Original Article

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# Assessment of Pathways to Care, Personality Traits and Quality of Life among Patients with Dhat Syndrome: A Cross-sectional Study

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## ABSTRACT

**Introduction:** Dhat syndrome, a culturally specific psychosomatic disorder, predominantly affects young men in South Asian countries. It is characterised by a constellation of somatic complaints, anxiety, and depressive symptoms, all attributed to the perceived loss of semen, a substance that has been traditionally considered vital for health and vitality in South Asian cultural contexts. Rooted in centuries-old beliefs, Dhat syndrome is often accompanied by profound psychological distress and misattributions regarding semen loss through nocturnal emissions, masturbation, or urination. This study seeks to comprehensively assess the clinical manifestations, care-seeking pathways, predominant personality traits, and Quality of Life (QoL) among individuals diagnosed with Dhat syndrome, thereby assessing critical gaps in culturally competent psychiatric intervention.

**Aim:** To study the pathways of care and phenomenology among patients with Dhat syndrome, at-risk personalities, and the QoL in these patients.

**Materials and Methods:** The present cross-sectional study was conducted at a tertiary care hospital in North Karnataka, India, involving 47 male patients diagnosed with Dhat syndrome per ICD-10 criteria. Data were collected using a semi-structured proforma for socio-demographic profile, World Health Organisation (WHO) Pathways Interview Schedule, International Personality Disorder Examination (IPDE) screening module and the World Health Organization Quality of Life - brief version (WHOQOL-BREF) questionnaires. Statistical analysis included descriptive statistics and correlation tests.

**Results:** The study comprised 47 male patients diagnosed with Dhat syndrome, predominantly young adults (mean age 24.91±5.11 years), unmarried 31 (65.96%) and from rural 29 (61.7%) and low-income backgrounds 26 (55.3%). The mean duration of untreated illness was 3.95 years, with patients consulting 1.6 (mean) providers before reaching psychiatric care, reflecting significant delays and fragmented pathways. Cluster C personality traits were predominant in 87.2% of participants, indicating heightened anxiety, dependency, and obsessive-compulsive tendencies. The WHOQOL-BREF scores revealed that physical (46.57±18.76) and psychological health (45.26±17.22) were most affected, followed by the environmental domain (54.20±13.62) and social relations (53.17±18.28). Delays in psychiatric care were associated with poorer physical ($r=-0.581$, $p<0.001$) and psychological health ($r=-0.589$, $p<0.001$). The findings underscore the need for early psychiatric intervention, targeted psychoeducation, and culturally sensitive care to mitigate prolonged delays and associated socioeconomic and psychological burdens.

**Conclusion:** The present study revealed prolonged care-seeking pathways, with a mean duration of untreated illness of 3.95±2.21 years. Poor QoL was significantly associated with longer illness duration. The findings underscore the urgent need for culturally sensitive psychoeducation, targeted interventions for at-risk personality profiles, and integrated mental health services to address the socio-cultural and economic barriers in managing Dhat syndrome effectively.

**Keywords:** Culture-bound syndromes, Health services accessibility, Sexual problems, Somatoform disorders

## INTRODUCTION

Culture-Bound Syndromes (CBS) are mental health conditions that arise within specific cultural contexts and are shaped by local beliefs, norms, and social structures. These syndromes reflect the diverse ways in which different societies conceptualise and respond to psychological distress, often blending somatic, emotional, and behavioural symptoms that may not align with Western diagnostic frameworks [1]. Unlike universally recognised psychiatric conditions, CBS highlight the role of cultural meaning systems in shaping illness narratives and help-seeking behaviours. They underscore that mental illness is not merely a biological or psychological phenomenon but is also profoundly influenced by sociocultural factors and lived experiences [2].

Among the various CBS identified worldwide, Dhat syndrome is one of the most frequently reported in the Indian subcontinent. First described by Wig NN in 1960 [3], Dhat syndrome primarily affects young South Asian men and is characterised by persistent anxiety, fatigue, weakness, depressive mood, and sexual dysfunction, attributed to the loss of semen through nocturnal emissions, masturbation, or urine. In many traditional Indian belief systems, semen is regarded as a highly refined and essential bodily fluid, and its loss is believed to weaken both body and mind [4]. This belief finds its roots in classical Ayurvedic texts such as the *Charaka Samhita* and *Sushruta Samhita*, where semen (*shukra dhatu*) is described as a distillate of vital energies, and its preservation is linked with strength, longevity, and masculinity [5,6].

