“ASSESSMENT OF PATHWAY TO CARE AND PHENOMENOLOGY AMONG PATIENTS WITH DHAT SYNDROME: A CROSS-SECTIONAL STUDY”

By

Dr. NISHANTH REDDY. A

Dissertation submitted to the

B.L.D.E (DEEMED TO BE UNIVERSITY)

VIJAYAPURA, KARNATAKA.

In partial fulfilment of the requirements for the degree of

DOCTOR OF MEDICINE

IN

PSYCHIATRY

Under the guidance of

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I hereby declare that this dissertation/ thesis entitled **"ASSESSMENT OF PATHWAY TO CARE AND PHENOMENOLOGY AMONG PATIENTS WITH DHAT SYNDROME: A CROSS-SECTIONAL STUDY"** is a Bonafide and genuine research work carried out by me under the guidance of **Dr. Santosh Ramdurg,** Professor and Head, Department of Psychiatry, BLDE (DU), Shri B M Patil Medical College, Hospital and Research Centre, Vijayapura, Karnataka.

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Finally, I bow my head silently, acknowledging all that **The Lord Almighty** has blessed me with.

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S.NO.	ABBREVIATION	FULL FORM
1	CBS	Culture-Bound Syndromes
2	QoL	Quality of Life
3	WHO	World Health Organization
4	WHOQOL-BREF	World Health Organization Quality of Life - Brief
5	IPDE	International Personality Disorder Examination
6	ICD-10	International Classification of Diseases, 10th Revision
7	DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
8	BPL	Below Poverty Line
9	APL	Above Poverty Line
10	P	Psychiatric Services
11	GP	General Practitioner
12	HD	Hospital Doctor (Other specialties)
13	AM	Alternative Medicine Practitioner
14	RH	Religious Healer
15	N	Native Healer
16	OCD	Obsessive-Compulsive Disorder

ABSTRACT

Background: Dhat syndrome is a culture-bound psychosomatic disorder prevalent among young South Asian men. It is characterized by anxiety and somatic symptoms attributed to semen loss, rooted in traditional beliefs. This study explored the clinical features, pathways to care, personality traits, and quality of life in affected individuals.

Materials and Methods: A cross-sectional study was conducted at a tertiary care hospital in Karnataka, India, involving 47 male patients diagnosed with Dhat syndrome per ICD-10 criteria. Data were collected using a semi-structured proforma, WHO Pathways Interview Schedule, IPDE screening module and the WHOQOL-BREF questionnaires. Statistical analysis included descriptive statistics and correlation tests.

Results: Participants were predominantly young (mean age 24.91 ± 5.11 years), unmarried, and from rural, low-income backgrounds. A significant proportion (87.2%) predominantly exhibited Cluster C personality traits. The average duration from symptom onset to psychiatric care was 3.95 years, with 1.6 ± 0.1 non-psychiatric consultations before reaching Psychiatric services. The financial burden increased with the delay in getting professional help and was significantly associated with a poorer quality of life. WHOQOL-BREF scores indicated lower physical (46.57) and psychological (45.26) health domain scores compared to Social relations (53.17) and environmental domain (54.20). A longer duration of Dhat syndrome is significantly associated with poorer Quality of Life, particularly in the physical ($r = -0.434$, $p = 0.002$) and psychological ($r = -0.400$, $p = 0.005$) domains, indicating that these areas are the most adversely affected.

Conclusion: Our study highlights that Dhat syndrome is associated with significant delays in psychiatric care, substantial financial burden, poor quality of life, and a high prevalence of Cluster C personality traits. The findings emphasize the need for early recognition, culturally sensitive psychoeducation, and better integration of mental health services to improve patient outcomes and reduce the overall burden of illness.

Keywords:

Dhat syndrome, culture-bound, pathways to care, quality of life, personality traits, somatization.

1 INTRODUCTION:

Culture-bound syndromes (CBS) refer to mental health patterns or behaviours closely tied to specific cultural contexts, groups, or regions. These syndromes are defined by the unique ways in which culture influences how mental illness is experienced, expressed, and treated. While some psychological conditions are universally recognized, culture-bound syndromes offer a profound example of how cultural norms, beliefs, and traditions shape mental health and illness. [1] Understanding these conditions is crucial for mental health professionals and fostering cultural competence and sensitivity in global health systems. Culture-bound syndromes illustrate the idea that mental illness is not merely a biological or psychological phenomenon but one that is deeply interwoven with the cultural, social, and environmental fabric of individuals' lives. [2] This study will delve into the nature of culture-bound syndromes, their implications, examples, and challenges to mental health care.

The formalization of the concept of culture-bound syndromes began to take shape in the 1950s and 1960s when medical anthropologists and psychiatrists started to study the relationship between culture and mental illness more systematically. One of the most significant contributions to the field came from the work of anthropologist Arthur Kleinman. In his groundbreaking book *Patients and Healers in the Context of Culture* (1980) [1], Kleinman emphasized the importance of culture in shaping the experience of illness. He argued that psychiatric disorders could not be understood solely in terms of biological or psychological factors but must also be interpreted in the context of the cultural meanings and beliefs that underlie them. Kleinman's work brought attention to the need for culturally competent psychiatric care. He challenged the Western medical model, which often assumed that mental health disorders had universal manifestations and could be diagnosed using standard criteria. Kleinman's recognition of CBS marked a turning point in the field of cross-cultural psychiatry, which was further developed by other scholars in the following years. The history of culture-bound syndromes reveals the complex interplay between culture and mental health. The recognition of CBS has shifted the focus in psychiatry and anthropology, challenging the notion that mental health disorders can be universally defined and treated. Instead, CBS emphasizes the importance of cultural context in understanding mental illness. As cultural diversity grows globally, studying culture-bound syndromes will remain essential in developing more inclusive and culturally competent approaches to mental health care.

The study of culture-bound syndromes has led to the identification of numerous disorders unique to particular cultures worldwide. These syndromes often reveal how cultural beliefs, values, and practices shape the experience of mental illness. Some of the most well-known CBS globally include, **Koro** – Southeast Asia: Fear that genitalia are retracting into the body, often associated with anxiety. **Susto** – Latin America: A condition caused by fright or trauma, leading to symptoms like depression and anxiety. **Ataque de Nervios** – Latin America and the Caribbean: Emotional distress, anxiety, and uncontrollable crying, often linked to family conflicts. **Hikikomori** – Japan: Extreme social withdrawal, where individuals isolate themselves for extended periods. **Wiitis** – Sweden: Anxiety and loss of identity, often seen in young women facing societal pressures. **Nervios** – Latin America and the Caribbean: Anxiety, stress, and somatic symptoms, often in response to emotional strain. **Running Amok** – Southeast Asia: A violent outburst characterized by running and attacking others, followed by amnesia. **Pibloktoq** – Arctic regions (Inuit communities): Episodes of uncontrollable behaviour and agitation, followed by amnesia. **Kufungisisa** – Zimbabwe: Obsessive thinking and anxiety, often due to stress or economic hardship. **Zar** – North Africa and the Middle East: A spirit possession syndrome where individuals exhibit dissociative behaviour and unusual actions. [3] Here are some CBS prevalent in the Indian sub-continent:

1. **Dhat Syndrome**: A condition where men experience anxiety, weakness, and fear of semen loss during urination or nocturnal emissions. It is linked to cultural beliefs about the vital nature of semen in traditional medicine.

2. **Amok**: Involves sudden outbursts of violent behaviour, often resulting in aggression and followed by amnesia. It is thought to stem from intense emotional stress or family conflicts.

3. **Kali Dahan**: Belief in demonic possession or evil influences, leading to symptoms like hysteria or loss of consciousness. It is treated with exorcism or religious rituals rooted in Hindu spiritual beliefs.

4. **Sadhin Syndrome**: Women, particularly in rural areas, enter a trance-like state or dissociative behaviour believed to be caused by divine possession or spiritual awakening.

5. **Bhungar**: Observed in rural or tribal areas, characterized by excessive yawning, tremors, and unexplainable movements, often attributed to witchcraft or supernatural forces. [4]

These syndromes reflect India's diverse cultural, spiritual, and social beliefs that shape mental health and behaviour. An Indian study in the 1990s identified that Dhat syndrome was the most prevalent, accounting for 76.7% of cases, followed by possession syndrome at 13.3%. Depression emerged as the most common comorbid psychiatric disorder among these patients. The findings highlight the importance of culturally sensitive psychological evaluations to detect and appropriately treat associated psychiatric comorbidities in patients presenting with culture-bound syndromes. [5] A subsequent cross-sectional study conducted by M.S. Bhatia and colleagues in 2011 further explored the prevalence and psychiatric comorbidities of culture-bound syndromes in a similar setting. This study reported that Dhat syndrome remained the most common (80%), followed by possession syndrome (14%), with other syndromes like ascetic syndrome, Gilhari syndrome, and Koro each constituting 2% of cases. Depression continued to be the most frequently associated psychiatric disorder. These consistent findings underscore the need for careful psychological assessment and culturally informed treatment approaches for patients with culture-bound syndromes in the Indian subcontinent. [6]

"Dhat syndrome" is a clinical entity first described in Western Psychiatry texts by an Indian doctor named Narendra Wig in 1960. It consists of nebulous somatic symptoms such as weakness, fatigue, anxiety, weight loss, guilt and sexual dysfunction, which the patient attributes to the loss of semen in urine, night emissions and masturbation. [7][8]The word 'Dhat' is derived from the Sanskrit word *Dhatu, which, according to Sushruta Sanhita,* means 'elixir that constitutes the body'. Semen's role as an essential human body component has been acknowledged in writing since 1500 BC. The Charaka Samhita explains the Dhatus disorders and mentions a condition called Shukrameha in which semen passes into the urine. Various names are used in other countries (China- *Shen K'uei,* Sri Lanka- *Prameha,* Japan- *Imu,* different parts of Southeast Asia- *Jiryan*) to describe symptoms and conditions like Dhatus. [9] Dhat syndrome is categorized as other specified neurotic disorders (F48.8) in the International Classification of Diseases (ICD-10) [10] as well as a culture-specific disorder brought on by "undue concern about the devastating effects of the passage of semen" in DSM-V.[11]

Dhat syndrome and the ideas of semen loss and consequent anxiety are not confined to India; [7] they have also been reported from Sri Lanka and other parts of the subcontinent. The fear of semen loss and resulting problems is so intense that many traditional healers advertise the cures everywhere- on walls, TV, newspapers and on roadside hoardings. [12] Dhat syndrome is most commonly reported in young men,

unmarried or recently married, of low or medium socio-economic status and have a conservative attitude towards sex.[13] Though most studies report these, *Kendurkar* et al., based on a review study of 1242 patients, reported Dhat syndrome was irrespective of the domicile or the educational status of the patient [14] which was also reported in another study by *Singh* et al.,[15] *Bhatia* and *Malik* also concluded in a study that prevalence of Dhat syndrome was irrespective of religion.[13] As they visit various traditional healers, health specialists practicing Unai, Ayurveda or Homeopathy and other physicians, there is a delay in index consultation with a psychiatrist. Different cultural, social, and psychological factors influence the reason for the delay in seeking expert care for Dhat syndrome. Stigma and shame play a significant role, as the loss of semen is often linked to weakness or moral degradation, causing individuals to avoid seeking help due to fear of judgment or being labeled mentally ill. Cultural beliefs and misunderstandings, such as viewing Dhat syndrome as a physical or spiritual issue, further complicate the situation, leading individuals to seek alternative or spiritual treatments. Embarrassment and sexual taboos prevent open discussions about sexual health, and the lack of confidentiality increases fear of exposure. Many individuals lack awareness of mental health, viewing their condition as physical, and may not be familiar with psychological treatments, which delays seeking appropriate care. Family pressure and societal expectations around masculinity discourage individuals from admitting to psychological distress, while limited access to mental health professionals and financial barriers further hinder help-seeking. [16] [17] The quality of life (QoL) among patients with Dhat syndrome is significantly compromised owing to a complex interplay of physical, psychological, social, and financial difficulties that they experience even before they reach psychiatric services. Physically, the persistent somatic symptoms—such as fatigue, weakness, palpitations, and musculoskeletal aches—lead to reduced stamina, impaired functioning in daily activities, and feelings of physical vulnerability. [13] These physical complaints are not merely perceived but subjectively experienced as debilitating, often limiting the patient's ability to engage in work, education, or recreational activities, thereby eroding their overall sense of well-being. Psychologically, the pervasive anxiety and preoccupation with semen loss create a chronic state of emotional distress. Patients frequently experience excessive worry, low mood, irritability, and feelings of hopelessness. [13] The guilt associated with normal sexual behaviours such as masturbation or nocturnal emissions—often viewed through a cultural lens of moral failure—intensifies internalized shame and contributes to depressive symptomatology. [20] Over time, these unresolved psychological conflicts can culminate in full-blown psychiatric conditions like

major depressive disorder or generalized anxiety disorder, further diminishing quality of life. Thus, by the time patients finally access psychiatric care, they are burdened not only by the direct symptoms of Dhat syndrome but also by substantial deterioration across multiple domains of life. This multifactorial impairment underscores the urgent need for early detection, culturally sensitive psychoeducation, and integrated mental health services to prevent the progressive decline in quality of life among these vulnerable individuals.

Studying the pathway to care in Dhat syndrome is crucial for enhancing diagnosis and treatment strategies. It provides critical insights into the cultural factors such as stigma, misconceptions about semen loss, and traditional health beliefs—that often delay or obstruct help-seeking behaviour. By systematically identifying barriers, including limited access to mental health services, societal pressures, and financial constraints, healthcare providers can design interventions that are not only clinically effective but also culturally sensitive and contextually appropriate. Such research fosters improved awareness of the psychological dimensions underlying Dhat syndrome, promotes early detection, and emphasizes the need for mental health services that are accessible, acceptable, and tailored to the population's unique needs. Ultimately, this approach supports the development of more effective, timely, and holistic models of care for individuals affected by Dhat syndrome. Moreover, understanding the personality traits predisposing individuals to Dhat syndrome is equally essential. Knowledge of at-risk personality profiles can help predict behavioural patterns, inform preventive strategies, and guide the design of psychotherapeutic interventions to modify maladaptive traits and enhance coping mechanisms. This proactive approach could lead to improved long-term outcomes and reduced morbidity. Assessment of quality of life (QoL) among patients with Dhat syndrome is another critical dimension, as the disorder exerts a profound impact not only on physical health but also on psychological well-being, social relationships, and occupational functioning. Given its strong cultural underpinnings and frequent association with anxiety, depression, and somatic symptoms, evaluating QoL offers a comprehensive understanding of the disorder's actual burden on individuals and communities.

