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# SOCIO DEMOGRAPHIC PROFILE IN PATIENT DIAGNOSED WITH DHAT SYNDROME

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**ABSTRACT** **BACKGROUND:** "Dhat syndrome" is a culture-bound disorder which manifests in the form of preoccupation with passive semen passage among the patients in the Indian sub-continent. 64% of men attending Psychiatric clinics in India for sexual complaints have Dhat syndrome. Many myths are prevalent among peoples regarding it, mostly among young males, belonging to average or low socioeconomic status, medium or low education level e.t.c. **AIM:** To study the socio demographic profile in patients diagnosed with Dhat syndrome. **METHODOLOGY:** Study is cross-sectional study held in the Department of Psychiatry, MGMMC, Indore, consists of 100 male study participants. All socio-demographics were recorded & diagnosis of Dhat syndrome was based on diagnostic criteria of D.S.M – 5. **RESULTS:** Majority of subjects belong to the 21-30 age group, single, Hindu, educated up to higher secondary or above, employed, belongs to nuclear family, lives in urban areas. **CONCLUSION:** Dhat syndrome prevalence among males can be predicted from certain socio demographic variable.

**KEYWORDS :** Dhat, Men, Education

## INTRODUCTION

"Dhat syndrome" was first described in western psychiatric texts by Wig[1] who coined the term "Dhat syndrome," characterized by vague somatic symptoms of fatigue, weakness, anxiety, loss of appetite and guilt. These symptoms were attributed to semen loss through nocturnal emissions, urine and masturbation[1].

Term "Dhat" originated from the word Dhatu of Sanskrit language, which means "metal," "elixir" or "constituent part of the body". The syndrome is not only confined to India, it is widespread in all communities of the Indian subcontinent [2], it has been reported among Sikhs in Punjab, Buddhists in Sri Lanka and Muslims in Pakistan. The ancient doctrine of semen conservation which states that loss of semen leads to physical and mental illness has a long philosophical history in Europe and Asia as it showed global presence, like "shenk'uei" in China[3].

An underlying psychiatric morbidity may be super added by Dhat syndrome, where it can be an attribution of the psychiatric illness as well as an association by chance. Loss of semen in the urine was very common among men who present with psychosexual problems.

The patients diagnosed with Dhat syndrome are mostly young males, belonging to low or average socioeconomic status [4,5]. Evidence to suggest that the syndrome is more common among men those from rural areas, those belonging to families with conservative attitudes and those who are either unmarried or have married recently[4].They generally belong to medium or low education level [6] present from all religious backgrounds[5].

## AIM

To study the socio demographic profile in patients diagnosed with Dhat syndrome.

## METHODOLOGY

Study was conducted cross sectionally using purposive sampling technique with 100 study subjects as sample size in Department of Psychiatry, M.G.M.M.C, Indore (O.P.D patients of M.Y.H and M.H.I) within 1 year from the date of approval of Ethical committee.

## INCLUSION CRITERIA

- Patients with complaint of passing of whitish discharge from penis.
- Male patient above age 18 years, giving written, informed consent before assessment.

## EXCLUSION CRITERIA

- The cases with preexisting mental retardation.
- Any major medical / surgical illness.

## TOOLS

The following materials would be used for the present study :

1) Informed Consent Form
2) Semi structured data entry performa
3) Diagnosis by clinical interview of treating consultant Psychiatrist using D.S.M 5[7]

Statistical analysis done using appropriate software for the analysis of the data.

## RESULT & DISCUSSION

**TABLE 1**

**Description of Socio demographic variable of study participants (categorical data)**

| Variable | N | Percent | Total |
|---|---|---|---|
| **Age Group (in years)** | | | |
| 18-20 year old | 35 | 35.0 | |
| 21-30 year old | 53 | 53.0 | 100 |
| 30-40 year old | 9 | 9.0 | |
| >40 year old | 3 | 3.0 | |
| **Marital status** | | | |
| Unmarried | 82 | 82.0 | 100 |
| Married | 18 | 18.0 | |
| **Religion** | | | |
| Hindu | 95 | 95.0 | 100 |
| Muslim | 5 | 5.0 | |
| **Education** | | | |
| Below Higher secondary | 42 | 42.0 | 100 |
| Higher secondary or above | 58 | 58.0 | |
| **Occupation** | | | |
| Unemployed | 48 | 48.0 | 100 |
| Employed | 52 | 52.0 | |
| **Income of patient/month (in INR)** | | | |
| ≤10000 | 38 | 73.1 | 52 |
| >10000 | 14 | 26.9 | |
| **Family income/month (in INR)** | | | |
| ≤15000 | 45 | 45.0 | 100 |
| >1500 | 55 | 55.0 | |
| **Family type** | | | |
| Nuclear | 57 | 57.0 | 100 |
| Joint or extended | 43 | 43.0 | |
| **Locality** | | | |
| Urban | 62 | 62.0 | 100 |
| Rural | 38 | 38.0 | |