Dhat syndrome is recognised in the International Classification of Diseases (ICD-10) under “other neurotic disorders” (F48.8) and acknowledged in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) as a culture-specific syndrome. Despite its inclusion in global diagnostic systems, Dhat syndrome often remains under-recognised or misdiagnosed in clinical practice due to the prominence of somatic symptoms and the sociocultural taboo surrounding sexual health discussions. The condition typically affects young, unmarried men from rural or semi-urban areas with limited education and low socioeconomic status [7].

These individuals frequently lack access to accurate sexual health information and often rely on culturally sanctioned health providers such as traditional healers, religious practitioners, or general physicians. This results in a fragmented, non-linear, and frequently prolonged pathway to appropriate psychiatric care. Many patients seek help only after multiple non-psychiatric consultations, by which time the condition has progressed, often leading to increased distress, financial burden, and diminished functioning [8].

Psychiatric co-morbidities such as depression, generalised anxiety, and somatisation disorders are commonly associated with Dhat syndrome [9]. Additionally, studies have shown a high prevalence of Cluster C personality traits, particularly avoidant, dependent, and obsessive-compulsive patterns, which are characterised by anxious and fearful behaviours [10-12]. These personality vulnerabilities may amplify health-related anxiety and perpetuate maladaptive coping patterns, further delaying recovery. QoL in patients with Dhat syndrome is significantly impaired across physical, psychological, social, and environmental domains [13]. Patients report reduced vitality, poor concentration, social withdrawal, and occupational difficulties, all of which may be compounded by guilt, stigma, and lack of emotional support. The psychological burden is often exacerbated by socioeconomic pressures and misinformation propagated by unqualified practitioners, leading to a cycle of distress and ineffective treatment-seeking [7].

Studying the pathway to care, associated personality profiles, and QoL in patients with Dhat syndrome is crucial for tailoring culturally appropriate mental health interventions. While Dhat syndrome is recognised in ICD-10 (F48.8) and DSM-5 as a culture-specific syndrome, existing literature inadequately explores the interplay between help-seeking delays, personality pathology, and QoL in affected individuals. Most prior research has focused on symptomatology and cultural beliefs, with limited data on care pathways, financial burden, and associated personality traits [8,10]. The present study addressed these gaps by evaluating the correlation between duration of illness and QoL. The study also assessed the predominant personality cluster in these patients. The novelty lies in the use of validated scales and tools to assess these interlinked variables, enabling a culturally informed, biopsychosocial profile of Dhat syndrome. A deeper understanding of these factors can inform the development of psychoeducational strategies, early screening tools, and integrative models of care that align with cultural beliefs while promoting evidence-based psychiatric support. Such an approach is necessary to reduce stigma, improve access, and ultimately enhance outcomes for individuals affected by this culturally bound yet clinically significant disorder. Thus, the aim of the present study was to study the pathway of care and phenomenology among patients with Dhat syndrome, at-risk personalities, and the QoL of these patients.

## MATERIALS AND METHODS

The present study was a cross-sectional study conducted in the Department of Psychiatry at BLDE (Deemed to be University) Shri BM Patil Medical College, Hospital and Research Centre, Vijayapura, Karnataka, India, from May 2023 to December 2024. The study was approved by the Institutional Ethics Committee (IEC Approval No.: BLDE (DU)/IEC/ 870/2022-23).

**Inclusion and Exclusion criteria:** Male patients aged 18 years and above who are/were diagnosed with Dhat syndrome as per ICD-10 criteria by a qualified psychiatrist, presenting to the psychiatry outpatient department or referred from other departments, were included in the study. Patients with co-morbid active psychotic disorder, organic brain syndrome or with intellectual disability were excluded from the study.

**Sample size estimation:** Based on previous literature, with an anticipated Mean±SD of Dhat-related symptoms prior to psychiatric consultation being 6.78±6.94 years [7], a minimum sample size of 47 was calculated to achieve a 95% confidence level with a precision of 2.