2 REVIEW OF LITERATURE:

In a study done in 2016 by Sandeep Grover et al., the pathway of care among patients with Dhat syndrome in a tertiary care center in North India was studied and found that most patients were single (70.2%). Most received formal education till 10th grade (66.0%) and had jobs (59.6%). It was more commonly seen in the Hindu population (68.1%), and most of them belonged to middle socio-economic status (59.6%). Comorbid psychiatric illness and/ or sexual dysfunction were present in 61.7% of the samples. The mean age of onset of symptoms of Dhat syndrome was 20.38 years ± 6.91, and the mean duration was 6.78 years ± 6.94. These patients had contacted 2.85 (SD: ±1.40; range: 1-5) prior agencies/ helpers. Native practitioners were most frequently chosen as the initial point of contact, followed by approaching friends for assistance. The study concluded that most Dhat syndrome patients arrive at specialized psychosexual clinics very late. To encourage patients with Dhat syndrome to seek early help, there is a need to improve community sexual education and attitudes. The significant delay in patients presenting to the psychosexual clinic is directly implied by the long duration of illness at the time of reporting (mean = 6.78 years). Before coming to the psychosexual clinic, patients contacted an average of 2.85 different organizations or sources of assistance. Most patients consulted native doctors or traditional or religious healers at some point during their illness. This pattern resembles other psychiatric disorders in some ways. Existing evidence indicates that indigenous medical practices, such as Ayurveda, support patients with Dhat syndrome beliefs about the adverse effects of semen loss. The study's limitations include the fact that participants were limited to those who went to a single tertiary care facility and had a small sample size. It is entirely possible that other primary and secondary care psychosexual clinics, where a more representative population could be studied, might produce different findings. The study did not investigate the patient's stated delays. Future studies involving patients from various centers need to be planned with these restrictions in mind. [19]

In the 2016 study by Prakash S, Sharan P, and Sood M, titled "A Study on Phenomenology of Dhat Syndrome in Men in a General Medical Setting," the researchers explored the psychological and physical symptoms associated with Dhat syndrome in South Asian men seeking help in a general medical clinic. Dhat syndrome is a culture-bound condition predominantly found in South Asia, where men experience significant anxiety and distress due to the perceived loss of semen, often associated with nocturnal emissions or

masturbation. The syndrome is typically characterized by symptoms like fatigue, dizziness, and weakness, which patients attribute to the loss of semen, a vital life force in many cultures. The study involved 50 male patients who presented with complaints of physical symptoms and psychological distress. Through structured interviews and psychological assessments, the researchers aimed to understand the clinical features of Dhat syndrome, the role of cultural beliefs in its development, and the patients' help-seeking behaviours. A key finding was that patients misinterpreted their physical symptoms, believing them to be caused by semen loss, and often sought treatment from general medical practitioners rather than mental health professionals. The study also highlighted the significant role of cultural beliefs, such as the belief that semen loss led to a depletion of vitality, in the development and persistence of the syndrome. Psychologically, many patients exhibited symptoms of anxiety and depression, with feelings of guilt and shame surrounding sexual behaviours and nocturnal emissions. These feelings were intensified by social stigma and a reluctance to discuss sexual health openly. The cultural reluctance to acknowledge mental health issues and the stigma surrounding them led many individuals to avoid seeking psychiatric care, opting instead for traditional healers or medical professionals who could address the physical symptoms. This study emphasized the importance of understanding Dhat syndrome as not just a physical condition but a psychosomatic disorder rooted in cultural beliefs and psychological distress. The researchers concluded that effective treatment for Dhat syndrome requires a comprehensive approach, integrating both psychological counseling and medical care, while addressing the cultural beliefs and stigma that prevent individuals from seeking timely help. The findings of this study have important implications for improving the recognition and treatment of Dhat syndrome in South Asia, emphasizing the need for culturally sensitive care. [20]

In another cross-sectional study by Mohit Kumar Shahi et al. 2022, 117 patients with Dhat syndrome and 117 matched controls were enrolled. The International Classification of Diseases- 10th revision, diagnostic criteria for research, served as the basis for diagnosing Dhat syndrome. The MINI 6.0.0 comorbidity assessment was used to classify the patients into two groups: those with and those without comorbidities. Using standardized tools, the QoL and disability of patients with and without comorbidity, as well as their corresponding control groups made up of healthy volunteers, were estimated. To conclude, patients with Dhat syndrome had a lower quality of life and more disability than healthy controls. In comparison to healthy

controls and patients without comorbidities, patients with psychiatric or sexual comorbidities had lower QoL and higher disability. Compared to healthy controls, patients with Dhat syndrome have lower QoL and higher levels of disability; the presence of comorbidities with Dhat syndrome is linked to an even more significant reduction in QoL and disability. Patients with Dhat syndrome who also had comorbid conditions had significantly worse quality of life (P 0.001) than those who did not. Comorbidities and QoL are correlated in both directions. In turn, poor QoL may increase subjective distress, increasing the development of comorbid mental illness. More comorbidities are anticipated to compromise QoL. Patients with comorbidities who have Dhat syndrome may have a worse quality of life due to the comorbidities alone rather than Dhat syndrome itself. Dhat Syndrome patients frequently experience severe psychological distress because of their symptoms. These symptoms hamper their daily activities. The poor Quality of Life in patients with Dhat syndrome may be related to the distress and its associated impairments. [21]

A study done in 1990 by R. K. Chadda et al., included all patients seen in the psychiatry outpatient clinic over six months (January 1988 -June 1988) who had a presenting complaint of Dhat passage in urine. Patients underwent a thorough psychiatric evaluation as well as questions about the symptoms' causes and effects on them. The study involved 52 patients, most were teenagers or young adults. The majority were married. 32 of the patients were from families of manual laborers. Farmers, store owners, and office workers were among the others. Twenty patients had only received primary education or were illiterate. Five of the others had graduated from college after completing their education. Four patients had symptoms for less than a month, while 28 patients had symptoms for more than a year. The frequency of Dhat passage ranged from once or twice daily to once every 10 to 15 days, though for most patients, it was once every 1 to 7 days. The symptoms of hypochondria (bodily weakness, numerous aches and pains, and hazy somatic sensations) were reported by more than 80% of the patients. Half of the patients had depression, and 37 others had anxiety. As a result of the passage of Dhat, 22 people complained of premature ejaculation and 19 of erectile dysfunction. In ten cases, there was an excess of worry about nocturnal emissions. In five cases, burning micturition and increased frequency were the symptoms of urinary complaints. All the patients thought their symptoms were semen and attributed them to the passage of Dhatu. 24 patients believed that their earlier masturbation habits were to blame for their illness. In 11 and 3 patients, respectively, pre- and extramarital relationships, as well

as previous homosexual contacts, were also thought to be the cause. Unexpectedly, none of the patients acknowledged having sexual or marital issues as a result of their illness. Most of the urine tests were normal. The study concluded that these patients rarely come for regular follow-up. [7] Singh (1985) reported a similar discovery. These patients may not be satisfied with our explanation that they are not experiencing any semen loss and that semen loss is, in any case, not harmful as a possible explanation for this. The speedy recovery of patients is another potential factor. However, more research needs to be done on this issue. [22] In a study by Behere and Natraj (1984), 22% of the patients had improved, and 66% had fully recovered after a year of follow-up. Sexual counseling and the management of any resulting anxiety, depression, or hypochondria were used as treatment modalities. [23]

In conclusion, the existing body of literature highlights the complex and multifaceted nature of Dhat syndrome, encompassing psychological, cultural, and social dimensions. The studies reviewed collectively demonstrate the considerable challenges faced by individuals with Dhat syndrome in accessing timely and appropriate mental health care. Factors such as societal stigma, deeply ingrained cultural misconceptions regarding semen loss, and reliance on traditional healing systems contribute to significant delays in seeking specialized psychiatric intervention. These barriers underscore the need for a comprehensive, culturally sensitive approach to both diagnosis and treatment that integrates psychoeducation, community awareness, and early intervention strategies. Personality vulnerabilities, notably Cluster C traits, further complicate the clinical picture and suggest the need for individualized psychotherapeutic interventions. As research in this field progresses, it is imperative to broaden the scope of studies to encompass diverse demographic and geographic populations and to develop innovative, culturally attuned interventions aimed at reducing stigma, promoting early help-seeking behaviour, and improving long-term outcomes for individuals affected by Dhat syndrome.

3 AIM:

To study the pathway of care and phenomenology among patients with Dhat syndrome, at-risk personalities, and the quality of life of these patients.

OBJECTIVES

1. To know the pathway of care.

2. To analyze the sociodemographic profile of these patients and the reasons for delay in receiving prompt and professional help in these patients.

3. To assess the personality clusters that are+ at risk of developing Dhat syndrome.

4. To assess the Quality of Life among patients with Dhat syndrome when they first present to a psychiatrist.

4 MATERIAL AND METHOD:

4.1 SOURCE OF DATA:

The study was performed at BLDE (DU) Shri. B.M. Patil Medical College Hospital and Research Centre, Vijayapura, Karnataka.

4.2 METHOD OF COLLECTION OF DATA:

Data was collected with the help of a semi-structured questionnaire proforma that has been pre-designed using the *pathways interview schedule* from the *WHO Psychiatric Assessment Instruments catalogue, The ICD-10 International Personality Disorder Examination (IPDE) module screening questionnaire* and *WHOQOL-BREF*.

4.3 INCLUSION CRITERIA:

Patients above the age of 18 years who are a new case or already diagnosed case of Dhat syndrome as per the International Classification of Diseases- version 10 (ICD- 10) by a psychiatrist were included in the study.

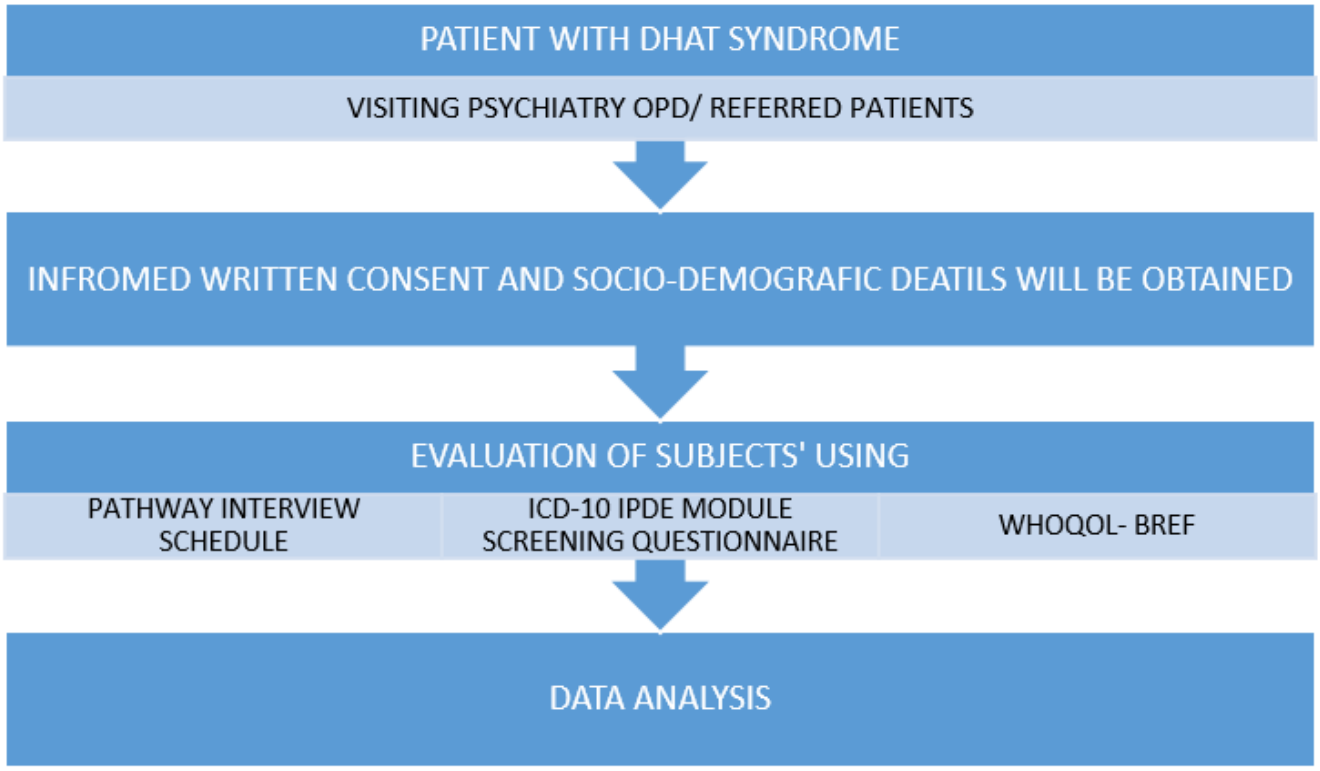
4.4 EXCLUSION CRITERIA:

Patients with co-morbid active psychotic disorder, organic brain syndrome or with IDD were excluded from the study.

4.5 STUDY DURATION: 18 MONTHS (May, 2023- December, 2024).

4.6 STUDY TYPE: Cross-Sectional Study.

4.7 METHODOLOGY:



4.8 SCALES USED FOR ASSESSMENT:

1. Pathways Interview Schedule from the Catalogue of WHO Psychiatric Assessment Instruments.
2. The ICD-10 International Personality Disorder Examination (IPDE) module screening questionnaire.
3. WHOQOL-BREF.

4.9 SAMPLING:

Sample size:

With an anticipated Mean ± SD of symptoms of Dhat before the patients presented to the psychosexual clinic, 6.78 ± 6.94 [19], the study would require a sample size of 47 patients with 95% confidence level and a precision of 2.

Statistical Analysis:

- The collected data were entered into a Microsoft Excel spreadsheet, and statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS), Version 21.
- Results were expressed as mean (or median) ± standard deviation (SD), frequencies, and percentages and illustrated using appropriate diagrams.
- Normally distributed continuous variables were compared using the independent samples t-test.
- Non-normally distributed continuous variables were analysed using the Mann–Whitney U test.
- Categorical variables were compared using the Chi-square test.
- Pearson's or Spearman's correlation coefficients were calculated, as appropriate, to assess relationships between variables.
- A p-value of <0.05 was considered indicative of statistical significance. All statistical tests were performed using two-tailed analyses.

4.10 INSTRUMENTS USED:

1. PATHWAYS INTERVIEW SCHEDULE FROM THE CATALOGUE OF WHO PSYCHIATRIC ASSESSMENT INSTRUMENTS:

The Pathways Interview Schedule is a structured tool developed by the World Health Organization (WHO) to examine how individuals seek care for mental health issues systematically. Initially designed for use in large-scale international psychiatric studies such as the International Pilot Study of Schizophrenia, the instrument provides a comprehensive framework for tracking the sequence of contacts, decisions, and barriers encountered by patients before reaching formal psychiatric services. This instrument explores various dimensions, including initial symptom recognition, the timeline of help-seeking behaviour, and the types of care providers consulted from general practitioners to traditional or religious healers, and psychiatric professionals. The Pathways Interview Schedule has shown good inter-rater reliability, with Cohen's kappa values ranging from 0.70 to 0.85 across different items and settings. It also demonstrates strong content and construct validity, supported by its consistent use in diverse international field studies. Its utility has been validated in high-income and low-middle-income countries, showing cultural adaptability and relevance in capturing help-seeking behaviour across populations. Its structured design ensures standardization, making it suitable for clinical research and health service evaluation to improve accessibility and mental health system responsiveness.

