Pathway of care among patients with Dhat syndrome attending a psychosexual clinic in tertiary care center in North India

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Aim: The aim of this study was to understand the pathway to care among patients with Dhat syndrome and to study the factors leading to delay in seeking professional psychiatric help. Materials and Methods: Forty-seven patients diagnosed with Dhat syndrome as per the International Classification of Diseases-10 criteria were assessed for sociodemographic and clinical details and information regarding previous treatment taken to determine the pathways to care at their first contact with the outpatient psychosexual clinic. Results: Majority of the patients were single (70.2%), received formal education for at least more than 10 years (66.0%), were employed (59.6%), followers of Hinduism (68.1) and from middle socio-economic class (59.6%), nuclear family setup (53.2%), and rural locality (63.8%). Comorbidity in the form of any psychiatric illness or sexual dysfunction was present on 61.7% of the patients. The mean age at onset of symptoms of Dhat syndrome was 20.38 years (standard deviation [SD] - 6.91). The mean duration of symptoms of Dhat before the patients presented to our psychosexual clinic was 6.78 years (SD - 6.94) while the mean number of agencies/help contacted before was 2.85 (SD - 1.40; range: 1–5). The favorite choice for the first contact was indigenous practitioners, followed by asking for help from friends or relatives, allopathic doctors, and traditional faith healers or pharmacists. The preference to visit indigenous practitioners gradually declined at each stage. Ayurvedic doctors remained the most preferred among all indigenous practitioners. The absence of any comorbid sexual dysfunction in patients with Dhat syndrome predicted an earlier visit to our center as compared to the patients with any comorbid sexual dysfunction. Conclusions: Majority of the patients with Dhat syndrome present very late to specialized psychosexual clinics. There is a need for improving the sexual knowledge and attitude at the community level which will facilitate the early help seeking in patients with Dhat syndrome.

Keywords: Dhat syndrome, help seeking, pathways to care

Dhat syndrome or “semen-loss anxiety” is considered a culture-bound syndrome and is characterized by preoccupation with semen loss and attribution of physical and psychological symptoms of weakness, fatigue, palpitation, and sleeplessness to the same.[1–3]

The term “Dhat” is derived from the Sanskrit word “Dhatu,” which is considered to be an important elixir of the body. Disorders related to loss of “Dhatus” have been described since the time of Charaka Samhita, in the form of “Shukrameha,” in which there is a passage of semen in the urine. Similar descriptions are also available with various names from other South Asian countries such as China (Shen-K’uei) and Sri Lanka (Prameha).[10]
It is one of the common reasons for seeking help in psychosexual clinics. Prior studies have reported that it constitutes around 18% of all patients seeking treatment for psychosexual disorders.[1] In a study examining 48 consecutive male patients of sexual disorders, about two-thirds were categorized as having Dhat syndrome.[7] The mean duration of illness for patients with Dhat syndrome has been reported to be as high as 5.4 years.[10]

It has been seen that majority of the patients with mental disorder do not seek professional psychiatric help as the first step and most of them utilize the help of unqualified medical practitioners, faith healers, and so on due to a lack of awareness about treatment services, the distance, and due to the fear of the stigma associated with seeking treatment from mental health professionals.[12] This situation further worsens in a case of psychosexual disorders. It has been found that only a minority of individuals seek medical help for psychosexual problems, largely due to the belief that the problem is not serious, or not being bothered by the problem, and/or a lack of awareness of available treatments.[13] About half of the patients with psychosexual disorders have prior consultations with physician before consulting a psychiatrist.[11]

Majority of the patients with Dhat syndrome have been found to consult various traditional healers and health specialists practicing Unani, Ayurveda, or Homeopathy, and physicians/surgeons before consulting mental health professionals. A study which included 54 patients with Dhat syndrome showed that almost all (52 out 54 patients) patients had sought some help for the symptoms of Dhat syndrome before the index consultation with the mental health-care facility. The commonly sought consultation included that from a physician (61.1%), vaid/hakim (57.4%), Unani/Ayurvedic/homeopathic doctor (46.3%), traditional “sex specialists” (13%), surgeons (20.4%), and dermatologists (5.6%). A significant proportion had contacted more than one health-care professional before consulting a psychiatrist.[10] However, none of the study has attempted to study the pathways to care of patients with Dhat syndrome.

