychiatry. 2015; 16 (2): XX-XX
9. Glenn D. Israel. Determining Sample Size. University of Florida Fact Sheet PEOD (Program Evaluation and Organizational Development) - 6. 1992: 1-5
10. Lee Baer, Mark A. Blais. Handbook of clinical Rating Scales and Assessment in Psychiatry and Mental Health. First Indian Reprint. New Delhi: Springer (India) Private Limited Humana Press; 2010. p 25-27
11. Vandana Mehta, Abhishek De, C Balachandran. Dhat Syndrome: A reappraisal. Indian J Dermatol. 2009; 54(1): 89–90
12. Mahesh Tripathi, Godishala Sridevi. CBT in Dhat syndrome and co-morbid conditions. International Journal of Scientific and Research Publications. 2014; 4(9): 1-8
13. Sandeep Grover, Sunil Gupta, Sudhir Mahajan, Ajit Avasthi. Pathway of care among patients with Dhat syndrome attending a psychosexual clinic in tertiary care center in North India. Ind Psychiatry J. 2016; 25(1): 72–77
14. Sandeep Grover, Sunil Gupta, Aseem Mehra, Ajit Avasthi. Comorbidity, knowledge and attitude towards sex among patients with Dhat syndrome: A retrospective study. Asian Journal of Psychiatry. 2015; 17: 50–55