2. THE ICD-10 INTERNATIONAL PERSONALITY DISORDER EXAMINATION (IPDE) MODULE SCREENING QUESTIONNAIRE:

The IPDE Screening Questionnaire is a validated tool used for the preliminary identification of individuals with personality disorders. It is a concise version of the full International Personality Disorder Examination (IPDE), specifically developed for use in clinical and research settings. The screening module includes structured questions to identify characteristic traits and behaviours across different personality disorder clusters (A, B, and C). The IPDE has demonstrated robust inter-rater reliability (kappa = 0.77) and test-

retest reliability (kappa = 0.69–0.85) across multiple studies. The tool also shows strong convergent validity with DSM-based clinical diagnoses (sensitivity = 79%, specificity = 84%). Its structured format and ease of administration make it a practical choice for psychiatric and primary care settings.

3. WHOQOL-BREF:

The WHOQOL-BREF is a widely accepted abbreviated version of the World Health Organization's Quality of Life 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. 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 quality of life. The WHOQOL-BREF demonstrates excellent internal consistency, with Cronbach's alpha values ranging from 0.66 to 0.84 across domains. It has also shown strong test-retest reliability (intraclass correlation coefficient, ICC = 0.73–0.87) and construct validity, as it correlates well with physical and psychological health indicators across diverse populations. Its brevity, ease of administration, and cross-cultural validation make it a valuable instrument for clinical research and global mental health assessment.

5 RESULTS

5.1 SOCIO-DEMOGRAPHIC DETAILS:

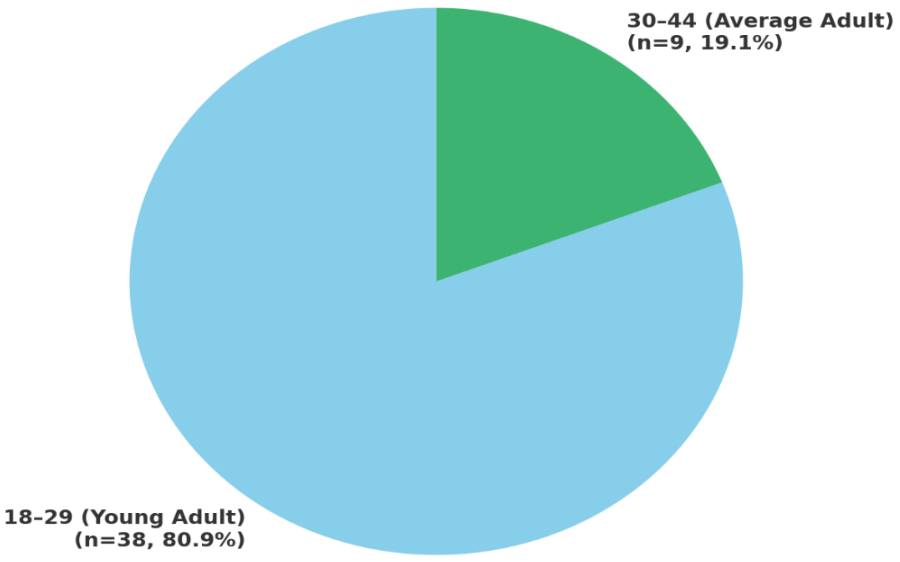
1. AGE AND GENDER DISTRIBUTION:

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 **(**80.85%**)** belonging to the young adult age group, followed by the average adult age group (19.15%) and none from other age groups. All patients were biologically male, in par with the diagnostic criteria of Dhat syndrome.

Table 1: Distribution of patients according to age:

Age Category	N (Frequency)	Mean	SD	Range
Young adult (18-29 years)	**38 (80.9%)**	**24.91**	**5.11**	**18- 42**
Average adult (30-44 years)	**9 (19.1%)**			

Graphical Representation 1: Age Distribution



2. BACKGROUND AND SOCIO-ECONOMIC CLASS:

In our study, most of the samples were from a rural background (61.70%, N=29), and owned a BPL card (55.32%, N=26).

Table 2: Distribution of patients according to background

	Frequency	Percentage
Rural	**29**	**61.70%**
Urban	**18**	**38.30%**
Total	**47**	**100.0%**

Table 3: Distribution of patients according to Socio-economic class

	Frequency	Percentage
APL	**21**	**44.68%**
BPL	**26**	**55.32%**
Total	**47**	**100.0%**

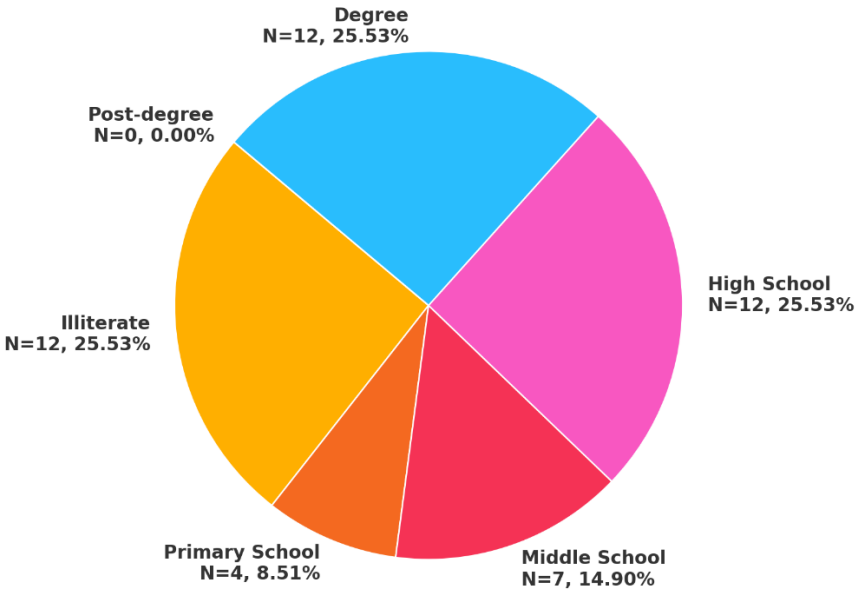
3. EDUCATIONAL BACKGROUND:

In the study population, most individuals were either illiterate, finished high school or a degree holder (each 25.53%, N=12), and fewer having middle or primary school education, and none with post-degree.

Table 4: Distribution of patients according to Educational Status

	Total	Percentage
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**
Total	**47**	**100%**

Graphical Representation 2: Distribution of patients according to Educational Status



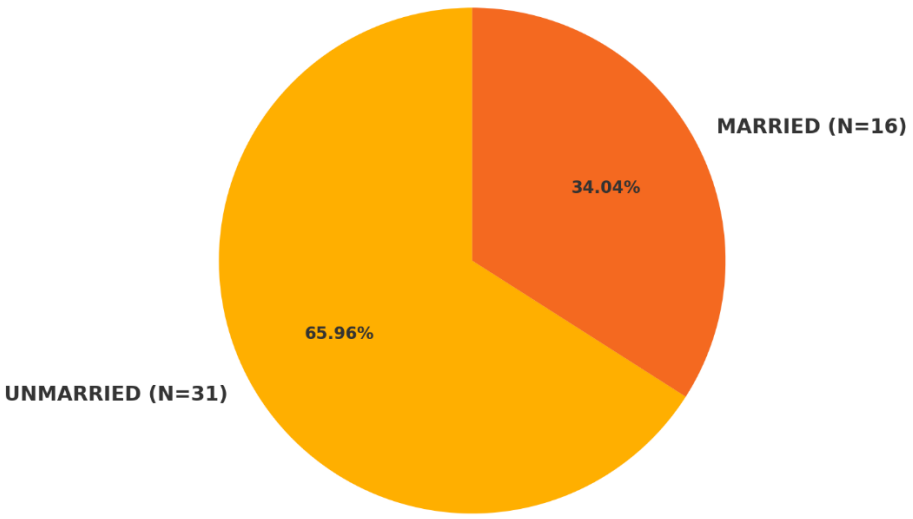
4. MARITAL STATUS:

The data shows that most individuals were unmarried males (N=31, 66%).

Table 5: Distribution of patients according to Marital Status

	Frequency	Percentage
MARRIED	16	34.04%
UNMARRIED	31	65.96%
Total	47	100.0%

Graphical representation 3: Distribution of patients according to marital status

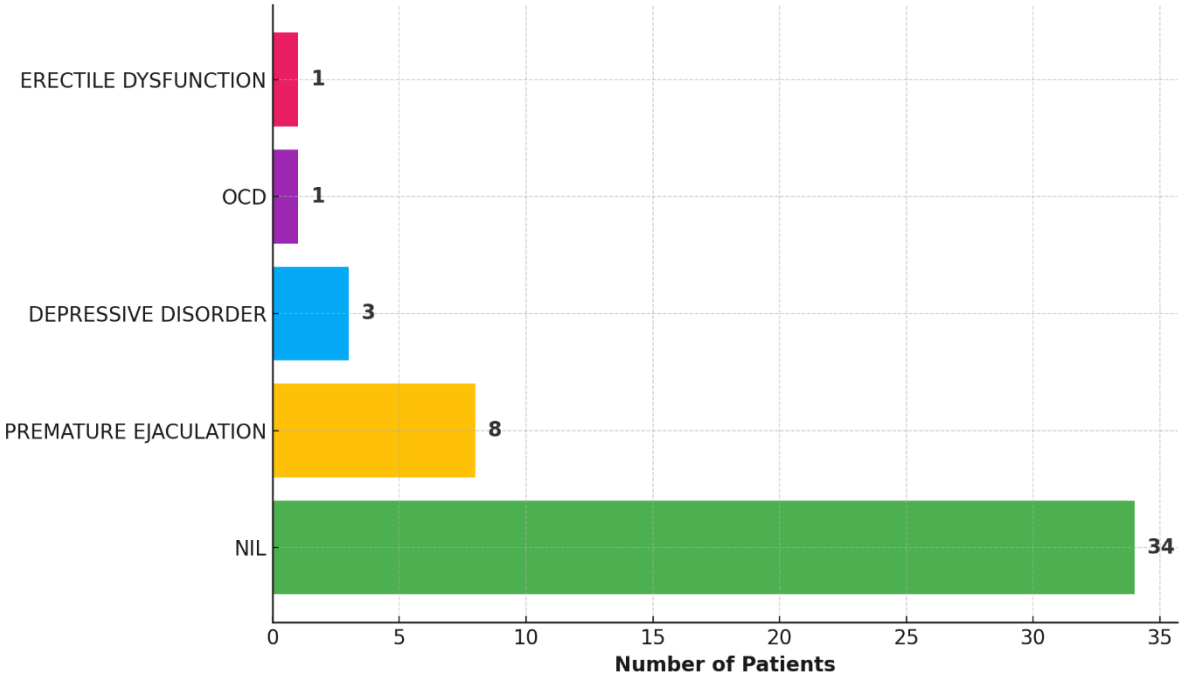


5.2 CLINICAL PROFILE:

From the collected data, the average duration of illness among patients was 3.95 years (±2.21 years), with illness durations ranging from six months to ten years. On average, patients sought their first help after 1.87 years (±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 median was used to better represent the typical delay to psychiatric care by minimizing the influence of outliers and skewed data.

The majority of patients (34 out of 47) reported no significant past history. At the same time, premature ejaculation was the most common issue among those with a history (eight cases), followed by depressive disorder (three cases) and isolated cases of OCD and erectile dysfunction (one each).

Graphical representation 4: Distribution of past history

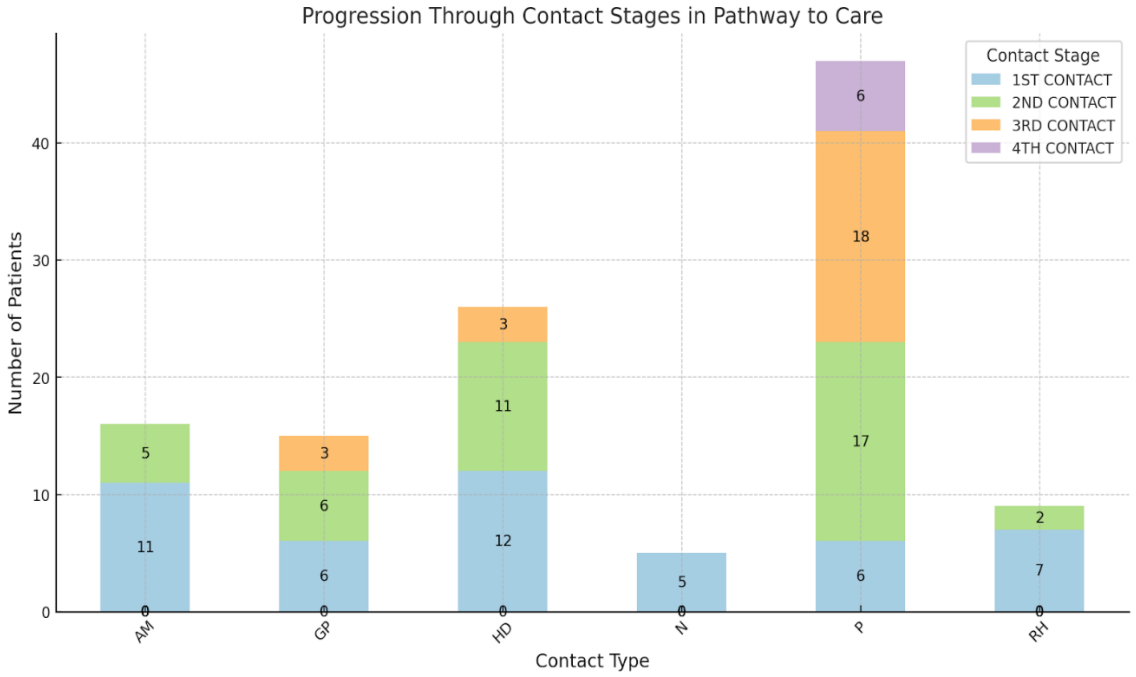


5.3 PATHWAY TO CARE:

1. CONTACTS MADE AND REASONS FOR DELAY:

The data highlights the indirect and often delayed routes patients take before reaching psychiatric care. Most began with primary care providers such as general practitioners (N=6), other specialties (N=12), or alternative medicine doctors (N=11) while psychiatric consultation rarely occurred at first contact. In many cases, patients saw up to four different providers, with psychiatry typically entering the pathway at the third or fourth step. The mean number of contacts before reaching Psychiatry services was 1.6 ± 0.1.In the observed data, cultural beliefs surrounding semen as a vital fluid and the moral significance attached to its loss contributed to the preference for non-psychiatric interventions. Patients, influenced by these culturally ingrained notions, often initially sought help from general practitioners, specialists, or traditional healers who failed to recognize the psychosomatic origin of symptoms. This tendency, coupled with low mental health literacy and the prevailing stigma surrounding psychiatric care, led to a fragmented and prolonged treatment pathway, significantly delaying appropriate intervention. While there is no single "pill" that cures Dhat syndrome, a comprehensive psychiatric approach i.e., combining psychoeducation, cognitive behavioural therapy (CBT), and symptom-specific pharmacotherapy has demonstrated high efficacy in clinical practice.