It is important to understand the pathways of care of patients with Dhat syndrome. Knowledge gained about pathways of care can be used to spread awareness at the community level to facilitate early referral and expert treatment. It can further assist in planning newer and more effective treatment modalities.[14][15]

Although the pathways to care for patients with various psychiatric disorders and even psychosexual disorders have been studied across the world including India,[12][13][16][26] none of the study has evaluated the pathways of care of patients with Dhat syndrome.[28] Therefore, this study was planned to evaluate the pathway to care among patients with Dhat syndrome.

**MATERIALS AND METHODS**

**Setting**

This study was carried out in the psychosexual outpatient clinic of a multispecialty teaching tertiary care hospital in North India. The study was approved by the Ethics Committee of the Institute. All the patients were recruited after obtaining proper written informed consent. To be included in the study, all new patients aged more than 16 years and diagnosed with Dhat syndrome as per the International Classification of Diseases (ICD-10) criteria[27] by a qualified psychiatrist were eligible for the study. Patients with comorbid mental retardation, psychotic disorders, or organic brain syndrome were excluded from the study. Eligible patients were approached and explained about the study. Those who agreed to participate and provided written informed consent were recruited in the study.

Sociodemographic and clinical details were recorded in a specifically designed proforma. Comorbid diagnosis of psychiatric disorders and sexual dysfunction was made as per the ICD-10 criteria by a qualified psychiatrist. Information regarding previous help/treatment taken for symptoms of Dhat syndrome was obtained.

**International Classification of Diseases-10**

ICD-10 criteria were used to make the diagnosis of Dhat syndrome and also comorbid psychiatric disorders and psychogenic/mixed erectile dysfunction and premature ejaculation.[27]

**Symptom severity and level of distress**

Depending on the symptom severity and level of distress in the patients, the treating psychiatrist rated the severity of Dhat syndrome on a 3-point Likert scale as mild, moderate, and severe.

**Definition of terms**

Based on the type of health-care providers, the various health-care providers were broadly categorized as:

- **Help at home/relatives**: Advise received from a family member, relative, or friends to overcome the symptoms
- **Allopathic practitioner**: A person who has the degree of MBBS from any medical college
- **Indigenous practitioner** is a person who is qualified in any stream of medicine (including registered medical practitioners) except allopathic medicine. Government of India recognizes Ayurveda, Unani, Siddha, Homeopathy, and Naturopathy as standard streams of medicine.
• Traditional healers/faith healers/quacks/others are the people who practice indigenous medicine without any degree or those who practice witchcraft and treat patients using magical or religious practices. In addition, this category also included help sought from pharmacists/drug stores for over the counter medications.
• The psychiatrist.

Statistical analysis
Statistical analyses were performed using the Statistical Package for the Social Sciences Version 14 (Chicago, SPSS Inc.). Descriptive analyses were computed in terms of mean and standard deviation (SD) for continuous variables and frequency with percentage for nominal variables.

RESULTS

During the study period of February to July 2014, 47 patients diagnosed with Dhat syndrome were recruited in the study.

Sociodemographic profile
The mean age of the study sample was 27.6 (SD - 8.28) years. Majority of the patients were single (70.2%), received formal education for at least 10 years (66.0%), were employed (59.6%), Hindu by religion (68.1), from middle socioeconomic class (59.6%), nuclear family setup (53.2%), and rural locality (63.8%).

Clinical profile
The mean age at onset of symptoms of Dhat syndrome was 20.38 years (SD - 6.91), whereas the mean duration of illness at the time of assessment was 6.78 years (SD - 6.94) [Table 1].

When assessed by a psychiatrist as per ICD-10 criteria, out of the 47 patients, 29 (61.7%) had at least one comorbid condition in the form of any psychiatric illness or sexual dysfunction. Depressive disorders (depression and dysthymia) were diagnosed in eight (17%) patients whereas seven (14.9%) patients fulfilled the criteria for one of the anxiety spectrum disorders. At least one comorbid sexual dysfunction coexisted in 21 (44.7%) patients, with erectile dysfunction and premature ejaculation in 11 (23.4%) patients each. As rated by the treating psychiatrist on the basis of symptom severity and level of distress in the patients, 26 (55.3%) patients had moderate level of distress, 12 (25.5%) patients had severe distress due to their symptoms of Dhat syndrome, and 9 (19.1%) patients had mild distress. Other details are shown in Table 2.

