ORIGINAL RESEARCH ARTICLE

Study of Comparison of Demographic & Phenomenological Variables among the Sexual Dysfunction Cases Attending the Psychiatric OPD of A Tertiary Care Centre, Maharashtra.

Jeevan Pawar[1] & Mahesh Bhirud[2]

[1]Assistant Professor, Department of Psychiatry, Shri Bhausaheb Hire Government Medical College, Dhule [MS], India.

[2]Associate Professor, Department of Psychiatry, Shri Vasantrao Pawar Medical College & Research Centre, Nasik [MS], India.

Abstract:

Introduction: Sexual dysfunction can be taken sources of anxiety, anguish and frustration that often leads to general unhappiness and distress in a personal relationships. In our country especially sexual myths and misconceptions are commonly seen. 'Dhat syndrome' is one such commonly recognized clinical entity in our culture. Hence studied demographic & phenomenological variables among "Dhat Syndrome, Pre-Mature Ejaculation and Male Erectile Disorders Methodology: The present cross sectional study carried during the year 2014 out at psychiatry outpatient department of a tertiary care hospital. Structured proforma was prepared to collect the specific data regarding the sexual dysfunction. All the collected data analyzed with descriptive analysis and applied statistical test for significance. Results: A total of 100 cases of Dhat Syndrome (48%), Premature Ejaculation (34%) and Male Erectile Disorder (18%) were included. 39(73.6%) cases of Dhat syndrome from 15-25 yrs age group while 53.7% &124.4%) of PME and MED cases respectively of 26-35 age group.[P<0.005]. DS is seen more in unmarried people (76.3%). Dhat syndrome cases had weakness with palpitation and weakness with giddiness in 68.8% & 90.9% of cases respectively.(P<0.05). 50.8% fear about their potency reported by DS group(P<0.05). Anxiety maximally reported by DS(68% among anxiety) while depression (38.5%) maximally reported in each PME and MED.(SS) Masturbation as a root cause was felt by 63.5% cases of DS. Nearly 50 % of the wives have no reaction to the present sexual dysfunction. Conclusion: The phenomenology of Dhat syndrome is significantly different form the other sexual dysfunctions. DS is more commonly observed in young unmarried adults with co-morbid psychiatric conditions. A more elaborative sex education among the community is need of hour.

Key Words: ***Dhat syndrome, Premature Ejaculation, Masturbation, Sexual dysfunction.***

Introduction:

Like many other body processes, when sexual function goes along smoothly, it is usually taken for granted and given little thought. But if sexual function is problem in one way or another, it can be taken sources of anxiety, anguish and frustration that often leads to general unhappiness and distress in a personal relationships [1].

Overall, studies conducted worldwide have reported the prevalence of sexual disorders in the range of 10-25% among men and 25-64% among women.[2] Studies have suggested a community prevalence rate ranging from of 4-10% for male orgasmic disorder, 4-9% for male erectile disorder, 5-10% for female orgasmic disorder, and 36-38% for PME [2].

Address for correspondence:
Dr. Jeevan Pawar,
Assistant Professor,
Department of Psychiatry,
SBH, Government Medical College,
Dhule [MS],India.
Email: jeevanpsy96@gmail.com

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In our country especially sexual myths and misconceptions are commonly seen even in today's so called educated and developed society people.

This give rises to special problems, which are not reported in western literature. 'Dhat syndrome' is one such commonly recognized clinical entity in our culture, both by lay people as well as clinician in their general practice. Dhat syndrome is generally believed to be a culture-bound syndrome of the Indian subcontinent, although this has often been debated [3].

The essential feature of the sexual dysfunction is inhibition in one or more of the phases, including disturbance in the subjective sense of pleasure or desire or in the objective performance. Either type of disturbance can occur alone or in combination. Sexual dysfunctions are diagnoses only when they are a major part of the clinical picture.

The patients presenting with primary sexual problems frequently have associated psychiatric symptoms of anxiety and depression, which further complicates the problem and requires additional therapeutic measures. Most studies found erectile dysfunction (22-62%) and premature ejaculation (22-44%) as commonly associated psychosexual dysfunctions, while depressive neurosis (40-42%), anxiety neurosis (21-38%), somatoform/ hypochondriasis (32-40%) as the most reported psychiatric disorders in patients diagnosed with Dhat syndrome [4,5].

Hence there was a need to study these problems more deeply and compare them with other types of sexual dysfunction so that necessary modification can be made in the therapy for treating these problems. Objective of the study is to compare "Dhat Syndrome, Pre-Mature Ejaculation and Male Erectile Disorder on Demographic & Phenomenological variables.