Graphical representation 5: Contacts in pathway to care

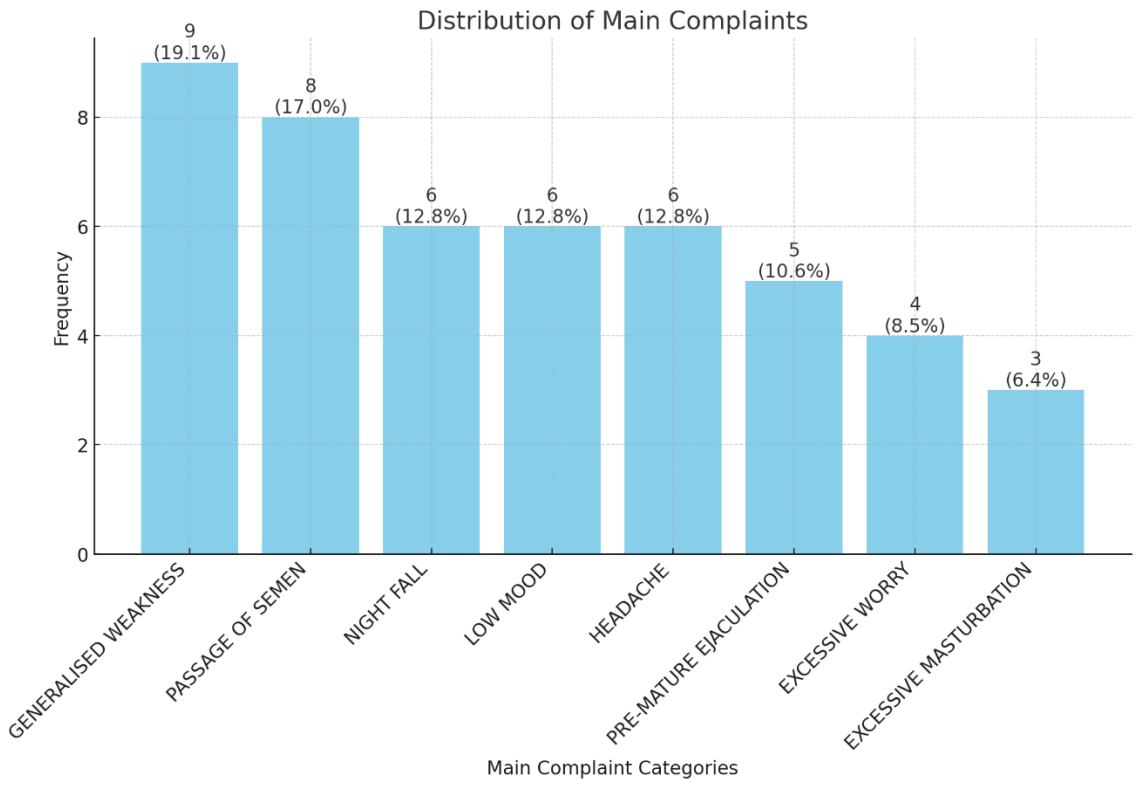


AM- ALTERNATIVE MEDICINE
GP- GENERAL PRACTITIONER
HD- HOSPITAL DOCTOR (OTHER SPECIALTIES)
N- NATIVE HEALER
P- PSYCHIATRIC SERVICES

2. PRESENTING COMPLAINTS:

The most common presenting complaint was generalized weakness (19.1%), followed by passage of semen in urine (17%), with excessive masturbation being the least reported (6.4%).

Graphical Representation 6: Main presenting complaint



3. WHO SUGGESTED TO SEEK HELP :

Most participants in the study sought help on their own (46.8%), followed by suggestions from friends (29.8%), while fewer were influenced by the internet (12.8%) or by family members (10.6%). These dynamics are particularly relevant in the context of Dhat syndrome, a culturally sensitive condition where help-seeking behaviour is often influenced by social and informational networks. Individuals with Dhat syndrome who turn to friends or family often receive emotional validation, shared experiences, and encouragement to consult professionals. Supportive peer groups help reduce the embarrassment often associated with discussing sexual health, fostering a more open attitude toward psychiatric help-seeking. Similarly, the internet serves as an accessible and anonymous platform, enabling individuals to explore their symptoms without fear of judgment. Exposure to scientific, destigmatizing content related to Dhat syndrome via websites, mental health forums,

and professional videos can dispel myths and promote earlier medical consultation. Even self-referrals, once awareness is gained through the internet or conversation can lead to meaningful psychiatric engagement when individuals recognize the psychosomatic nature of their symptoms.

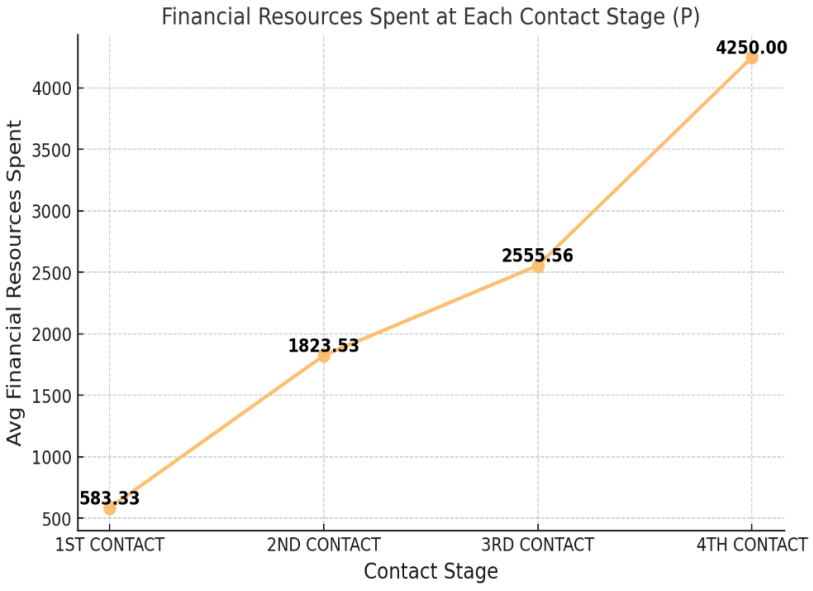
Table 6: Suggested to seek help by

	Frequency	Percentage
Self	22	46.8%
Friend	14	29.8%
Internet	6	12.8%
Family	5	10.6%
Total	47	100%

4. FINANCIAL RESOURCES SPENT:

Information on financial resources spent was collected retrospectively through verbal inquiries during the patient interview. This included asking for expenses such as consultation fees including payments to traditional or religious healers, medication costs, diagnostic tests, and travel expenses. The average financial burden increased steadily with each contact stage before reaching a psychiatrist (P), rising from ₹583.33 when a psychiatrist was the first contact to ₹4,250.00 by the fourth contact on average.

Graphical representation 7: Average financial resources spent and contact stage of psychiatric services



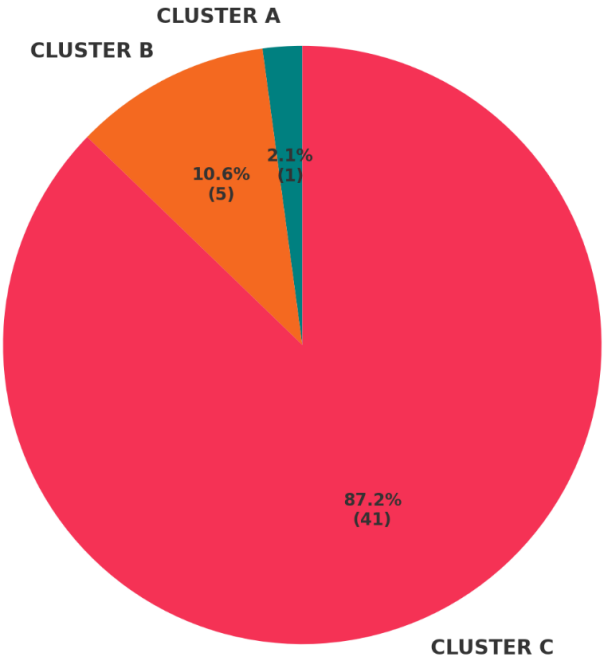
5.4 PERSONALITY TRAITS:

From the 47 patients that data was collected from, Cluster C personality traits are predominant among the participants, comprising 87.2% (41 individuals)**,** while Cluster B traits are present in 10.6% (5 individuals)**,** and Cluster A traits are the least represented at 2.1% (1 individual)**.** Cluster C personality disorders are characterized by anxious and fearful behaviour patterns. They include avoidant personality disorder, where individuals show social inhibition and fear of rejection; dependent personality disorder, marked by an excessive need for care and difficulty making independent decisions; and obsessive-compulsive personality disorder (OCPD), involving preoccupation with orderliness, perfectionism, and control.

Table 7: Distribution of Personality traits

	Frequency	Percentage
Cluster A	**01**	**02.13%**
Cluster B	**05**	**10.64%**
Cluster C	**41**	**87.23%**
Total	**47**	**100.0%**

Graphical representation 8: Distribution of Personality traits



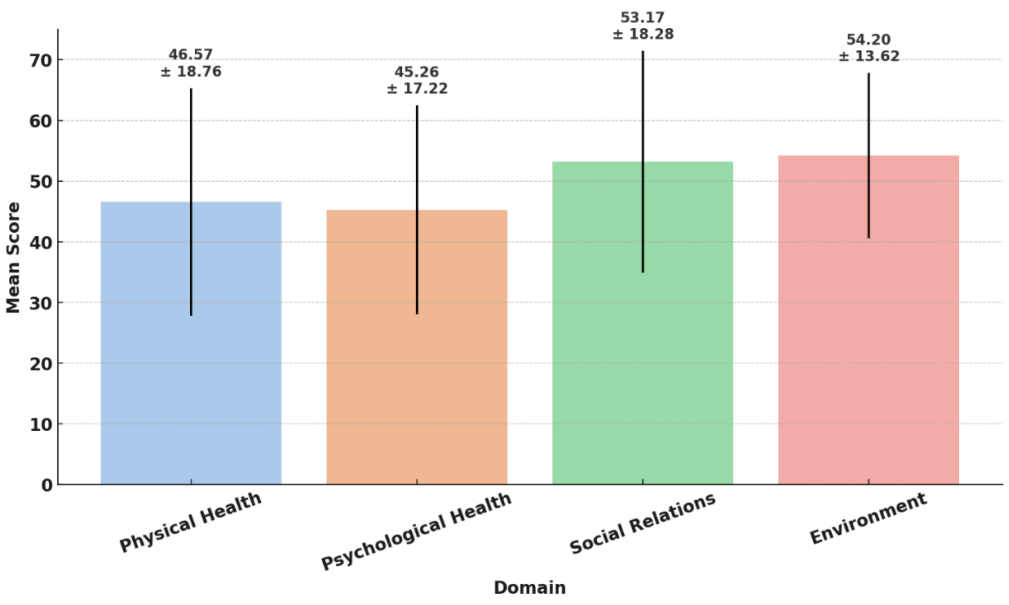
5.5 QUALITY OF LIFE:

In the WHOQOL-BREF scale, higher scores indicate better quality of life, interpretation ranges are (for converted 0-100 scores) classified as: 0–20.0 (poor), 20.1–40.0 (moderate), 40.1–60.0 (good), 60.1–80.0 (very good), and 80.1–100.0 (excellent). The quality of life assessment in the samples showed that the Environment domain had the highest mean score (M = 54.20, SD = 13.62), falling within the "good" range, suggesting satisfactory living conditions, financial resources, and access to healthcare. The Social Relationships domain also fell within the "good" category (M = 53.17, SD = 18.28), reflecting generally adequate interpersonal support and social satisfaction. In comparison, the Physical Health (M = 46.57, SD = 18.76) and Psychological Health (M = 45.26, SD = 17.22) domains, while still classified as "good," were closer to the lower threshold of the category, indicating relatively greater difficulties in areas such as fatigue, pain, sleep, emotional well-being, and cognitive functioning.

Table 8: Quality of Life score:

DOMAINS	MEAN SCORE	SD
Physical health	**46.57**	**18.76**
Psychological health	**45.26**	**17.22**
Social relations	**53.17**	**18.28**
Environment	**54.20**	**13.62**

Graphical representation 9: Quality of Life domains and scores



5.6 CORRELATION COEFFICIENTS AND TESTS OF SIGNIFICANCE:

1. 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 ($r = -0.400$, $p = 0.005$) quality of life significantly worsened. According to standard interpretation [0.00–0.19 = very weak, 0.20–0.39 = weak, 0.40–0.59 = moderate, 0.60–0.79 = strong, and 0.80–1.00 = very strong correlation, with negative values indicating an inverse relationship], these values represent moderate negative correlations, indicating that longer illness duration is moderately associated with declines in physical and psychological well-being. A negative correlation refers to an inverse relationship where an increase in one variable (illness duration) is associated with a decrease in another variable (quality of life). While there were also signs that longer illness might affect social relationships ($r = -0.205$, $p = 0.167$) and environment ($r = -0.294$, $p = 0.055$), these were weak negative correlations and did not reach statistical significance. Overall, longer-duration illness showed the most clear and consistent moderate negative impact on patients' physical and psychological health domains of quality of life.

Table 9: Correlation between total duration of illness and the QoL:

	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

2. FINANCIAL RESOURCES SPENT WITH TIME TAKEN TO REACH PSYCHIATRIST AND QoL DOMAINS:

The study revealed that longer delays in accessing psychiatric care were significantly associated with higher financial expenditure ($r = 0.670$, $p < 0.001$), indicating that patients who delayed psychiatric consultation

tended to spend more money. This increased financial burden showed the strongest negative correlation with physical and psychological health ($r = -0.581$, $p < 0.001$, $r = -0.589$, $p < 0.001$, respectively), suggesting that those who spent more were also the ones experiencing greater physical and psychological complaints than other domains of QoL.