### Study Procedure

Eligible participants were recruited consecutively after obtaining informed written consent. Sociodemographic and clinical data were collected using a semi-structured proforma. The following standardised tools were used:

- WHO Pathways Interview Schedule is a semi-structured tool developed by the World Health Organisation to trace the sequence and type of healthcare contacts made, main treatment received and the time spent by the patient before reaching psychiatric services. It helps identify delays and fragmentation in the care pathway [14]. In addition to these questions, an eighth question regarding the financial resources spent before reaching psychiatric care was added to the questionnaire. This response was recorded by retrospectively asking for expenses such as consultation payments to traditional or religious healers, medication costs, diagnostic tests, and travel expenses.
- ICD-10 IPDE (International Personality Disorder Examination) Screening Questionnaire is a validated tool used for the preliminary identification of individuals with personality disorders. It is specifically developed for use in clinical and research settings. The screening module includes 59 structured questions to identify characteristic traits and behaviours across different personality disorder clusters (A, B, and C) [15].The predominant cluster was then chosen based on the majority of answers under each cluster.
- WHOQOL-BREF is a widely accepted abbreviated version of the World Health Organisation's QoL assessment tool, created to measure an individual's subjective perception of their well-being. It includes 26 items that evaluate four key domains: physical health, psychological health, social relationships, and environmental factors. The scale also has two questions on overall QoL and patients' satisfaction about overall health, which are not included while calculating each domain's scores. Each item is rated on a 5-point Likert scale, reflecting intensity, frequency, satisfaction, or capacity. Domain scores are transformed to a 0-100 scale, where higher scores indicate better QoL [16].

## STATISTICAL ANALYSIS

Data were entered in Microsoft Excel and analysed using Statistical Package for Social Sciences (SPSS) Version 21. Descriptive statistics were employed to summarise the sociodemographic and clinical characteristics of the participants. Continuous variables were presented as mean±Standard Deviation (SD) or median, depending on the distribution. Group comparisons were performed using the independent samples t-test for normally distributed data and the Mann-Whitney U test for non-normally distributed data. Categorical variables were analysed using the Chi-square test. Correlation between variables was assessed using Pearson's or Spearman's correlation coefficients, as appropriate. A p-value of less than 0.05 was considered statistically significant in all two-tailed analyses.

## RESULTS

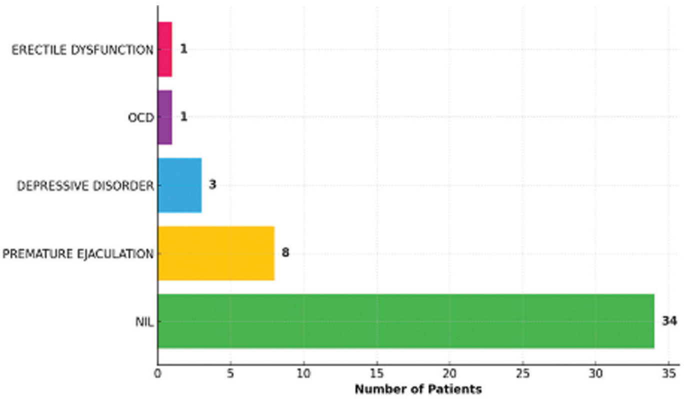
A total of 47 male patients diagnosed with Dhat syndrome were included in the study. The mean age of participants was 24.91±5.11 years (range: 18-42 years), with the majority belonging to the young adult age group 38 (80.9%), rural background 29 (61.7%) and were unmarried 31 (65.96%). Most owned a Below Poverty Line (BPL) card 26 (55.32%) and most individuals were either illiterate, had finished high school or were degree holders 12 (25.53%), and none had post-degree education, as represented in [Table/Fig-1].

From the collected data, the average duration of illness among patients was 3.95±2.21 years, with illness durations ranging

| Parameters | n (%) | Mean±SD |
|---|---|---|
| **Age category** | | |
| Young adult (18-29 years) | 38 (80.9%) | 24.91±5.11 |
| Average adult (30-44 years) | 9 (19.1%) | |
| **Place of residence** | | |
| Rural | 29 | 61.70% |
| Urban | 18 | 38.30% |
| **Socioeconomic status** | | |
| APL | 21 | 44.68% |
| BPL | 26 | 55.32% |
| **Marital status** | | |
| Married | 16 | 34.04% |
| Unmarried | 31 | 65.96% |
| **Educational status** | | |
| Illiterate | 12 | 25.53% |
| Primary school | 4 | 08.51% |
| Middle school | 7 | 14.90% |
| High school | 12 | 25.53% |
| Degree | 12 | 25.53% |
| Post-degree | 0 | 0 |