Pathways to care
The mean number of agencies/help sought before contacting the psychosexual clinic was 2.85 (SD - 1.40; range: 1–5). Out of the 47 patients, 11 had sought help from at least one source, 9 had sought help from two sources, 10 patients each had sought help from 3 and 4 sources, and 7 patients had sought help from 5 sources [Figure 1].

As shown in Table 1, the most common first contact was indigenous (Ayurvedic/Homeopathic/Siddha/Unani) practitioners (N = 17, 36.2%), followed by help sought from friends or relatives (n = 15, 31.9%), allopathic doctors from various specialties (N = 11, 23.4%), and traditional faith healers or drug stores (N = 4, 8.5%). Of the various indigenous practitioners, the most favored were ayurvedic doctors (N = 8, 17%). Among the allopathic doctors, 5 (10.7%) patients visited general physicians, 4 (8.5%) visited urologists, and 2 (4.2%) visited surgeon.

The preference to visit indigenous practitioners gradually declined at each stage, with 14 (29.8%) visiting them as second choice, 10 (21.3%) as third choice, 5 (10.6%) as fourth choice, and only one (2.1%) selecting them as fifth choice agency for treatment. Ayurvedic doctors remained the most preferred among all indigenous practitioners at each stage (5 [10.6%], 4 [8.5%], and 2 [4.3%] at 2nd, 3rd, and 4th stages, respectively).

None of the patients sought help from our OPD as first preference. Nearly, one-fourth (23.4%) of the patients sought help in the psychiatry OPD as second contact, 9 (19.1%) as third contact, 10 (21.3%) each as fourth and fifth contact, and 7 (14.9%) as sixth contact [Table 1].

Table 1: Pathways to care followed by patients with Dhat syndrome

| First contact, n (%) | Second contact, n (%) | Third contact, n (%) | Fourth contact, n (%) | Fifth contact, n (%) | Sixth contact, n (%) |
|----------------------|-----------------------|----------------------|-----------------------|---------------------|---------------------|
| Help at home/relatives | 15 (31.9) | 4 (8.5) | - | - | - |
| Indigenous practitioners | 17 (36.2) | 14 (29.8) | 10 (21.3) | 5 (10.6) | 1 (2.1) |
| Allopathic doctors | 11 (23.4) | 12 (25.5) | 11 (23.4) | 11 (23.4) | 5 (10.6) |
| Traditional healer/drug stores/others | 4 (8.5) | 6 (12.8) | 6 (12.8) | 1 (2.1) | 1 (2.1) |
| Psychiatry OPD | - | 11 (23.4) | 9 (19.1) | 10 (21.3) | 10 (21.3) | 7 (14.9) |

OPD – Outpatient department
However, psychiatrists other than our psychosexual clinic were preferred by the patients at each stage; 5 (10.6%), 1 (2.1%), 5 (10.6%), and 2 (4.2%) as second to fifth contacts, respectively.

We ran a comparison of various social demographic and clinical variables to see, if there was any factor which could help in predicting the preference for visiting our psychosexual clinic earlier on the basis of a number of agencies contacted before us. The difference was not significant on any of the variables other than the absence of comorbid sexual dysfunction. The mean number of agencies contacted by patients having comorbid sexual dysfunction was 3.38 (SD - 1.16) as against 2.42 (SD - 1.45) in those without comorbid sexual dysfunction ($t$ - 2.459*; $P < 0.05$).

**DISCUSSION**

To the best of our knowledge, this is the first study which attempted to evaluate the pathways to care in patients with Dhat syndrome.