Table 10: Correlation between financial resources spent with time taken to reach psychiatrist and QoL

	Variable	N	Pearson Correlation	p value
1	Duration to Psychiatrist	47	0.670	0.0001
2	Physical health	47	-0.581	0.0001
3	Psychological health	47	-0.589	0.0001
4	Social relations	47	-0.367	0.011
5	Environment	47	-0.478	0.001

3. BACKGROUND WITH TIME FOR FIRST CONTACT, DURATION TO PSYCHIATRIST AND QoL DOMAINS:

A comparative analysis between urban and rural patients revealed several important findings. Although the mean duration since first contact was longer among rural patients (mean = 2.14 years, SD = 1.60) compared to urban patients (mean = 1.44 years, SD = 0.97), this difference was not statistically significant ($p = 0.098$). However, a significant difference 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; $p = 0.020$). In terms of quality of life domains, no statistically significant differences were found between urban and rural groups. Physical health scores were marginally higher in urban patients (mean = 48.20, SD = 19.37) than in rural patients (mean = 45.55, SD = 18.65; $p = 0.643$). Psychological domain scores were nearly identical across groups (urban mean = 45.22, SD = 18.69; rural mean = 45.29, SD = 16.61; $p = 0.987$). Social relationship scores were slightly higher among rural patients (mean = 54.85, SD = 16.60) compared to urban patients (mean = 50.44, SD = 20.91; $p = 0.427$),

and environmental domain scores were similar between groups (urban mean = 55.21, SD = 13.26; rural mean = 53.57, SD = 14.04; p = 0.693). Overall, the findings indicate that rural patients face greater delays in accessing psychiatric care, although no significant urban-rural differences were observed in the quality of life outcomes.

Table 11: Correlation of background with time taken for first contact, duration to psychiatrist and QoL domains:

	Variable	Urban/ Rural (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	

4. SOCIO-ECONOMIC STATUS WITH TIME FOR FIRST CONTACT, DURATION TO PSYCHIATRIST AND QoL DOMAINS:

Patients below the poverty line (BPL) experienced significantly longer durations for both, duration since first contact and in reaching psychiatric services (mean being 2.29 and 1.61 years respectively) compared to those above the poverty line (APL) (mean = 1.36 years and 0.73 years, respectively; $p < 0.05$ for both comparisons). However, no statistically significant differences were found between APL and BPL groups across quality of life domains, including physical, psychological, social relationships, and environment. These findings suggest that economic disadvantage is associated with delays in accessing psychiatric care, though it does not significantly impact quality of life outcomes.

Table 12: Correlation of socio-economic status with the time taken for first contact, duration to psychiatrist and QoL domains:

	Variable	APL/ BPL (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	

5. 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. Although patients with lower levels of education (illiterate and primary education groups) tended to have longer durations since first contact (mean = 2.63 and 2.38 years, respectively) compared to those with higher education levels, such as high school (mean = 1.56 years) and degree holders (mean = 1.20 years), the differences were not statistically significant ($p = 0.119$). Similarly, the mean duration to reach psychiatric care was longer among illiterate patients (mean = 1.74 years) and those with only primary education (mean = 1.75 years) compared to patients with high school education (mean = 0.77 years) or a university degree (mean = 0.90 years), but these differences also did not reach statistical significance ($p = 0.272$). These findings suggest that while trends indicate that

lower education levels may be associated with longer delays in seeking psychiatric care, the differences were not statistically significant in our sample.

Table 13: Correlation of educational status with time taken for first contact and duration to psychiatrist:

	Variable	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	

6. SUGGESTED TO SEEK HELP BY AND DURATION TO FIRST HELP:

Those who sought help by themselves or upon suggestion from family experienced the longest delays in initiating care (2.15 and 2.3 years, respectively), whereas individuals influenced by the internet reached out for help the earliest (0.78 years). However, this difference was not statistically significant ($p = 0.181$), suggesting that the source of suggestion did not have a meaningful impact on the timing of the first help-seeking attempt.

Table 14: Correlation between factors prompting to seek help and time taken for first help sought:

	Variable	Suggested to seek help by	Mean	SD	p value
1	Years since first contact	Self	2.1441	1.60449	0.181
		Family	2.3000	1.20416	
		Friend	1.7621	1.28023	
		Internet	0.7783	0.65484	

6 DISCUSSION:

This study explored the clinical, psychological, and cultural dimensions of Dhat syndrome by assessing the pathway of care, personality clusters at risk, and quality of life in affected individuals. Dhat syndrome, classified under other specified neurotic disorders (F48.8) in the ICD-10, is a culturally specific condition marked by the attribution of various somatic and psychological symptoms, such as fatigue, weakness, palpitations, depressive mood, and anxiety to the perceived loss of semen through nocturnal emissions, masturbation, or urination. [10] In traditional South Asian societies, semen is often viewed as a vital and finite life force, the loss of which is thought to cause profound physical and mental deterioration. This belief is rooted in classical Indian medical literature, including Ayurvedic texts like the Charaka Samhita and Sushruta Samhita, which describe semen as a precious substance formed through the refinement of bodily fluids and nutrients. [7] These cultural interpretations frame semen retention as essential to strength, vitality, and manhood. As a result, even normal physiological phenomena such as nocturnal emissions or masturbation are often interpreted as pathological, leading to the development of health-related anxieties. These anxieties can manifest as genuine psychological distress and somatic symptoms, reinforcing the patient's belief in a physical ailment and setting off a cycle of fear and symptom escalation. [23] By focusing on the sociodemographic profile, pathway to care, and underlying personality structures, the study aimed to understand the broader context in which this condition manifests.

The sociodemographic profile identified in our study strongly aligns with previous research on Dhat syndrome, reaffirming a consistent pattern that highlights the intersection of age, education, socioeconomic status, marital status, and cultural context in shaping the presentation of this condition. In our sample, the syndrome predominantly affected young adult males, with a mean age of 24.91 ± 5.11 years, with 80.9% of the study sample were between 18 to 29 years of age. Similar findings were reported by Grover et al. (2016; mean age 20.38 years) [19], Khan et al. (2005; 24 years) [24], Nazir et al. (2024; 55.29% aged 20–30) [25], Kumari et al. (2017; 54.3% between 20–30 years) [26], and Deshmukh et al. (2024) [27], who also noted that the majority of cases were in the 16–35 year age group. This consistent age pattern confirms the syndrome's strong association with early adulthood, a phase often accompanied by intense cultural pressure related to sexual identity, masculinity, and performance expectations. These factors are especially

pronounced in South Asian societies where discussions around sexuality remain taboo. In such a context, young, sexually inexperienced men may experience normal physiological processes such as nocturnal emissions, masturbation, or pre-ejaculation as frightening or shameful, particularly when viewed through the cultural lens that equates semen with vitality, strength, and masculinity. The resulting anxiety and guilt can lead to the development of psycho-somatic symptoms that form the core of Dhat syndrome. In terms of marital status, our study found that 65.96% of the participants were unmarried, a finding nearly identical to those reported by Grover et al. (70.2%) and Khan et al. (75%). Dhat syndrome is traditionally more commonly observed in unmarried young men, particularly in conservative societies. Prakash et al. (2016) emphasized that a significant proportion of unmarried individuals presenting with Dhat syndrome experience distress rooted in sexual worries, low self-esteem, and concerns about masculinity and physical health. [19] Unmarried men are less likely to have had normative sexual experiences and are more prone to internalizing guilt and misconceptions about sexual behavior, especially related to masturbation. The lack of psychosocial support and minimal access to sex education further increases their vulnerability to developing Dhat syndrome. However, Dhat syndrome can also occur in married men, although fewer in number when compared to unmarried men according to our study and existing literature. In these individuals, persistent cultural beliefs and misconceptions about semen being a vital fluid, whose loss is perceived to cause serious physical and mental weakness, continue to exert a powerful influence. Despite being sexually active, many married men internalize anxieties about semen loss through nocturnal emissions, or even through sexual intercourse itself. In conservative societies, marriage does not necessarily correct misunderstandings about sexuality. Without proper sex education and open communication about sexual health, married men may continue to perceive normal sexual functioning or semen discharge as pathological. Adding to this, marital pressures, performance anxiety, guilt related to sexual practices, and strained spousal relationships can exacerbate feelings of weakness, fatigue, guilt, and the somatic complaints characteristic of Dhat syndrome. Thus, psychosocial stressors, cultural myths surrounding semen conservation, and a lack of accurate sexual knowledge continue to make both unmarried and married men vulnerable to Dhat syndrome.

The lack of psychosocial support, coupled with minimal access to sex education, leaves these individuals highly vulnerable. Socioeconomic status further compounds this vulnerability. In our study,

55.32% of participants were from below-poverty-line households, and 61.7% came from rural backgrounds. This is in line with Khan et al. (2005; 56% with income < Rs. 3,000), Nazir et al. (2024), and Deshmukh et al. (2024), all of whom observed a predominance of patients from economically weaker sections and rural communities. Deshmukh et al. also noted that financial instability and lack of healthcare access were strongly associated with poorer sexual quality of life in these patients. [27] Such populations often lack access to formal health infrastructure and mental health services, and are more likely to rely on traditional healers or local practitioners, who may reinforce rather than challenge the belief that semen loss is harmful. The role of education is also critical. In our study, 74.5% of the study population had education only up to 12th standard or less (with 25.53% being illiterate). Comparable educational levels were reported in Grover et al. (66% with less than 10 years of schooling), Nazir et al. (majority only up to 10th standard), Kumari et al. (29.8% up to Class X; 8.6% illiterate), and Deshmukh et al., who also found that limited education was associated with greater belief in myths about semen loss. However, slight variations in reported educational attainment across studies could be due to differences in study settings, sample sizes, regional literacy rates, and urban-rural compositions. Additionally, changing access to education over time, differences in how "schooling" levels were categorized, and variation in recruitment methods (such as tertiary care centers versus general clinics) could contribute to these discrepancies. Despite these variations, the overall trend remains consistent: limited education is strongly linked with persistent misconceptions about semen loss and delayed psychiatric help-seeking. Lack of formal education, particularly sexual health education, contributes significantly to misconceptions about reproductive physiology. In these settings, semen is often viewed not as a natural bodily fluid, but as a finite, vital essence, and its perceived loss is wrongly believed to cause fatigue, cognitive dullness, and other psycho-somatic symptoms. Finally, the gendered cultural construction of masculinity plays a pivotal role. In many South Asian communities, a man’s worth is closely tied to his sexual performance and procreative capacity. Myths that semen is produced from food over several days, and that each drop lost leads to physical and spiritual decay, remain deeply ingrained. This makes young, unmarried men with poor sexual literacy especially prone to have such beliefs and experiencing intense anxiety when they perceive any form of semen loss, regardless of its normalcy. In conclusion, our study reinforces the findings of prior research by showing that Dhat syndrome is deeply rooted in a specific sociodemographic and cultural context. It most commonly affects young, unmarried,

less-educated males from rural, low-income backgrounds, who often rely on non-scientific health beliefs and face significant barriers to mental health care. The interplay of cultural myths, vulnerable age group, lack of education, economic hardship, and restricted sexual expression creates an environment in which Dhat syndrome can flourish.

In our study, patients with Dhat syndrome experienced symptoms for an average of 3.95 years, with a mean delay of 1.87 years before first contact with any healthcare provider. This delay was shorter compared to Grover et al. (2016), who reported a mean illness duration of 6.78 years and an average of 2.85 care providers consulted before reaching psychiatric services. Several factors may explain this difference. Our study was conducted in a general psychiatry outpatient setting, likely allowing for earlier referrals, whereas Grover's specialized psychosexual clinic may have attracted more chronic cases. Increased mental health awareness, improved access to digital information, and changing attitudes toward sexuality and psychiatry may also contribute to earlier help-seeking in recent years. Additionally, better referral integration in our sample could have led to fewer intermediate consultations. These included general practitioners, alternative medicine providers (Ayurveda, Unani, Homeopathy), religious healers and other specialities, with only 12.8% of the seeking psychiatric services as first help. This pattern mirrors that reported by Nazir et al. (2024) [25], who found that only 8.82% of patients initially sought psychiatric help, reflecting widespread misconceptions about the nature of Dhat syndrome. Similarly, Prakash et al. (2016) [20] found that the majority of patients first sought help in general medical settings, where symptoms were frequently interpreted and managed as purely physical complaints, often without addressing the underlying psychological distress. In the other studies, as in ours, the pathway to care was nonlinear, fragmented, and culturally shaped, with very few patients presenting directly to psychiatric services. Such culturally influenced delays are further exacerbated by the belief reinforced by some general practitioners and traditional healers. In many South Asian settings, seeking psychiatric help is equated with being "mad" or "weak," resulting in significant delays in referral to appropriate services. Our findings corroborate this, as only 10.6% of referrals came from family members, despite the distress being evident for extended periods. This aligns with the observations of Shahi et al. (2022), who emphasized that mental health stigma, poor awareness, and societal taboos lead patients to exhaust multiple options before considering psychiatric care. [21] The economic burden associated with this delayed pathway is substantial. As reported by Grover et al.

(2016), repeated consultations with multiple non-specialist providers significantly inflate the cost of care. Our study demonstrated that the average cost increased approximately from ₹583.33 when psychiatry was the first point of contact to ₹4,250 by the fourth contact. This escalation is particularly harmful for patients from economically marginalized groups (55.32% of our sample belonged to below-poverty-line families) who already struggle with limited financial resources and healthcare access. This underscores the need for earlier identification and intervention. Given these findings, the need for public health interventions becomes apparent. Mental health literacy programs tailored to culturally specific beliefs about sexuality and masculinity are crucial. Training frontline healthcare providers including general practitioners and traditional medicine practitioners in basic mental health screening could bridge the gap between community beliefs and clinical care. In conclusion, the pathway to care in Dhat syndrome is delayed, indirect, and shaped by cultural narratives, misinformation, and systemic barriers. Our study along with other existing literature highlight the urgency of integrated mental health strategies that can address these challenges.