**[Table/Fig-1]:** Sociodemographic details.

from six months to ten years. On average, patients sought their first help after 1.87±1.41 years, from as early as two months to as long as six years. The median duration to reach a psychiatrist from their first contact was one year. The majority of patients 34 (72.34%) reported no illness in the past at the time of the interview, as depicted in [Table/Fig-2]. Premature ejaculation was the most common issue among those with a past history of illness (eight cases). Among the 47 patients, eight patients reported ongoing interpersonal relationship issues, followed by seven patients who reported financial stress, as tabulated in [Table/Fig-3]. From the 47 samples collected, only two patients had a family history of suicide in first-degree relatives.



**[Table/Fig-2]:** Distribution of illness in the past.

| Type of ongoing stress | N | Percentage |
|---|---|---|
| Family issues | 5 | 10.64% |
| Financial problems | 7 | 14.89% |
| Interpersonal relationship issues | 8 | 17.02% |
| Illness | 3 | 06.38% |
| Nil | 24 | 51.06% |

**[Table/Fig-3]:** Distribution of ongoing stress.

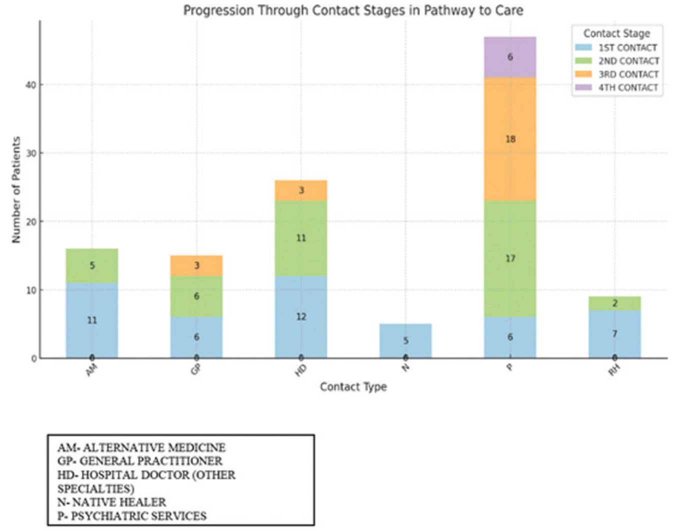
## Pathway to Care

1) **Contacts made:** Most of the patients first sought help at other specialities 12 (25.53%), or alternative medicine doctors 11 (23.4%), while psychiatric consultation as first contact 6 (12.76%) was relatively less often, as seen in [Table/Fig-4,5].

The mean number of contacts before reaching Psychiatry services was 1.6±0.1.

| Contact type | Contact stage | N | Percentage |
|---|---|---|---|
| Alternative medicine | 1st contact | 11 | 23.40% |
| | 2nd contact | 5 | 12.19% |
| General practitioner | 1st contact | 6 | 12.76% |
| | 2nd contact | 6 | 14.63% |
| | 3rd contact | 3 | 12.50% |
| Hospital doctor (other specialties) | 1st contact | 12 | 25.53% |
| | 2nd contact | 11 | 26.83% |
| | 3rd contact | 3 | 12.50% |
| Native healer | 1st contact | 5 | 10.64% |
| Psychiatric services | 1st contact | 6 | 12.76% |
| | 2nd contact | 17 | 41.46% |
| | 3rd contact | 18 | 75.00% |
| | 4th contact | 6 | 100% |
| Religious healer | 1st contact | 7 | 14.89% |
| | 2nd contact | 2 | 4.88% |

**[Table/Fig-4]:** Pathway to care- contact type and the stage.



**[Table/Fig-5]:** Contacts in the pathway of care.

2) **Presenting complaints:** The most common presenting complaint was generalised weakness 9 (19.1%), followed by passage of semen in urine 8 (17%), as represented in [Table/Fig-6].

| Main presenting complaint | Frequency | Percentage |
|---|---|---|
| Generalised weakness | 9 | 19.1% |
| Passage of semen (in urine) | 8 | 17% |
| Night fall | 6 | 12.8% |
| Low mood | 6 | 12.8% |
| Headache | 6 | 12.8% |
| Pre-mature ejaculation | 5 | 10.6% |
| Excessive worry | 4 | 8.5% |
| Excessive masturbation | 3 | 6.4% |
| Total | 47 | 100% |

**[Table/Fig-6]:** Distribution of main presenting complaint.

3) **Who suggested to seek help:** Most participants in the study sought help on their own 22 (46.8%) and least often on suggestion by family 5 (10.6%) as seen in [Table/Fig-7].