Material and Methods:

The present cross sectional study carried out at psychiatry outpatient department of a tertiary care hospital attached to Government Medical College, located at rural area of Maharashtra. The study conducted during the year 2014. The cases either referred or presented with sex related problems attending the psychiatry OPD were included for study purpose.

A careful detailed psychiatric interview was carried out to collect the required data. Help of present mental Status Examination Scale (PSE) was taken to judge the associated psychiatric symptoms and clinical diagnosis. A special proforma was prepared to collect the specific data regarding the chief complaints, associated complaints, sex education, misconceptions, earlier sexual experiences and disability due to present problem.

Dhat Syndrome (DS) is a condition where a patient presents with complaints of loss of semen. Patients complain of loss of semen through night discharge and masturbation or through sexual intercourse. Sometimes complain of whitish discharge along with or preceding passage of urine which is believed to be semen.

Premature Ejaculation (PME) is a persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of sexual partner, or situation and recent frequency of sexual activity.

Male Erectile Disorder (MED) is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

The study includes male patients cases suffering from any one of sexual dysfunction i.e. Dhat syndrome, PME and MED, with age more or equal to 16 years and less than and equal to 55 years, not suffering from any major illness and willing to participate in the study to give information for study purpose. The study excludes cases with history of diabetes or hypertension, having more than one sexual dysfunction, on medications known to cause sexual problems, patients whose age is outside range of inclusion criteria and more than 55 years and not willing to participate.

All the collected data entered, cleaned and analyzed using Microsoft TM Excel 2010. Descriptive analysis and statistical test of significance applied and value less than 0.05 is considered as a significant.

Results:

A total of 100 cases were included for study purpose. Among which sexual dysfunction DS (48%), PME (34%) and MED (18%) observed.

Demographic profile of the cases shows amongst the 53 cases of 15-25 years age group, 39(73.6%) having DS while amongst the 41 cases of 26-35 age group, 22(53.7%) & 10(24.4%) having PME and MED respectively. The association of young adults and having DS was statistically significant [P=0.01]. DS is seen more in unmarried people 33(76.3%)] where among married PME & MED found [26(45.6%)] & [16(28.1%)] respectively. The association of unmarried people and DS was found to be statistically significant [P=0.01]. 5 (50%) having DS among the 10 illiterates. 12(66.7%) out of 18 cases from non working group having Dhat syndrome while 36% and 29.3 % PME & Med respectively were skill workers. The association of having DS among non workers found to be statistically significant.[P=0.04]. Premature ejaculation cases [21(43.8%)] have income more than 3000 and less than 6000 rupees. The association with more income and having PME was significant [P=0.03] (Table 1).

Table 1: Demographic profile among the Dhat Syndrome, Premature Ejaculation and Male Erectile Disorder cases during study period.

Variables		DS N(%)	PME N(%)	MED N(%)	Total (n=100)	P Value
Age(yrs)	15-25 26-35 36-45	39(73.6) 9(22) 0(.0)	9(17) 22(53.7) 3(50)	5(9.4) 10(24.4) 3(50)	53 41 6	P=0.01 (SS)
Marrital status	Married Unmarried	15(26.3) 33(76.7)	26(45.6) 8(18.6)	16(28.1) 2(4.7)	57 43	P=0.01 (SS)
Educational status	Literate Up to 10th >10th	5 (50.0) 38 (55.9) 5(22.7)	3 (30.0) 19 (27.9) 12 (54.5)	2 (20.0) 11(16.2) 5 (22.7)	10 68 22	P=0.101 (NS)
Occupation	Not working Skilled Unskilled	12(66.7) 14(34.1) 22(53.7)	6(33.3) 15(36.6) 13(31.7)	0(0.0) 12(29.3) 6(14.6)	18 41 41	P=0.04 (SS)
Income	Not Earning Rs. 1000-3000 Rs. 3001-6000 Rs. 6001-10000	12(66.7) 19(67.9) 17(35.4) 0(0.0)	6(33.3) 4(14.3) 21(43.8) 3(50.0)	0(0.0) 5(17.9) 10(20.8) 3(50.0)	18 28 48 6	P=0.03 (SS)

SS=Statistically Significant. NS=Not Significant.

Table 2: Phenomenological variables among Dhat Syndrome, Premature Ejaculation and Male Erectile Disorder cases during study period.