A significant and revealing component of our study was the assessment of personality traits among individuals diagnosed with Dhat syndrome, conducted using the ICD-10 International Personality Disorder Examination (IPDE) screening module. In our study, 87.2% of patients diagnosed with Dhat syndrome exhibited personality traits consistent with Cluster C of the DSM-V classification, which includes avoidant, dependent, and obsessive-compulsive personality patterns. [11] This cluster is broadly characterized by anxious, fearful, and self-doubting behaviour, often linked with heightened sensitivity to criticism, difficulty in decision-making, and excessive need for reassurance, traits that can significantly influence illness perception and help-seeking behaviour. These findings are in line with previous research by Prakash et al. (2016), who assessed the phenomenology of Dhat syndrome in a general medical setting and found that many patients demonstrated high levels of neuroticism, low self-esteem, and heightened suggestibility, particularly in relation to health and sexuality.[20] Neuroticism refers to a personality trait characterized by a tendency to experience negative emotions such as anxiety, fear, irritability, sadness, and self-doubt more intensely and more frequently than others. Individuals high in neuroticism are often more emotionally reactive, vulnerable to stress, and prone to interpret normal bodily sensations as signs of illness. The authors also suggested that Dhat syndrome may not only be a culturally bound condition but also a manifestation of underlying psychological vulnerabilities, including maladaptive personality traits. In the case of Dhat

syndrome, symptoms like fatigue, weakness, and cognitive dullness are interpreted not as manifestations of anxiety or depression but rather as direct consequences of semen loss, thus providing a socially acceptable outlet for internal distress. Anxious, dependent, and avoidant individuals may be more prone to developing Dhat syndrome because their heightened fear of physical harm, need for reassurance about bodily functions, and sensitivity to perceived weakness create fertile ground for somatic misinterpretations. The culturally reinforced belief that semen is vital for health acts as a potent trigger for these individuals, amplifying normal sexual phenomena into sources of intense health anxiety. Cluster C traits have been associated with poorer treatment compliance, greater symptom persistence, and higher relapse rates in various psychiatric and psychosomatic disorders. [20] Therefore, recognizing these underlying personality patterns is critical for formulating individualized treatment plans. Incorporating psychotherapeutic interventions, such as cognitive behavioural therapy (CBT) to address maladaptive thought patterns, or interpersonal therapy (IPT) to improve self-concept and coping skills, can enhance outcomes in Dhat syndrome by addressing both the somatic symptoms and the psychological framework that sustains them. [31] In conclusion, the high prevalence of Cluster C personality traits in our study highlights the complex interplay between personality structure, cultural beliefs, and symptom expression in Dhat syndrome. These findings support the view that Dhat syndrome is not solely a culturally mediated condition but also reflects enduring psychological vulnerabilities.

Our study found that patients diagnosed with Dhat syndrome experienced significant impairments in quality of life (QoL), particularly in the psychological and physical health domains. Among the four WHOQOL-BREF domains assessed, the environmental domain showed the highest mean score (54.20 ± 13.62), indicating relatively better satisfaction with aspects such as financial resources, access to healthcare, and living conditions. This was followed by the social relationships' domain (53.17 ± 18.28), suggesting moderate levels of interpersonal support. In contrast, the physical health (46.57 ± 18.76) and psychological health (45.26 ± 17.22) domains were lower, indicating significant distress in areas like energy levels, sleep, emotional wellbeing, and cognitive functioning. These findings are in line with those reported by Shahi et al. (2022), who conducted a comparative study using WHOQOL-BREF and WHODAS 2.0. They observed that patients with Dhat syndrome scored significantly lower in all QoL domains (physical health: 46.90 ± 16.67, psychological health: 41.31 ± 18.01, social relationships: 39.87 ± 20.89, environment: 48.03 ± 15.83)

compared to healthy controls and had higher levels of disability. [21] Similarly, Deshmukh et al. (2024) reported greater distress among younger and unmarried males, groups also predominant in our sample. [27] The emotional burden of semen loss beliefs in this age group, compounded by limited sexual experience and high social expectations around masculinity, likely contributes to the diminished psychological and physical QoL scores observed in our study. Additional support comes from a study by Kumar et al., which used the SF-36 QoL scale and found that patients with Dhat syndrome showed poor functioning in both physical and mental health domains. [28] This aligns with our observation that the psychological domain was among the most affected, supporting the hypothesis that Dhat syndrome represents not only a culturally-bound syndrome but also a somatic expression of underlying affective distress. Several factors may explain the reduced QoL in individuals with Dhat syndrome. Firstly, the persistent anxiety and guilt surrounding semen loss can result in stress and low mood. Secondly, lack of accurate sexual education and health literacy leads patients to misattribute normal physiological events (like nocturnal emissions or masturbation) to disease, perpetuating health-related anxieties. Thirdly, stigmatized views toward mental illness and masculinity often prevent timely help-seeking, delaying intervention and allowing symptoms to worsen over time. Furthermore, comorbid sexual dysfunctions (e.g., premature ejaculation or erectile difficulties) are common and contribute to diminished emotional and functional wellbeing. Lastly, the socioeconomic disadvantages commonly seen in this population such as rural background, low income, and poor access to specialized care further restrict coping mechanisms and reinforce illness behaviour. Together, these findings suggest that Dhat syndrome significantly compromises patients' quality of life across multiple domains. Our results, consistent with previous literature, underscore the need for integrated care approaches that combine psychoeducation, early psychiatric intervention, and culturally informed mental health support to improve outcomes in this vulnerable population.

The findings suggest that the total duration of illness significantly impacts certain domains of quality of life (QoL), particularly physical and psychological health. Both showed moderately strong negative correlations with illness duration ($r = -0.434$, $p = 0.002$ and $r = -0.400$, $p = 0.005$, respectively), indicating that prolonged illness is associated with worsening physical and mental well-being. This can be explained by the cumulative burden of persistent somatic symptoms, such as fatigue, weakness, and poor concentration, which often go unrelieved till psychiatric intervention. Over time, these untreated symptoms

may contribute to chronic stress, sleep disturbances, and emotional exhaustion, thereby lowering both physical vitality and psychological resilience. Additionally, continuous preoccupation with semen loss and associated health anxieties may reinforce maladaptive beliefs and worsen affective distress, contributing to a cycle of psychological decline. Conversely, the social relationships and environmental domains showed weaker, non-significant negative correlations ($r = -0.205$, $p = 0.167$ and $r = -0.294$, $p = 0.055$, respectively), suggesting these areas may be less directly affected by illness duration. One possible explanation is that individuals may continue to maintain functional social roles despite their internal distress, particularly in supportive family structures common in South Asian cultures. Moreover, access to mobile technology and digital communication may provide ongoing emotional support and exposure to health information, which can help preserve social engagement and buffer environmental challenges even during prolonged illness. These findings emphasize the role of external supports and coping strategies in modulating the broader impact of Dhat syndrome on everyday functioning.

The findings indicate a significant association between financial resources spent and both the delay in accessing psychiatric care and overall quality of life (QoL) in patients with Dhat syndrome. A strong positive correlation ($r = 0.670$, $p < 0.001$) was observed between financial expenditure and the time taken to reach a psychiatrist, suggesting that greater delays in receiving appropriate mental health care are associated with increased financial burden. This may reflect systemic barriers such as limited access to specialized services, misdiagnosis, or repeated consultations with traditional or non-specialist practitioners before psychiatric care is finally sought. Notably, increased financial expenditure was also associated with worse QoL across all domains. This may be explained in part by the fact that more severe physical or psychological symptoms often drive patients and families to pursue multiple, and sometimes costly, treatment avenues in search of relief. Additionally, the burden of ongoing expenses can generate stress, anxiety, and helplessness, further affecting mental health. Social functioning may also deteriorate due to stigma, financial dependence, or strained family relationships arising from prolonged illness-related costs, while the environmental domain can be impacted by compromised housing, safety, and healthcare access.

The results show that patients from rural backgrounds experienced a significantly longer delay in accessing psychiatric care compared to their urban counterparts, mean duration being 0.7 years in the urban

group, whereas it took 1.55 years in the rural population group, despite no statistically significant differences in years since first contact or any of the QoL domains. The longer delay among rural patients may reflect systemic barriers such as fewer mental health services, longer travel distances, lower mental health awareness, and stigma associated with psychiatric care in rural areas. These access issues can lead to delayed diagnosis and treatment initiation, worsening clinical outcomes over time. Interestingly, despite the longer delay in accessing psychiatric care among rural patients, no significant differences were found in physical, psychological, social, or environmental QoL scores between urban and rural groups. This may be because the core distress in Dhat syndrome is centered around health anxieties and cultural beliefs about semen loss is prevalent across both urban and rural populations, irrespective of access to services. Additionally, stigma, misconceptions about sexual health, and emotional suppression are widespread in both settings, leading to similar levels of psychological and somatic impairment. Even in urban areas, where services are more available, barriers like fear of judgment, lack of mental health literacy, and delayed help-seeking can lead to significant distress. Furthermore, strong family and community support systems in rural areas might provide some protective effect on social and environmental well-being, offsetting disadvantages linked to delayed care. Thus, the overall burden of Dhat syndrome on QoL remains comparable across rural and urban groups. Additionally, the lack of difference in years since first contact may indicate that initial symptom recognition and help-seeking behaviour are occurring at comparable times, but rural patients may face more significant obstacles in reaching specialized psychiatric services. [30] This may be due to limited availability of specialists, greater travel distances, financial barriers, and stronger mental health stigma in rural areas. Lower health literacy and reliance on traditional healers may also contribute to delayed specialist referrals, despite early symptom awareness.

The data reveals that patients from the below poverty line (BPL) group faced significantly longer delays in both the time since first contact and duration to psychiatrist compared to those above the poverty line (APL)**.** These findings highlight the economic barriers faced by low-income individuals in accessing timely psychiatric care. Financial hardship often limits access to health services due to out-of-pocket expenses, transportation costs, and missed wages, leading to prolonged pathways to care. Additionally, those from lower socio-economic backgrounds may initially seek help from traditional healers or general practitioners, delaying specialist psychiatric consultation. [31] Despite these delays, the differences in quality

of life (QoL) domains—physical, psychological, social, and environmental—were not statistically significant between BPL and APL groups. This suggests that the impact of Dhat syndrome is not solely determined by economic status. One likely reason is that the distress in Dhat syndrome arises primarily from cultural beliefs, sexual misconceptions, and psychological anxiety related to semen loss, factors that are pervasive across socioeconomic groups. Even individuals in the APL category may lack access to accurate sexual health education and carry similar misconceptions, particularly if they come from conservative or rural backgrounds. [33] Additionally, mental health stigma and reluctance to seek psychiatric care affect both groups equally, leading to comparable impairment in psychological and social functioning. In some cases, APL individuals may experience greater psychological strain due to heightened awareness or expectations, which can offset the assumed advantage of better financial resources. These factors collectively contribute to a similar level of QoL disruption in both groups, despite differences in income.

Results also show a trend indicating that individuals with higher education levels such as those with high school or degree qualifications tend to seek psychiatric care earlier and make their initial healthcare contact sooner. However, these differences across education groups were not statistically significant for either the years since first contact or the duration taken to reach a psychiatrist. One possible explanation is that while education may contribute to better health awareness and access to information, it may not be sufficient on its own to overcome the deeply ingrained cultural beliefs and stigma surrounding sexual health and mental illness associated with Dhat syndrome. Even educated individuals may internalize myths about semen loss and prefer non-psychiatric avenues first, such as general physicians, traditional healers, or alternative medicine. Additionally, education alone does not always equate to mental health literacy, particularly in societies where sexual education is lacking in formal curricula. Therefore, while education may offer some advantages in help-seeking behaviour, its impact may be moderated by cultural, familial, and societal influences, resulting in non-significant statistical differences across groups.

The data shows no statistically significant difference in years since the first contact based on who suggested psychiatric help. However, there is a notable trend: individuals who were referred via the Internet sought help much earlier (mean = 0.778 years) compared to those who were self-referred or influenced by family or friends. This may reflect the growing impact of digital health literacy, with individuals accessing

online mental health information becoming more proactive and timelier in seeking care. [34] In contrast, suggestions from family or friends may involve delays due to hesitancy, stigma, or attempts to manage symptoms informally before professional help is pursued. Self-referral may also be delayed due to poor insight, fear of social labelling, or lack of awareness about mental health services. Internet-based suggestions possibly through forums, blogs, or awareness campaigns appear to promote early recognition and intervention, which is critical in reducing the duration of untreated illness. The absence of statistical significance in this finding could be attributed to limited sample size within each referral subgroup, which reduces the power to detect meaningful differences. Additionally, overlapping social dynamics where digital access, peer advice, and self-reflection may coexist can blur the distinctions between categories. Moreover, individual differences in symptom perception, access to healthcare, and readiness to act on advice may further contribute to variability within groups. While not statistically conclusive, the observed trend underscores the potential of technology-driven mental health promotion and highlights the importance of expanding psychoeducation efforts within families and communities to encourage timely and appropriate psychiatric referrals.

The clinical implications of these findings are substantial. First and foremost, there is a need for early screening and intervention, especially at the primary healthcare level. Given that most patients initially present to non-psychiatric providers, such as general practitioners or traditional medicine practitioners, it is imperative to equip these frontline workers with the skills to recognize culture-bound syndromes like Dhat syndrome. [19] Basic training in mental health screening, coupled with referral protocols, can drastically reduce delays in psychiatric care and minimize the risk of chronicity. Second, psychoeducation must form the foundation of all interventions for Dhat syndrome. Emphasizing that semen loss is a regular physiological occurrence and not harmful can help counter the pervasive myths that fuel health anxiety and guilt. Previous research suggests that cognitive-behavioural therapy (CBT) when adapted to include culturally relevant narratives and beliefs can be highly effective in addressing the distorted cognitions and maladaptive behaviours associated with Dhat syndrome as described by Prakash O, 2016. [29] CBT techniques focusing on restructuring illness beliefs, improving body image, and teaching relaxation strategies may alleviate both somatic and psychological symptoms. Third, there is a broader public health dimension to consider. Mental health services in rural and underserved areas where Dhat syndrome is most

commonly reported remain scarce, stigmatized, and underutilized. Policymakers and public health authorities must prioritize the integration of psychiatric consultation into community health programs. Innovative strategies such as mobile mental health units, telepsychiatry, and digital health platforms can extend the reach of psychiatric services and reduce the urban-rural divide. Furthermore, public health campaigns should aim to normalize conversations around sexual health, debunk prevalent myths about semen loss, and promote the view of mental health as a component of overall well-being. Furthermore, the continued prevalence of Dhat syndrome across India and other South Asian regions points to its enduring status as a public health concern. This presents a multifaceted challenge that cannot be addressed through isolated clinical interventions alone. A comprehensive response must involve a multidisciplinary framework that includes psychiatry, community medicine, public health, and medical anthropology. Strategies should also involve collaboration with traditional and informal care networks to bridge the gap between cultural and medical paradigms.

Future research must adopt longitudinal methodologies to better understand Dhat syndrome's progression, the impact of early interventions, and the long-term outcomes of various treatment approaches. Moreover, assessing the adaptability and effectiveness of culturally modified psychotherapeutic modalities—such as cognitive-behavioural therapy tailored to local belief systems—remains an essential area of inquiry. With the increasing penetration of mobile technology and internet access, digital platforms offer promising avenues for disseminating accurate information, reducing stigma, and expanding access to mental health care in rural and underserved populations. Ultimately, addressing Dhat syndrome and similar culture-bound syndromes demands more than just symptom management. It calls for a paradigm shift in psychiatric practice — one that genuinely integrates culture into the diagnostic and therapeutic process. Only through a holistic, culturally responsive, and community-oriented approach can we aspire to achieve meaningful and sustainable improvements in the mental health outcomes of individuals affected by such conditions.