The long duration of illness at the time of reporting to our psychosexual clinic (mean = 6.78 years) directly implies the significant delay among patients presenting to psychosexual clinic. The mean number of agencies/help contacted by the patients before reporting to our psychosexual clinic was 2.85. Majority of the patients had contacted indigenous doctors or traditional/faith healers at some point of time during the course of illness. This pattern is similar to that of other psychiatric disorders. Existing data suggest that indigenous practices of medicine including Ayurveda reinforce the beliefs of the patients with Dhat syndrome regarding the harmful effects of semen loss which further increases the distress associated with it.$^{[28,29]}$ Another

![Figure 1: Pathways of care followed by patients before consulting specialized psychosexual clinic (Green: Help at home/relatives; Red: Indigenous practitioners; Blue: Allopathic doctors; Black: Traditional healer/drug stores)](image)

**Table 2: Clinical profile of the study sample ($n=47$)**

| Variables                                      | Mean (SD)/frequency (%) |
|------------------------------------------------|-------------------------|
| Age of onset in years                          | 20.38±6.91              |
| Duration of passage of Dhat (years)            | 6.78±6.94               |
| Distress due to Dhat                           |                         |
| Mild                                           | 9 (19.1)                |
| Moderate                                       | 26 (55.3)               |
| Severe                                         | 12 (25.5)               |
| Comorbid psychiatric diagnosis                 |                         |
| Depression                                     | 4 (8.5)                 |
| Dysthymia                                      | 4 (8.5)                 |
| Anxiety, neurotic, and stress related          | 7 (14.9)                |
| Number of patients with one or more psychiatric morbidity | 15 (31.9)              |
| Comorbid sexual dysfunction                    |                         |
| Lack or loss of sexual desire                  | 5 (10.6)                |
| Sexual aversion                                | 7 (14.9)                |
| Lack of sexual enjoyment                       | 6 (12.8)                |
| Failure of genital response                    | 11 (23.4)               |
| Orgasmic dysfunction                           | 3 (6.4)                 |
| Premature ejaculation                          | 11 (23.4)               |
| Excessive sexual drive                         | 2 (4.3)                 |
| Other sexual dysfunction, not caused by organic disorder or disease | 1 (2.1)                |
| Number of patients with one or more sexual dysfunction | 21 (44.7)              |
| Number of patients with psychiatric morbidity and/or sexual dysfunction | 29 (61.7)              |

SD – Standard deviation

SD – Standard deviation

However, psychiatrists other than our psychosexual clinic were preferred by the patients at each stage; 5 (10.6%), 1 (2.1%), 5 (10.6%), and 2 (4.2%) as second to fifth contacts, respectively.
The absence of any comorbid sexual dysfunction in patients with Dhat syndrome predicted an earlier visit to our center as compared to the patients with any comorbid sexual dysfunction. This can be due to multiple reasons. First, presence of any kind of sexual dysfunction among men in Indian culture is equated with defect with the person as such and leads to a lot of anxiety in the person. Discussing about the same with family members further enhances the anxiety, and this possibly leads to a panic-like situation. This possibly triggers multiple consultations. Second, patients with sexual dysfunction prefer to visit “quacks” and “sex clinics/local sex specialists” rather than to the hospital setting because of various reasons.

This study must be seen in the light of its limitations. This study involved small sample size and participants attending a single tertiary care center only. It is quite possible that other psychosexual clinics at primary and secondary care levels, where more representative population could be studied could provide varying results. We also did not look into the reasons of delay as given by the patient. Future studies could include patients from multiple centers must be planned keeping these limitations in mind.

Despite these limitations, it has to be emphasized that this is the first study on pathways to care for patients with Dhat syndrome. The primary aim was to understand and generate hypotheses regarding factors involved in the delay in seeking help in such patients.

CONCLUSION

This study suggests that majority of the patients with Dhat syndrome present very late to specialized psychosexual clinics. Indigenous practitioners and help sought at the home or from family members are the most preferred initial treatment agency for the majority of the patients. There is a need to improving the sexual knowledge and attitude at the community level which will facilitate the early recognition of Dhat syndrome which in turn will lead to early treatment seeking from specialized centers. It is also important to incorporate an efficient and effective referral mechanism where the primary service providers are trained adequately. The study also underlines the importance of various indigenous practices in imparting health care in India and steps must be taken to strengthen/modernize such health-care systems, so as to provide good services to the patients.

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Conflicts of interest
There are no conflicts of interest.

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