Variables		DS No.(%)	PME No.(%)	MED No.(%)	Total	P Value
A/w Physical symp.	*No Symptom*	*0(0.0)*	*14(63.6)*	*8(36.4)*	*22*	*P<0.001 (SS)*
	Weakness(WK)	*11(40.7)*	*12(44.4)*	*4.(14.8)*	*27*	
	WK+Palpitation	*11(68.8)*	*4(25.0)*	*1(6.3)*	*16*	
	WK+Giddiness	*10(90.9)*	*1(9.1)*	*0(0.0)*	*11*	
	WK+Bodyache+Joint pain	*11(57.9)*	*3(15.8)*	*5(26.3)*	*19*	
	WK+Bodyache+Palpitation	*5(100.0)*	*0(0.0)*	*0(0.0)*	*5*	
Associated fears	*Regarding potency*	*33(50.8)*	*21(32.3)*	*11(16.9)*	*65*	*P=0.03 (SS)*
	Physical illness	*4(66.7)*	*2(33.3)*	*0(0.0)*	*6*	
	STD	*0(0.0)*	*2(66.7)*	*1(33.3)*	*3*	
	Regarding genitals	*10(66.7)*	*3(20.0)*	*2(13.3)*	*15*	
	Mental illness	*1(33.3)*	*0(0.0)*	*2(66.7)*	*3*	
	No fear	*0(0.0)*	*6(75.0)*	*2(25.0)*	*8*	
H/o STD	Yes	*1(14.3)*	*5(71.4)*	*1(14.3)*	*7*	*P= 0.08 (NS)*
	No	*47(50.5)*	*29(31.2)*	*17(18.3)*	*93*	
H/O Masturbation	*Yes*	*44(48.99)*	*31(34.4)*	*15(16.7)*	*90*	*P=0.58 (NS)*
	No	*4(40.0)*	*3(30.0)*	*3(30.0)*	*10*	
Homosexual coitus	*Present*	*0(0.0)*	*0(0.0)*	*2(100.0)*	*2*	*P=0.01 (SS)*
	Absent	*48(49.0)*	*34(34.7)*	*16(16.3)*	*98*	
H/O Exposure	*Yes*	*8(25.0)*	*15(46.9)*	*9(28.1)*	*32*	*P=0.01 (SS)*
	No	*40(58.8)*	*19(27.9)*	*9(13.2)*	*68*	
Substance Abuse	*Yes*	*19(41.3)*	*14(30.4)*	*13(28.3)*	*46*	*P=0.04 (SS)*
	No	*29(53.7)*	*20(37.0)*	*5(9.3)*	*54*	
Comorbid illness	*Depression*	*6(23.1)*	*10(38.5)*	*10(38.5)*	*26*	*P=0.01 (SS)*
	Anxiety	*32(68.1)*	*13(27.7%)*	*2(4.3)*	*47*	
	Somatization	*6(85.7)*	*1(14.3)*	*0(0.0)*	*7*	
	Schizophrenia	*1(100.0)*	*0(0.0)*	*0(0.0)*	*1*	
	Absent	*3(15.8)*	*10(52.6)*	*6(31.6)*	*19*	

SS=Statistically Significant. NS=Not Significant

Table 3: Knowledge, treatment seeking and attitude among the Dhat Syndrome, Premature Ejaculation and Male Erectile Disorder cases during study period.

Variables		DS N(%)	PME N(%)	MED N(%)	Total	P Value
Cause of illness	Masturbation	40(63.5%)	15(23.8%)	8(12.7%)	63	P=0.01 (SS)
	Others	1(10.0%)	4(40.0%)	5(50.0%)	10	
	Dont Know	7(25.9%)	15(55.6%)	5(18.5%)	27	
Treatment saught before referral	Medical persons	4(28.6%)	7(50.0%)	3(21.4%)	14	P=0.747 (NS)
	Quacks	6(50.0%)	3(25.0%)	3(25.0%)	12	
	Both	2(50.0%)	1(25.0%)	1(25.0%)	4	
	No treatment	36(51.4%)	23(32.9%)	11(15.7%)	70	
Masturbation attitude	Not harmful	0(0.0%)	2(50.0%)	2(50.0%)	4	P=0.01 (SS)
	Excessive is harmful	4(16.7%)	16(66.7%)	4(16.7%)	24	
	Positively harmful	44(61.1%)	16(22.2%)	12(16.7%)	72	
Night emission	Not harmful	0(0.0%)	5(55.6%)	4(44.4%)	9	P=0.01 (SS)
	Excessive is harmful	4(16.0%)	17(68.0%)	4(16.0%)	25	
	Positively harmful	44(66.7%)	12(18.2%)	10(15.2%)	66	
Reaction of spouse@	Upset	2(10.5%)	14(73.7%)	3(15.8%)	19	P=0.01 (SS)
	Supportive	2(20.0%)	3(30.0%)	5(50.0%)	10	
	No reaction	11(39.3%)	9(32.1%)	8(28.6%)	28	

@57 were married cases. SS=Statistically Significant. NS=Not Significant.