**TABLE 2**
**Description of Socio demographic variable of study participants (continuous data)**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Age (in years) | 100 | 18 | 42 | 23.91 | 6.12 |
| Income of patient(in rupees) | 52 | 7000 | 13000 | 9615.38 | 1805.80 |
| Family Income per Month (in rupees) | 100 | 4000 | 60000 | 20080.0 | 12226.72 |

## DISCUSSION

Mean age group of study participants was 23.91 ± 6.12 years which is close to Khan N. 2005[6] (mean 24 ± 8.5 years). Most common age group which had Dhat syndrome in our study was 21-30 year (53%) which was similar to Grover et al. 2016[8] in which 21-30 year (55.3%). The occurrence of Dhat syndrome in this age group most commonly can be understood by the fact that most boys enter in their adulthood around this age, and they started exploring things pertaining to sexuality; so it is the time in which they get some myths and false belief regarding sex and sexual health. Majority (82%) of the study participants were single while the rest 12% were married which is close to Khan N. 2005[6] (75% single). Similar results were obtained in Grover et al. 2015[9] where majority of cases were single. Majority (95%) of the study participants were Hindu while rest 5% was Muslim. Similar results were found in study of Meena & Rathore.2018[10] in which 88% were Hindu and rests were Muslim.

Majority (58%) of the study participants were either educated up to higher secondary or above while the rest 42% were educated below higher secondary. Similar results were found in the study of Grover et al. 2015[9] in which 57.3% patients had been educated above 10th. However, these results are in contrast to Meena & Rathore. 2018[10] in which most commonly Dhat syndrome patients belong to the group of education of till 10th or below as 64% respectively. This difference may be due to certain demographic characteristics of study population and the criteria for enrollment of study. Majority (52%) of the study participants were employed and working somewhere while the rest 48% were unemployed. Similar results were found in the study of Prakash S. 2016[11] in which 62% were employed.

Mean income of the study participant's was 9615.38 ±1805.80rupees. A very few studies talks about patient income per month in Prakash S. 2016[11] monthly income of >50% patients of Dhat syndrome was less than 5000 rupees. Although as per Meena & Rathore. 2018[10] mean income of Dhat syndrome patient is 14360 ± 6965.69. The difference in studies for mean per month income of study subjects might be because of more graduate & post graduate subjects in Meena & Rathore. 2018[10] than in comparison to our study in which above matriculation subjects are mostly who weren't graduated and none is postgraduate.

Majority (72%) of the study participants were earning less than 10000 and rest 28% were earning above 10000 rupees. Similar results were found in the study of Prakash S. 2016[11] in which 75% patients of Dhat syndrome earn less than 10000 rupees. Mean family income of participants of study was 20080.0 ± 12226.72 rupees. All studies provide information about family income in groups rather than mean. Majority (55%) of the study participants' family income was less than 15000 and the rest of the 45% family income was greater than 15000 rupees. In Grover et al. 2015[9] 69.7% study subjects' family income was less than 10000.

Majority (57%) of the study participants belonged to nuclear families while 43% belonged to joint or extended families. Similar results were obtained in Grover et al. 2015[9] in which 61.45% study subjects, respectively belonged to the nuclear family. Reason for most of the study subjects coming from nuclear family is due to the fact that in India, there is still a hesitation among parents and children to freely talk on matter related to sexual health resulting in children learning false information from whatever source they can get, without getting rectified by anyone in family who could guide them. Majority (62%) of the study participants were living in urban areas while the rest of the 38% were living in rural areas. Similar results were obtained in study by Grover et al. 2016[12] in which 55.6% subjects of study belong to the urban population. Although the rest of the many studies like Meena & Rathore. 2018[10]; Grover et al. 2015[9] indicate that most study subjects of their studies belong to rural areas rather than urban areas as found out by our study. One possible explanation for this can be that the majority of study subjects were in the city where study was conducted for many years for their study purposes, although their native place was rural backdrop but they were considered urban based on the time since they were living in the city.

## CONCLUSION

Maximum study participants were belonging to the 21-30 year age group, unmarried, Hindu, educated higher secondary or above, employed, earning less than or equal to 10000/month, family income greater than 15000, belonging to urban locality, & nuclear family. The mean per month income of study participants himself 9615.38 ± 1805.80 rupees, while mean per month income of study participants' family 20080.0± 12226.72 rupees.

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## LIMITATION

1. There is a lack of longitudinal follow-up to know the effectiveness of our intervention on study participants' view about their presenting complaint & in comparison to each other's intervention.
2. Although seemingly large for a study of such design the sample size was still low and could have been increased.

## RECOMMENDATION

1. There is a huge lacuna in the field of sex education. Future studies should assess the effect of sex education in school or college on the prevalence of Dhat syndrome.
2. Replication of current study with more ethnically diverse samples would be beneficial.

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