7 STRENGTHS OF THE STUDY:

1. This study is one of the few to comprehensively assess pathways to care, personality traits, and quality of life specifically among patients with Dhat syndrome in an Indian tertiary care setting.
2. Using standardized and validated tools such as the WHOQOL-BREF and the ICD-10 IPDE screening questionnaire enhances the reliability and comparability of the findings.
3. The study offers a culturally sensitive perspective, acknowledging the role of traditional beliefs and socio-economic factors in the clinical presentation and healthcare-seeking behaviour.
4. It identifies key psychosocial barriers and financial burdens patients face, providing practical insights for improving early intervention strategies.
5. The research highlights the significant association between delay in psychiatric care, financial expenditure, and poor quality of life, underlining the importance of integrated mental health services.

8 LIMITATIONS OF THE STUDY:

1. The sample size was relatively small (47 patients), limiting the generalizability of the findings to the broader population affected by Dhat syndrome.
2. The study was conducted at a single tertiary care centre, which may introduce selection bias and might not represent patients in primary care or community settings.
3. The retrospective data collection regarding healthcare pathways, financial resources spent and symptom history may introduce recall bias in this study.
4. Psychiatric comorbidities were not explored beyond basic categorization, which could have enriched the understanding of quality of life impairments and clinical outcomes.

9 CONCLUSION:

This study concludes that Dhat syndrome represents a complex interaction between cultural beliefs, psychological vulnerabilities, and systemic healthcare barriers. This 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 quality of life. 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 and more significant financial burden were significantly linked with poorer quality of life 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.

10 SUMMARY:

1. The study aimed to assess the pathway to care, clinical features, personality traits, and quality of life among patients diagnosed with Dhat syndrome.
2. It was a cross-sectional study conducted at a tertiary care hospital in Karnataka, India, over a period of 18 months.
3. A total of 47 male patients aged between 18 and 42 years were included, with a mean age of 24.91 years.
4. Most participants were unmarried, from rural areas, and belonged to lower socio-economic classes which was similar to previous literature on Dhat syndrome.
5. Educational levels were generally low, with a significant portion either illiterate or having completed only till 12^{th} standard.
6. The average delay between onset of symptoms and psychiatric consultation was around 3.95 years.
7. Initial help-seeking was commonly through general physicians, alternative medicine practitioners, or native/ religious healers.
8. The main presenting complaints were generalized weakness and concerns about semen loss.
9. Financial expenditure increased with the number of healthcare contacts before reaching psychiatric services.
10. Cluster C personality traits were predominant among patients, suggesting an anxious and fearful personality style.
11. Quality of life scores were lowest in the physical and psychological health domains.
12. Longer duration of illness was significantly associated with poorer physical and psychological quality of life.
13. Patients from rural backgrounds and below-poverty-line economic status faced greater delays in reaching psychiatric care.
14. Education level showed a trend toward earlier help-seeking, although it was not statistically significant.
15. Internet-based awareness was associated with faster help-seeking compared to advice from friends or family.

16. Cultural myths and beliefs about semen as a vital fluid heavily influenced patient perceptions and delays in seeking psychiatric help.
17. The syndrome reflects a complex interaction between somatic distress, psychological vulnerability, and sociocultural factors.
18. Early psychoeducation and culturally adapted psychotherapy were emphasized as critical to management.
19. Community-level mental health awareness programs were recommended to promote early intervention.
20. The study concluded that addressing Dhat syndrome requires integrated, culturally sensitive approaches across healthcare levels.

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ANNEXURE-I

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Azadi Ka Amrit Mahotsav

BLDE

(DEEMED TO BE UNIVERSITY)

Declared as Deemed to be University u/s 3 of UGC Act, 1956

Accredited with 'A' Grade by NAAC (Cycle-2)

The Constituent College

SHRI B. M. PATIL MEDICAL COLLEGE, HOSPITAL & RESEARCH CENTRE, VIJAYAPURA

BLDE (DU)/IEC/ 870/2022-23 1/4/2023

INSTITUTIONAL ETHICAL CLEARANCE CERTIFICATE

The Ethical Committee of this University met on **Saturday, 18th March, 2023 at 11.30 a.m. in the CAL Laboratory, Dept. of Pharmacology,** scrutinizes the Synopsis/ Research Projects of Post Graduate Student / Under Graduate Student /Faculty members of this University /Ph.D. Student College from ethical clearance point of view. After scrutiny, the following original/ corrected and revised version synopsis of the thesis/ research projects has been accorded ethical clearance.

TITLE: "ASSESSMENT OF PATHWAY TO CARE AMONG PATIENTS WITH DHAT SYNDROME: A CROSS SECTIONAL OBSERVATIONAL STUDY".

NAME OF THE STUDENT/PRINCIPAL INVESTIGATOR: DR NISHANTH REDDY A.

NAME OF THE GUIDE: DR. SANTOSH RAMDURG, PROFESSOR & HOD, DEPT. OF PSYCHIATRY.

Dr. Santoshkumar Jeevangi
Chairperson
IEC, BLDE (DU),
VIJAYAPURA

Chairman,
Institutional Ethical Committee,
BLDE (Deemed to be University)
Vijayapura

Dr.Akram A. Naikwadi
Member Secretary
IEC, BLDE (DU),
VIJAYAPURA

MEMBER SECRETARY
Institutional Ethics Committee
BLDE (Deemed to be University)
Vijayapura-586103. Karnataka

Following documents were placed before Ethical Committee for Scrutinization.

- Copy of Synopsis/Research Projects
- Copy of inform consent form
- Any other relevant document

Smt. Bangaramma Sajjan Campus, B. M. Patil Road (Sholapur Road), Vijayapura - 586103, Karnataka, India.
BLDE (DU): Phone: +918352-262770, Fax: +918352-263303, Website: www.bldedu.ac.in, E-mail:office@bldedu.ac.in
College: Phone: +918352-262770, Fax: +918352-263019, E-mail: bmpmc.principal@bldedu.ac.in

ANNEXURE –II

BLDE (DU), SHRI BM PATIL MEDICAL COLLEGE HOSPITAL & RC VIJAYAPURA - 586103

9.0. INFORMED CONSENT FOR PARTICIPATION IN DISSERTATION/ RESEARCH

I, the undersigned,_____ , S/O D/O W/O_____, aged _____ years, ordinarily resident of_____ do hereby state/declare that Dr. NISHANTH REDDY of Shri. B. M. Patil Medical College Hospital and Research Centre have explained to me in a language I understand that he is conducting dissertation/research titled "PATHWAY TO CARE AMONG PATIENTS WITH DHAT SYNDROME" under the guidance of Dr. Santosh Ramdurg, and requesting my participation in the study. Apart from routine treatment procedures, follow-up observations will be utilized for the study as reference data. Further Doctor has informed me that my participation in this study helped in the evaluation of the results of the study, which is a useful reference for the treatment of other similar cases in the near future. The Doctor has also informed me that information given by me, observations made photographs, and video graphs taken upon me by the investigator will be kept confidential and not assessed by a person other than my legal hirer or me except for academic purposes.

The Doctor informed me that though my participation is purely voluntary, based on the information given by me, I can ask for any clarification during the course of treatment/study related to diagnosis, procedure of treatment, the result of treatment or prognosis.

At the same time, I have been informed that I can withdraw from my participation in this study at any time if I want, or the investigator can terminate me from the study at any time from the study but not the procedure of treatment and follow-up unless I request to be discharged.

After understanding the nature of dissertation or research, diagnosis made, mode of treatment, I the undersigned Shri/Smt_____under my full conscious state of mind agree to participate in the said research/dissertation.

Signature of the patient:

Signature of Doctor:

Dr. NISHANTH REDDY A
(Psychiatry Junior Resident)

Witness: 1.

ANNEXURE III

PROFORMA FOR SOCIODEMOGRAPHIC DETAILS COLLECTION

BLDE'S (DU) SHRI BM PATIL MEDICAL COLLEGE HOSPITAL & RC, VIJAYAPURA.

Name: CASE NO:

Age: UHID NO:

Sex:

Religion:

Occupation:

Residence: Urban / Rural

Family income:

Address:

Educational status:
No schooling, 1-5 class, 5-10 class, 11-12 class, Degree, Post Degree

Socio-Economic status: APL/ BPL

Stressor - Family issue/ Financial / IPR issue / Illness / Others

Details of Illness:

Any previous h/o Psychiatric Illness:

Any past history of sexual dysfunction:

Any history of Suicide in Family:

Any acute stressor present- YES / NO

PROFORMA TO ASSESS THE PATHWAY TO CARE AMONG PATIENTS WITH DHAT SYNDROME

1. Who was seen? (native/ religious healer, general practitioner, alternative medicine, social worker, hospital doctor, psychiatric services etc.)
2. How long ago?
3. Who suggested that care was sought?
4. What was the main complaint presented?
5. How long ago did the main problem begin?
6. What was the main treatment received?
7. Duration of patient's first journey to carer?
8. Financial resources spent during this time?

PROFORMA TO SCREEN FOR PERSONALITY TRAITS

1	I usually get fun and enjoyment out of life.	T	F
2	I don't react well when someone offends me.	T	F
3	I'm not fussy about little details.	T	F
4	I can't decide what kind of person I want to be.	T	F
5	I show my feelings for everyone to see.	T	F
6	I let others make my big decisions for me.	T	F
7	I usually feel tense or nervous.	T	F
8	I almost never get angry about anything.	T	F
9	I go to extremes to try to keep people from leaving me.	T	F
10	I'm a very cautious person.	T	F
11	I've never been arrested.	T	F
12	People think I'm cold and detached.	T	F
13	I get into very intense relationships that don't last.	T	F
14	Most people are fair and honest with me.	T	F
15	I find it hard to disagree with people if I depend on them a lot.	T	F
16	I feel awkward or out of place in social situations.	T	F
17	I'm too easily influenced by what goes on around me.	T	F
18	I usually feel bad when I hurt or mistreat someone.	T	F
19	I argue or fight when people try to stop me from doing what I want.	T	F
20	At times I've refused to hold a job, even when I was expected to.	T	F
21	When I'm praised or criticized I don't show others my reaction.	T	F
22	I've held grudges against people for years.	T	F
23	I spend too much time trying to do things perfectly.	T	F
24	People often make fun of me behind my back.	T	F
25	I've never threatened suicide or injured myself on purpose.	T	F
26	My feelings are like the weather; they're always changing.	T	F
27	I fight for my rights even when it annoys people.	T	F
28	I like to dress so I stand out in a crowd.	T	F
29	I will lie or con someone if it serves my purpose.	T	F
30	I don't stick with a plan if I don't get results right away.	T	F
31	I have little or no desire to have sex with anyone.	T	F
32	People think I'm too strict about rules and regulations.	T	F
33	I usually feel uncomfortable or helpless when I'm alone.	T	F
34	I won't get involved with people until I'm certain they like me.	T	F
35	I would rather not be the centre of attention.	T	F
36	I think my spouse (or lover) may be unfaithful to me.	T	F
37	Sometimes I get so angry I break or smash things.	T	F
38	I've had close friendships that lasted a long time.	T	F
39	I worry a lot that people may not like me.	T	F
40	I often feel "empty" inside.	T	F
41	I work so hard I don't have time left for anything else.	T	F
42	I worry about being left alone and having to care for myself.	T	F
43	A lot of things seem dangerous to me that don't bother most people.	T	F
44	I have a reputation for being a flirt.	T	F
45	I don't ask favors from people I depend on a lot.	T	F
46	I prefer activities that I can do by myself.	T	F

47	I lose my temper and get into physical fights.	T	F
48	People think I'm too stiff or formal.	T	F
49	I often seek advice or reassurance about everyday decisions.	T	F
50	I keep to myself even when there are other people around.	T	F
51	It's hard for me to stay out of trouble.	T	F
52	I'm convinced there's a conspiracy behind many things in the world.	T	F
53	I'm very moody.	T	F
54	It's hard for me to get used to a new way of doing things.	T	F
55	Most people think I'm a strange person.	T	F
56	I take chances and do reckless things.	T	F
57	Everyone needs a friend or two to be happy.	T	F
58	I'm more interested in my own thoughts than what goes on around me.	T	F
59	I usually try to get people to do things my way.	T	F

IPDE ICD-10 module screening questionnaire scoring summary

Last Name First Name Middle I. Date

1 Circle the item numbers not followed by F, if they were answered True.
2 Circle the remaining item numbers (those followed by F), if they were answered False.
3 If three or more items from a disorder are circled, the subject has failed the screen for that disorder, and should be interviewed. Clinicians and investigators may wish to adopt lower or higher screening standards, depending on the nature of the sample, and the relative importance to them of errors of sensitivity (false-negative cases) vs. specificity (false-positive cases). The screen should not be used to make a diagnosis or to calculate a dimensional score for a personality disorder.

F60.0	Paranoid:	2	14F	22	24	27	36	52		
F60.1	Schizoid:	1F	8	12	21	31	46	55	57F	58
F60.2	Dissocial:	11F	18F	20	29	38F	47	51		
F60.30	Impulsive:	19	30	37	53	56				
F60.31	Borderline:	4	9	13	25F	40				
F60.4	Histrionic:	5	17	26	28	35F	44			
F60.5	Anankastic:	3F	10	23	32	41	48	54	59	
F60.6	Anxious:	7	16	34	39	43	50			
F60.7	Dependent:	6	15	33	42	45	49			

PROFORMA TO ASSESS THE QUALITY OF LIFE

WHOQOL-BREF

Field Trial Version
December 1996

PROGRAMME ON MENTAL HEALTH
WORLD HEALTH ORGANIZATION
GENEVA

For office use only

	Equations for computing domain scores	Raw score	Transformed scores*	
			4-20	0-100
Domain 1	(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	=		
Domain 2	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26) ☐ + ☐ + ☐ + ☐ + ☐ + ☐	=		
Domain 3	Q20 + Q21 + Q22 ☐ + ☐ + ☐	=		
Domain 4	Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	=		

* Please see Table 4 on page 10 of the manual, for converting raw scores to transformed scores.

I.D. number

ABOUT YOU

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your **gender?** Male Female

What is you **date of birth?** _____ / _____ / _____
Day / Month / Year

What is the highest **education** you received?
None at all
Primary school
Secondary school
Tertiary

What is your **marital status?**
Single Separated
Married Divorced
Living as married Widowed

Are you currently **ill?** Yes No

If something is wrong with your health what do you think it is?_____illness/ problem

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. **Please answer all the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks.** For example, thinking about the last two weeks, a question might ask:

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	(4)	5

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.

Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1(G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4(F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5(F4.1)	How much do you enjoy life?	1	2	3	4	5
6(F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7(F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18(F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20(F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21(F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22(F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23(F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24(F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25(F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?.....