Among the 22 cases of sexual dysfunction with no symptoms,14(63.6%)were from PME group. 11(68.8%) % 10(90.9%) of Dhat syndrome cases had weakness with palpitation and weakness with giddiness respectively, which is higher than among PME (25.3% 9.1%) & MED (6.3% & 0.0%) group. Sexual dysfunction and associated symptoms were found to be associated more with the DS group and it was statistically significant as compares to PME and MED group.[P=0.01]. Out of 65 cases had fear about their potency, 50.8% were from DS group as compared to 32.1% & 16.9% from PME and MED group. Sexual dysfunction and fear about potency were found to be more in DS group as compares to PME and MED group and it was statistically significant (P=0.03). Maximum (90%) patients from all three groups had practiced masturbation at sometime in their adolescence, 44(48.9%) were from DS group. The association of having practiced masturbation and type of sexual dysfunction was not found to be statistical significant (P=0.747).

32 cases had history of exposure, in which 15(46.9%) from PME group. The association of history of exposure and having PME was found to be statistically significant as compared to other sexual dysfunction i.e. DS and PME.(P=0.01). Among 46 cases having addicted to various substances, 19(41.3%), 14(30.4%) & 13(28.3%) were from DS,PME and MED group. These association of having an addiction and DS was found to be statistically significant.(P=0.04). 81 cases had co morbidity for psychiatric condition in which, 47%, having anxiety (68% from DS). 26% had depression (10(38.5%) from each PME and MED. This psychiatric co-morbidity having strong association with DS sexual dysfunction. This association of psychiatric co-morbidity specially anxiety is more with DS while depression was more with the PME and MED found to be statistically significant (P=0.01).

63 cases felt that practicing masturbation in the past was the root cause of their illness, among which 40(63.5%) cases were of Dhat syndrome. This association of root causes is masturbation is statistically significant among the DS group (P=0.01). Among the 72 cases who reported masturbation as positively harmful, 44(66.1%) were of DS while 16 (66.7%) out of who reported excessive harmful were from PME group. Association of masturbation is positively harmful for having DS while excessive masturbation and having PME is found to be statistically significant (P=0.01). Among the 66 cases who reported night emission as positively harmful, 44(66.7%) were of DS while 17 (68.0%) out of 25 who reported excessive harmful were from PME group. Association of night emission positively harmful for having DS while excessive night emission for PME is found to be statistically significant (p=0.01). Majority i.e. 70 cases not seeking treatment from anyone before this. Among the 12 cases visited quacks, 6(50%) were of DS. Association of seeking treatment and type of sexual dysfunction not found statistically significant (P=0.747). Nearly 50 % of the wives have no reaction to the present sexual dysfunction and majority (39.3%) among wives of Dhat syndrome while upset (14 out of 19 i.e. 73.7) was found more in PME group. The reaction of spouse is different in different sexual dysfunction. This found to be statistically significant (p=0.01). (Table 3).

Discussion:

The present study conducted at psychiatric OPD of a tertiary care centre attached to a medical college

located at rural area of Maharashtra. A total of 100 cases having sexual dysfunction were included for study purpose. Majority (54 %) of which were referred from skin OPD while 19% self reported.

We observed majority Dhat Syndrome (48%) as compared to Premature Ejaculation (34%) and Male Erectile Disorder (18%) among the studied cases. The most common sexual dysfunction reported from other studies [3,6,7,8] reported similar problems but more or less in percentage. These findings are similar with the other studies in Indian context. The variation could be related to geographical, social & cultural backgrounds of the places were study conducted.

Demographic factors among the three common sexual dysfunction shows that young adults (15-25 years age group) have more problem of having Dhat syndrome(73.6%) while 26-35 age group reported PME(53.7%) & MED (24.4%. The association of young adults and having DS was statistically significant [P=0.01]. DS is seen more in unmarried people 33(76.3%)] where among married PME & MED found [26(45.6%)] & [16(28.1%)] respectively. The association of unmarried people and DS was found to be statistically significant [P=0.01]. Those who are skilled worker and income more than more than 3000 rupees reported more cases of Premature ejaculation. This finding corroborates the finding reported by Behere and Natraj[9] and Bhatia and Malik [10] found that the patients with symptoms of Dhat syndrome were mostly young, recently married, poor, rural and from family with conservative attitudes towards sex. Nakera [11] , where Dhat syndrome was found to be more common in late teens and young adults where as Premature ejaculation is seen more common in age range of 26-35 years and Male erectile disorder in elderly, range 36-45.