4) **Main treatment offered:** From the gathered data, most patients who sought help were reassured about the illness 17 (36.17%) and then closely followed by prescription of medications 15 (31.91%), as in [Table/Fig-8].

| Suggestions offered by | Frequency | Percentage |
|---|---|---|
| Self | 22 | 46.8% |
| Friend | 14 | 29.8% |
| Internet | 6 | 12.8% |
| Family | 5 | 10.6% |
| Total | 47 | 100% |

**[Table/Fig-7]:** Suggested to seek help by:

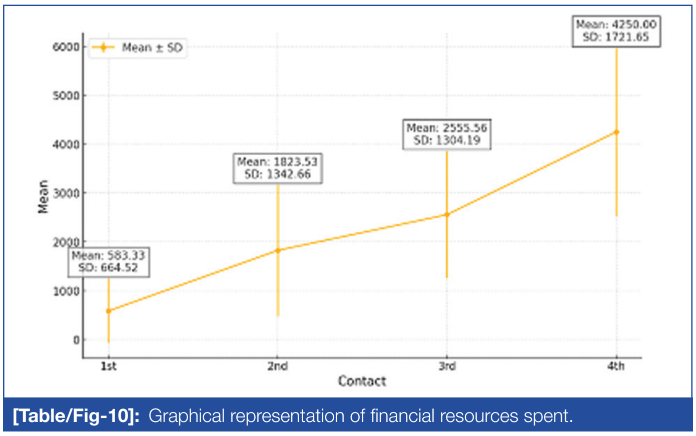
| Treatment offered | N | Percentage |
|---|---|---|
| Reassurance | 17 | 36.17% |
| Medications | 15 | 31.91% |
| Performed rituals/ prayers | 5 | 10.64% |
| Referred elsewhere | 10 | 21.28% |
| Total | 47 | 100% |

**[Table/Fig-8]:** Distribution of main treatment offered.

5) **Financial resources spent:** The average financial burden increased steadily with each contact stage before reaching a psychiatrist (P), rising from ₹583.33±664 when a psychiatrist was the first contact to ₹4,250.00±1721.65 by the fourth contact on average, as depicted in [Table/Fig-9,10].

| Contact of psychiatry services | N | Mean | SD |
|---|---|---|---|
| 1st contact | 6 | 583.33 | 664.52 |
| 2nd contact | 17 | 1823.53 | 1342.66 |
| 3rd contact | 18 | 2555.56 | 1304.19 |
| 4th contact | 6 | 4250.00 | 1721.65 |

**[Table/Fig-9]:** Financial resources (in rupees) spent at each contact stage of psychiatric services.



**[Table/Fig-10]:** Graphical representation of financial resources spent.

## Personality Traits

Among the 47 patients from whom data were collected, Cluster C personality traits are predominant among the participants, comprising 87.2% (41 individuals). Anxious and fearful behaviour patterns characterise Cluster C personality disorders, as in [Table/Fig-11].

| Personality traits | Frequency | Percentage |
|---|---|---|
| Cluster A | 01 | 02.13% |
| Cluster B | 05 | 10.64% |
| Cluster C | 41 | 87.23% |
| Total | 47 | 100.0% |

**[Table/Fig-11]:** Distribution of personality traits.

## Quality of Life (QoL)

In the WHOQOL-BREF scale, higher scores indicate better QoL. The mean score of overall QoL and health satisfaction was 48.64±15.72. Further assessment of individual domains showed that the environment domain had the highest mean score (54.20±13.62), whereas the psychological health (45.26±17.22) domain had the lowest, as described in [Table/Fig-12].

| Domains | Mean score | SD |
|---|---|---|
| Overall QoL and satisfaction | 48.62 | 15.72 |
| Physical health | 46.57 | 18.76 |
| Psychological health | 45.26 | 17.22 |
| Social relations | 53.17 | 18.28 |
| Environment | 54.20 | 13.62 |

**[Table/Fig-12]:** Quality of Life (QoL) score.

## Correlation Coefficients and Tests of Significance

- **Total duration of illness and QoL:** Pearson correlation analysis showed that as the duration of illness increased, patients' physical (r=-0.434, p=0.002) and psychological (r=-0.400, p=0.005) QoL significantly worsened, whereas social relationships (r=-0.205, p=0.167) and environmental domain (r=-0.294, p=0.055) showed weak negative correlation and were not statistically significant as shown in [Table/Fig-13].

| S. No. | Domain | N | Pearson correlation | p-value |
|---|---|---|---|---|
| 1 | Physical health | 47 | -0.434 | 0.002 |
| 2 | Psychological health | 47 | -0.400 | 0.005 |
| 3 | Social relationships | 47 | -0.205 | 0.167 |
| 4 | Environment | 47 | -0.294 | 0.055 |

**[Table/Fig-13]:** Correlation between total duration of illness and the QoL.

- **Place of residence with time for first contact, duration to psychiatrist and QoL domains:** Though the mean duration since first contact was longer among rural patients (mean=2.14 years, SD=1.60), this difference was not statistically significant (p=0.098). However, a significant difference (p=0.020) was observed in the duration taken to reach psychiatric services, with rural patients experiencing a longer delay (mean=1.55 years, SD=1.37) compared to their urban counterparts (mean=0.69 years, SD=0.81). Overall, the findings indicate no significant urban-rural differences in the QoL outcomes as seen in [Table/Fig-14].

| S. No. | Variables | Urban/Rural (N=18/29) | Mean | SD | p-value |
|---|---|---|---|---|---|
| 1 | Years since first contact | Urban | 1.4356 | 0.96659 | 0.098 |
| | | Rural | 2.1438 | 1.60077 | |
| 2 | Duration to Psychiatrist | Urban | 0.6900 | 0.81138 | 0.020 |
| | | Rural | 1.5490 | 1.37021 | |
| 3 | Physical health | Urban | 48.2000 | 19.36656 | 0.643 |
| | | Rural | 45.5528 | 18.65384 | |
| 4 | Psychological health | Urban | 45.217 | 18.6486 | 0.989 |
| | | Rural | 45.286 | 16.6067 | |
| 5 | Social relations | Urban | 50.4444 | 20.90759 | 0.427 |
| | | Rural | 54.8541 | 16.60454 | |
| 6 | Environment | Urban | 55.2111 | 13.25712 | 0.693 |
| | | Rural | 53.5707 | 14.04201 | |

**[Table/Fig-14]:** Association of place of residence with time taken for first contact, duration to psychiatrist and QoL domains.

- **Socioeconomic status with time for first contact, duration to psychiatrist and QoL domains:** Patients having Below the Poverty Line (BPL) card experienced significantly longer (p=0.024 and 0.015, respectively) durations for both, duration since first contact and in reaching psychiatric services (mean being 2.29 and 1.61 years, respectively) compared to those who had Above Poverty Line (APL) card (mean=1.36 years and 0.73 years, respectively) as depicted in [Table/Fig-15]. However, no statistically significant differences were found between APL and BPL groups across QoL domains. These findings suggest that economic disadvantage is associated with delays in accessing psychiatric care, though it does not significantly impact QoL outcomes [Table/Fig-15].

| S. No. | Variables | APL/ BPL (N=21/ 26) | Mean | SD | p-value |
|---|---|---|---|---|---|
| 1 | Years since first contact | APL | 1.3576 | 1.37024 | 0.024 |
| | | BPL | 2.2885 | 1.35036 | |
| 2 | Duration to psychiatrist | APL | 0.7343 | 1.12780 | 0.015 |
| | | BPL | 1.6123 | 1.22574 | |
| 3 | Physical health | APL | 48.7981 | 19.33103 | 0.470 |
| | | BPL | 44.7642 | 18.47609 | |
| 4 | Psychological health | APL | 47.448 | 18.3506 | 0.440 |
| | | BPL | 43.492 | 16.3921 | |
| 5 | Social relations | APL | 53.9524 | 17.61802 | 0.794 |
| | | BPL | 52.5296 | 19.11609 | |
| 6 | Environment | APL | 58.0357 | 10.10859 | 0.083 |
| | | BPL | 51.1000 | 15.40928 | |

**[Table/Fig-15]:** Association of socioeconomic status with the time taken for first contact, duration to psychiatrist and QoL domains.