This preponderance of unmarried males could be due to the fact that they are worried about the implications of semen loss for their future marital life and therefore seek treatment earlier. Level of education plays a key role in this syndrome and that it is more prevalent in less educated people. We also found nearly 50 % illiterates had Dhat Syndrome and similar reported by Gurmeet Singh [12].

In the present study, associated symptoms like weakness with palpitation(68.8%) and weakness with giddiness (90.9%) in Dhat syndrome were more as compared to PME (25.3% & 9.1%) and MED (6.3% & 0.0%) group which was statistically significant. This findings are similar to one reported by M.S. Bhatia and S.C. Malik [10] where weakness was major symptom followed by palpitation. Fears regarding potency, genitals and physical illness is more common with patients of Dhat syndrome (50.8%) as compared to PME(32.1%) and MED(16.9%).(P<0.05). Nakra BR et al [11] observed Dhat syndrome (with impotence/PME 10.7%; without 10%) and apprehension about potency (18%).

PME group has maximum cases (46.9%) of having history of exposure and the association of history of exposure and having PME was found to be statistically significant as compared to other sexual dysfunction i.e. DS and PME.(p=0.01). Maximum (90%) reported practiced masturbation, out of which 44(48.9%) were from DS group (NS). nearly 75% of the patients had practiced masturbation before developing potency disorders [13]. 19(41.3%), 14(30.4%) & 13(28.3%) were from DS, PME and MED group having addiction. These association of having an addiction and DS was found to be statistically significant.(p=0.04). PME group has maximum (57%) reported exposure to the CSW. Homosexual contact was seen in 2% of the patients all were from MED group. Similar finding was given by the Kaushal K. et al in his study [14].

Anxiety maximally reported by DS(68% among anxiety) while depression (38.5%) maximally reported in each PME and MED. Anxiety state (57%), schizophrenia (16%) and reactive depression (16%) were common psychiatric diagnosable conditions in Dhat sample. contrast to above findings various other studies showed incidence neurotic depression was more than anxiety neurosis [11,12].

The above findings regarding phenomenology of Dhat syndrome shows that the patients of Dhat syndrome suffered from variety of physical symptoms which were psychogenic in origin. Along with these disabling symptoms they had fear that they were loosing their power due to the passage of semen. All this was thought to be due to some undiagnosed physical illness. Many of these patients were also guilt ridden about their previous sexual outlets like masturbation and earlier sexual encounters.

In the present study, mastrubation as a cause of illness is reported (63%) by all types if sexual dysfunction but majority by the Dhat syndrome group. Misconceptions regarding masturbation and nocturnal emission are widely prevalent and Dhat syndrome reported its harmful while premature ejaculation and male erectile disorder group reported its harmful when it is excess. This corroborates the finding of the other studies regarding this misconception [11,12,13,15].

Majority (70%) not seek treatment from anyone before reporting to our institute while 14 percent visited medical professional as compared to 12 percent visited quacks. Among the quacks visited, majority (50%) were of Dhat syndrome. Out findings contradict to the study by Nashi Khan et al [16] showed half of the patients seek help from 'hakims' and least number of patients consulted medical professionals. This could depend upon availability of the quacks or health seeking behavior in the geographical area. Nearly 50 % of the wives have not shown any reaction to the problem and majority from Dhat syndrome wives. But upset and supportive type if reaction also shown by the PME and MED group

respectively. The exact reaction of the wives was not studied as wives were not interviewed. However mixed type of reaction observed in our study. The wives of these patients showed either helpful or indifferent attitudes towards the problem of sexual dysfunction [11].

Conclusion:

The phenomenology of Dhat syndrome is significantly different from the other sexual dysfunctions. The community perception about the sexual dysfunction is also low. DS is more commonly observed in young unmarried adults. There is still stigma in the community that cases with sexual dysfunction are not reporting directly to the Psychiatry department. Comorbid psychiatric conditions present in sexual dysfunctions. A more elaborative sex education through Information Education and communication strategy among the community is need of hour to remove the misconception about the cause and improve attitude towards the sexual dysfunctions specially Dhat Syndrome.

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