- **Educational status with time taken for first contact and duration to psychiatrist:** Analysis based on educational status revealed no statistically significant differences in either the duration since first contact or the time taken to reach psychiatric services as shown in [Table/Fig-16]. Statistically significant differences were observed in the psychological health (p=0.034) and environment (p=0.002) domains, with higher education levels correlating with better scores. Overall, individuals with higher educational attainment reported better perceived well-being, particularly in psychological and environmental aspects. Variables such as educational status, place of residence, and economic class were prioritised for analysis because they are more modifiable and relevant to public health.

| S. No. | Variables | Educational status | Mean | SD | p-value |
|---|---|---|---|---|---|
| 1 | Years since first contact | Illiterate | 2.6250 | 1.26356 | 0.119 |
| | | Primary school | 2.3750 | 1.49304 | |
| | | Middle school | 2.0000 | 1.38444 | |
| | | High school | 1.5558 | 1.57340 | |
| | | Degree | 1.1950 | 1.19055 | |
| 2 | Duration to Psychiatrist | Illiterate | 1.7433 | 1.25375 | 0.272 |
| | | Primary school | 1.7500 | 1.44338 | |
| | | Middle school | 1.3329 | 1.23648 | |
| | | High school | 0.7708 | 1.42804 | |
| | | Degree | 0.9033 | 0.88860 | |
| 3 | Physical health | Illiterate | 35.3917 | 14.06598 | 0.078 |
| | | Primary school | 37.5250 | 19.56432 | |
| | | Middle school | 50.5100 | 20.95836 | |
| | | High school | 54.4500 | 19.13585 | |
| | | Degree | 50.5717 | 17.41505 | |
| 4 | Psychological health | Illiterate | 35.417 | 11.8801 | 0.034 |
| | | Primary school | 31.250 | 17.5265 | |
| | | Middle school | 50.086 | 15.0883 | |
| | | High school | 50.775 | 19.3175 | |
| | | Degree | 51.442 | 15.8256 | |
| 5 | Social relationships | Illiterate | 46.4975 | 18.60681 | 0.144 |
| | | Primary school | 45.8250 | 25.95116 | |
| | | Middle school | 67.8143 | 16.98994 | |
| | | High school | 52.7750 | 18.93804 | |
| | | Degree | 54.1250 | 12.04968 | |
| 6 | Environment | Illiterate | 42.2000 | 11.19529 | 0.002 |
| | | Primary school | 47.7000 | 10.64613 | |
| | | Middle school | 59.3857 | 20.63385 | |
| | | High school | 58.6000 | 10.08164 | |
| | | Degree | 60.9375 | 5.09086 | |

**[Table/Fig-16]:** Association of educational status with time taken for first contact, duration to psychiatrist and QoL domains.

## DISCUSSION

The present study explored the sociocultural, clinical, and psychological dimensions of Dhat syndrome, reaffirming its prevalence among young, unmarried, socioeconomically disadvantaged males from rural backgrounds, with limited education. The syndrome which marked by somatic and psychological complaints attributed to semen loss is culturally reinforced by traditional beliefs, particularly in South Asia, where semen is viewed as a vital fluid [3,4]. Anxiety about semen loss leads to health-related fears and delays in psychiatric care [7,9].

The mean age of participants in the study was 24.9±5.11 years, with over 80% between 18-29 years, consistent with Grover S et al., (2016), Khan N (2005), and Nazir D et al., (2024), who also reported similar age groups [7,17,18]. A majority (65.96%) were unmarried, aligning with findings by Prakash S et al., (2016) [9], who noted that sexual guilt, anxiety, and lack of psychosocial support contribute to vulnerability. Despite marriage, misconceptions may persist, especially in the absence of formal sex education. Demographic factors like the place of residence (urban/rural) and socioeconomic status (APL/BPL) also played a role, as 61.7% of the study population were from rural backgrounds and 55.3% owned a BPL card. These findings align with Khan N (2005) [17], Nazir D et al., (2024) [18], and Deshmukh R et al., (2024) [13], who linked financial hardship and poor health literacy with delayed psychiatric access. Education also played a role; nearly 75% had only secondary education or less. Poor sexual health literacy perpetuates myths about semen loss, delaying care and worsening outcomes.

The mean illness duration was 3.95±2.21 years, with a 1.87±1.41 years delay in seeking first contact, shorter than Grover S et al., (2016) [7], suggesting improvements in mental health awareness or service accessibility. Still, only 12.8% sought psychiatric care initially, with most approaching general physicians, alternative healers, or religious practitioners. As highlighted by Shahi MK et al., (2022) sociocultural stigma and fragmented pathways exacerbate delays [10]. Delays in approaching first-contact providers in Dhat syndrome are driven by stigma, low sexual health literacy, cultural taboos, and mistrust of psychiatric services [7]. Patients often somatise their distress and initially consult general physicians or traditional healers, which postpones appropriate psychiatric care [7]. Financial barriers, rural residence, and lack of awareness further exacerbate these delays. These factors have serious public health implications such as prolonging illness, increasing costs, and lowering QoL [8]. The practical implications of these findings call for a multitiered response to promote early identification and management. Training frontline healthcare providers including general practitioners, AYUSH practitioners, and community health workers to recognise the psychosomatic features of Dhat syndrome is vital. Community-based campaigns involving respected local figures and media should be used to disseminate accurate information, reduce stigma, and encourage timely help-seeking. Culturally sensitive psychoeducation using local languages, metaphors, and illustrations can effectively address myths about semen loss. Schools and colleges should incorporate age-appropriate sexual health education to improve awareness among young men. Additionally, the use of telepsychiatry and digital platforms can enhance access in remote areas, while collaboration with traditional healers can foster mutual referrals and reduce resistance to psychiatric care. This underlines the need for early identification, especially in low-income populations.

Psychologically, 87.2% of participants exhibited Cluster C personality traits (avoidant, dependent, obsessive-compulsive), echoing Prakash S et al., (2016), who noted that neuroticism and health-related anxiety may predispose individuals to Dhat syndrome [9]. These traits contribute to somatic misinterpretation and hinder help-seeking.

QoL was significantly reduced, especially in the physical and psychological domains. The findings of this study were consistent with Shahi MK et al., (2022), the study showed that patients with Dhat syndrome score lower on QoL metrics [10]. Duration of illness was inversely correlated with QoL, while factors like rural residence and low income were associated with longer delays in psychiatric access but not necessarily lower QoL scores, possibly due to community support or cultural normalisation of distress. Higher education is associated with better QoL as it enhances health awareness, access to healthcare, financial security, psychological resilience, and living conditions, all of which positively influence physical, psychological, and environmental well-being [19].

Clinically, the findings highlight the importance of early screening, public health education, and training of frontline providers. Psychoeducation and culturally adapted Cognitive Behavioural Therapy (CBT), as suggested by Salam KPA et al., (2012), can be effective. Integration of psychiatric services in rural health systems, use of telepsychiatry, and community campaigns can bridge the access gap [20]. In conclusion, Dhat syndrome represents a complex interaction between cultural beliefs, personality vulnerabilities, socioeconomic barriers, and psychological distress. A culturally sensitive, community-based, and multidisciplinary approach is essential for effective management and improved outcomes.

### Limitation(s)

Limitations of the study included conducting the study at a single tertiary care center which may introduce selection bias, limiting its applicability to primary care or community settings. Additionally, the retrospective nature of data collection on healthcare pathways, main treatment given and symptom history may lead to recall bias. Finally, psychiatric co-morbidities were only broadly categorised, which may have limited deeper insights into their impact on QoL and clinical outcomes.

## CONCLUSION(S)

The present study concludes that Dhat syndrome represents a complex interaction between cultural beliefs, psychological vulnerabilities, and systemic healthcare barriers. The present study highlights that Dhat syndrome predominantly affects young, unmarried males from rural, low-income backgrounds, with delayed access to psychiatric care contributing to worsened physical and psychological health. Cultural beliefs surrounding semen loss, reliance on non-psychiatric healers, and financial constraints significantly delayed appropriate intervention, increasing overall distress and reducing QoL. Personality assessments revealed a strong association with Cluster C traits, suggesting that underlying anxious and dependent personality patterns contribute to symptom persistence. Longer illness duration was significantly linked with poorer QoL outcomes. The findings underscore the urgent need for early identification, culturally sensitive psychoeducation, integration of mental health services at the primary care level, and interventions targeting maladaptive personality patterns. Future strategies must bridge cultural and medical paradigms to ensure timely, accessible, and effective care for individuals affected by Dhat syndrome.

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