How long did it take to fill this form out?.....

Do you have any comments about the assessment?

.....

.....

ANNEXURE- IV

SOCIODEMOGRAPHIC PROFILE / PATHWAY TO CARE

CASE NUMBER	NAME	AGE	SEX	MARITAL STATUS	UHID NO	RELIGION	URBAN/ RURAL	EDUCATION	OCCUPATION	ECONOMIC STATUS	PAST HISTORY	1ST CONTACT	2ND CONTACT	3RD CONTACT	4TH CONTACT	YEARS SINCE FIRST CONTACT	SUGGESTED BY	MAIN COMPLAINT	TOTAL DURATION	DURATION TO PSYCHIATRIST	FINANCIAL RESOURCES
1	MALLESHI. B. BIRADAR	36	M	MARRIED	67391	H	RURAL	HIGH SCHOOL	KSRTC RETIRED	APL	NIL	GP	HD	P		6 YEARS	SELF	PASSAGE OF SEMEN	10 YEARS	5 YEARS	3000
2	SANGANGOUDA MANOHAR	34	M	UNMARRIED	49591	H	RURAL	DEGREE	STUDENT	BPL	NIL	AM	P			4 YEARS	FAMILLY	NIGHT FALL	10 YEARS	3 YEARS	2000
3	SANAPPA YELLUGURUDAPPA	42	M	MARRIED	68967	H	RURAL	NIL	FARMER	BPL	PREMATURE EJACULATION	RH	HD	P		4 YEARS	SELF	PRE-MATURE EJACULATION	5 YEARS	2 YEARS	3000
4	SHANAMUKH PAWAR	30	M	MARRIED	69233	H	RURAL	NIL	DAILY WAGE	BPL	NIL	N	AM	HD	P	2 YEARS	SELF	GENERALISED WEAKNESS	5 YEARS	2 YEARS	5000
5	MOHAMMAD SHAHID	26	M	MARRIED	69468	M	URBAN	HIGH SCHOOL	REAL ESTATE	APL	NIL	GP	HD	P		1 YEAR	SELF	EXCESSIVE WORRY	4 YEARS	0.5 YEARS	4000
6	MURTUJASAB MULLA	20	M	UNMARRIED	71345	M	RURAL	DEGREE	TEACHER	APL	NIL	HD	P			0.5 YEARS	SELF	PASSAGE OF SEMEN	2 YEARS	0 YEARS	1000
7	SHRISHAIL KAKHANDKI	32	M	MARRIED	57734	H	URBAN	DEGREE	AYURVEDA DOCTOR	APL	PREMATURE EJACULATION	AM	HD	P		3 YEARS	SELF	GENERALISED WEAKNESS	6 YEARS	1.5 YEARS	2000
8	RUBAN FERNANDES	28	M	MARRIED	74520	C	URBAN	POST DEGREE	TEACHER	APL	NIL	HD	P			0.5 YEARS	INTERNET	PASSAGE OF SEMEN	4 YEARS	0.5 YEARS	3000
9	PRASHANTH MALLAPPA	22	M	UNMARRIED	153025	H	RURAL	HIGH SCHOOL	STUDENT	BPL	NIL	AM	GP	P		2 YEARS	SELF	LOW MOOD	3 YEARS	1.5 YEARS	3000
10	SHANATKUMAR LAXMAN	24	M	MARRIED	271730	H	RURAL	NIL	FARMER	BPL	NIL	RH	HD	P		1 YEAR	FRIEND	PASSAGE OF SEMEN	4 YEARS	0.67 YEARS	2000
11	SURESH SIKKALAGAR	21	M	UNMARRIED	70106	H	RURAL	NIL	FARMER	BPL	NIL	GP	P			1.5 YEARS	SELF	EXCESSIVE WORRY	2 YEARS	0.5 MONTHS	2000
12	KHEERU SHETEPPA LAMANI	23	M	UNMARRIED	44974	H	URBAN	HIGH SCHOOL	SHOP KEEPER	APL	NIL	P				2 YEARS	SELF	LOW MOOD	2.5 YEARS	0 YEARS	1000
13	KASHIM IMAMSAHEB	20	M	UNMARRIED	330731	M	URBAN	NIL	MECHANIC	BPL	NIL	N	AM	GP	P	3 YEARS	FRIEND	GENERALISED WEAKNESS	4 YEARS	3 YEARS	4000
14	RAMANINGAYYA MATHPATI	33	M	MARRIED	79966	H	RURAL	NIL	FARMER	BPL	DEPRESSIVE DISORDER	AM	GP	P		3 YEARS	SELF	PASSAGE OF SEMEN	7 YEARS	1.5 YEARS	1000
15	BASAVARAJ BADACHI	19	M	UNMARRIED	253261	H	URBAN	PRIMARY SCHOOL	DRIVER	APL	NIL	AM	HD	P		2 YEARS	FRIEND	LOW MOOD	2.5 YEARS	0.5 YEARS	3000
16	JAGADISH RATHOD	25	M	UNMARRIED	409226	H	URBAN	NIL	DAILY WAGE	BPL	NIL	HD	P			2 YEARS	SELF	EXCESSIVE WORRY	3 YEARS	0 YEARS	2000
17	PRANEET G PATTANSHETTI	19	M	UNMARRIED	57421	H	URBAN	HIGH SCHOOL	STUDENT	APL	PREMATURE EJACULATION	P				0.5 YEARS	SELF	NIGHT FALL	2 YEARS	0 YEARS	0
18	MOHAMMAD HUSSAIN	23	M	UNMARRIED	149140	M	RURAL	MIDDLE SCHOOL	SHOP KEEPER	BPL	NIL	N	RH	HD	P	5 YEARS	FRIEND	GENERALISED WEAKNESS	6 YEARS	4 YEARS	6000
19	DUNDAPPA UKKALI	27	M	MARRIED	41909	H	URBAN	DEGREE	LAWYER	APL	NIL	HD	P			2 YEARS	INTERNET	HEADACHE	4 YEARS	2 YEARS	3000
20	MUTHU SADDAM	26	M	UNMARRIED	88932	H	URBAN	NIL	FARMER	APL	NIL	RH	HD	P		3 YEARS	FAMILY	EXCESSIVE MASTURBATION	8 YEARS	1 YEAR	3000
21	ANIL GIRIMALLAPPA	22	M	UNMARRIED	80277	H	RURAL	DEGREE	STUDENT	BPL	DEPRESSIVE DISORDER	HD	P			0.5 YEARS	SELF	LOW MOOD	2 YEARS	0.17 YEARS	1000
22	BHIMASHANKAR HIRIMIDI	24	M	UNMARRIED	106051	H	URBAN	DEGREE	ENGINEER	APL	NIL	HD	P			0.5 YEARS	INTERNET	PASSAGE OF SEMEN	2 YEARS	0.5 YEARS	1000
23	RAGHAVENDRA ODEYAR	21	M	UNMARRIED	108045	H	RURAL	HIGH SCHOOL	STUDENT	APL	OCD	P				0.17 YEARS	FRIEND	EXCESSIVE WORRY	0.5 YEARS	0 YEARS	1500
24	TULSIRAM MORE	25	M	MARRIED	2501052317	H	RURAL	PRIMARY SCHOOL	FARMER	BPL	NIL	RH	GP	P		4 YEARS	SELF	HEADACHE	6 YEARS	3 YEARS	5000
25	IRANNA. P. JANNA	26	M	UNMARRIED	2501127698	H	RURAL	MIDDLE SCHOOL	DRIVER	BPL	NIL	RH	AM	P		2 YEARS	FRIEND	GENERALISED WEAKNESS	3 YEARS	1 YEAR	1000
26	NEPAL SINGH	25	M	UNMARRIED	2501162329	H	URBAN	HIGH SCHOOL	SHOP KEEPER	APL	ERECTILE DYSFUNCTION	HD	P			0.5 YEARS	SELF	NIGHT FALL	3 YEARS	0.25 YEARS	1000
27	SUDEEP KANNI	18	M	UNMARRIED	2501178414	H	RURAL	DEGREE	STUDENT	APL	NIL	GP	P			1 YEAR	INTERNET	EXCESSIVE MASTURBATION	2 YEARS	1 YEAR	2000
28	SHRISHAIL. H. UPPAR	30	M	MARRIED	2500604115	H	RURAL	MIDDLE SCHOOL	FARMER	BPL	NIL	AM	HD	P		2 YEARS	FRIEND	LOW MOOD	6 YEARS	1.5 YEARS	2500
29	BASAYYA AMARKHEDA	25	M	UNMARRIED	2500659321	H	RURAL	PRIMARY SCHOOL	FARMER	BPL	PREMATURE EJACULATION	N	AM	P		3 YEARS	FRIEND	HEADACHE	4 YEARS	3 YEARS	5000
30	KISHTU SANGAPPA	32	M	MARRIED	2501171597	H	RURAL	NIL	FARMER	BPL	NIL	RH	GP	HD	P	5 YEARS	SELF	HEADACHE	6 YEARS	4 YEARS	6000
31	BASAVRAJ YANKANCHI	30	M	MARRIED	2501038642	H	RURAL	HIGH SCHOOL	DRIVER	BPL	NIL	AM	HD	P		2 YEARS	FAMILY	PRE-MATURE EJACULATION	5 YEARS	1 YEAR	500
32	AKASH BAGALI	23	M	UNMARRIED	2500822006	H	RURAL	MIDDLE SCHOOL	DRIVER	APL	NIL	HD	P			1 YEAR	FRIEND	PASSAGE OF SEMEN	3 YEARS	1 YEAR	3000
33	SANTOSH SHINAKED	29	M	UNMARRIED	2500844423	H	RURAL	NIL	FARMER	BPL	NIL	N	RH	GP	P	4 YEARS	SELF	GENERALISED WEAKNESS	8 YEARS	3.5 YEARS	2500
34	GURUPAD KANNUR	19	M	UNMARRIED	2500846092	H	RURAL	PRIMARY SCHOOL	DRIVER	BPL	NIL	GP	HD	P		0.5 YEARS	FRIEND	LOW MOOD	1 YEAR	0.5 YEARS	2000
35	SUNIL BAGALI	20	M	UNMARRIED	2500861612	H	RURAL	HIGH SCHOOL	STUDENT	APL	NIL	HD	P			0.5 YEARS	INTERNET	PRE-MATURE EJACULATION	2 YEARS	0 YEARS	0
36	KENCHAPPA MYAGERI	25	M	MARRIED	2500866983	H	RURAL	NIL	DAILY WAGE	BPL	NIL	AM	HD	P		1 YEAR	FAMILY	GENERALISED WEAKNESS	6 YEARS	0.75 YEARS	3000
37	PRAJWAL METRI	21	M	UNMARRIED	2503160592	H	URBAN	DEGREE	STUDENT	APL	NIL	P				0.17 YEARS	INTERNET	EXCESSIVE MASTURBATION	3 YEARS	0 YEARS	0
38	ARIF NADAF	19	M	UNMARRIED	2503268466	M	URBAN	DEGREE	CIVIL OFFICER	APL	NIL	HD	P			0.67 YEARS	SELF	HEADACHE	1 YEAR	0.67 YEARS	3000
39	MOUNESH BIRADAR	22	M	UNMARRIED	2500876183	H	RURAL	MIDDLE SCHOOL	DAILY WAGE	BPL	PREMATURE EJACULATION	AM	P			1 YEAR	FRIEND	GENERALISED WEAKNESS	2 YEARS	0.33 YEARS	2000
40	BHAVURAJ ESARAGOND	26	M	MARRIED	2503140840	H	URBAN	HIGH SCHOOL	STUDENT	APL	DEPRESSIVE DISORDER	P				2 YEARS	FRIEND	GENERALISED WEAKNESS	4 YEARS	0 YEARS	1000
41	ASLAM GOUNDI	21	M	UNMARRIED	2503180727	M	URBAN	DEGREE	SHOP KEEPER	APL	NIL	HD	P			1 YEAR	SELF	HEADACHE	2 YEARS	1 YEAR	4000
42	RAJESH NADAF	21	M	UNMARRIED	2519623648	M	URBAN	HIGH SCHOOL	STUDENT	BPL	PREMATURE EJACULATION	AM	GP	P		1.5 YEARS	SELF	PRE-MATURE EJACULATION	3 YEARS	1 YEAR	2000
43	KUMAR WALIKAR	25	M	UNMARRIED	2503136019	H	RURAL	MIDDLE SCHOOL	FARMER	BPL	NIL	AM	GP	P		1.5 YEARS	FRIEND	NIGHT FALL	4 YEARS	0.5 YEARS	1000
44	KASAPPAGOUDA BIRADAR	25	M	UNMARRIED	2503410595	H	RURAL	NIL	FARMER	BPL	PREMATURE EJACULATION	RH	AM	GP	P	2 YEARS	SELF	PASSAGE OF SEMEN	6 YEARS	2 YEARS	2000
45	RAMANGOUDA CHOUDHARI	18	M	UNMARRIED	2501095572	H	RURAL	MIDDLE SCHOOL	FARMER	BPL	NIL	GP	P			1.5 YEARS	FAMILY	NIGHT FALL	2 YEARS	1 YEAR	0
46	AKASH KARIKABBI	25	M	MARRIED	2503235501	H	RURAL	DEGREE	FARMER	BPL	PREMATURE EJACULATION	HD	P			0.5 YEARS	FRIEND	PRE-MATURE EJACULATION	3 YEARS	0.5 YEARS	1000
47	MUTESH BILLUR	24	M	UNMARRIED	2503811639	H	URBAN	HIGH SCHOOL	STUDENT	APL	NIL	P				0.5 YEARS	SELF	NIGHT FALL	2 YEARS	0 YEARS	0

PERSONALITY TRAITS

CLUSTER A			CLUSTER B					CLUSTER C				TRAITS
PARANOID	SCHIZOID	PERCENTAGE	DISSOCIAL	IMPULSIVE	BORDERLINE	HISTRIONIC	PERCENTAGE	ANANKASTIC	ANXIOUS	DEPENDENT	PERCENTAGE	
2	1	18.75	3	2	1	2	34.7	3	4	2	45	[illegible]
3	2	31.25	3	2	3	1	36.1	2	4	3	45	[illegible]
3	3	37.5	4	1	3	1	36.1	4	2	4	50	[illegible]
3	2	31.25	3	2	2	2	36.1	4	3	3	50	[illegible]
1	5	37.5	1	1	2	2	26.08	2	2	1	25	[illegible]
3	3	37.5	4	2	2	1	39.1	3	5	3	55	[illegible]
2	0	12.5	0	1	1	0	8.7	2	2	1	25	[illegible]
2	3	31.25	1	1	1	0	13.04	3	4	3	50	[illegible]
2	2	25	1	4	1	1	30.43	4	1	1	30	[illegible]
2	1	18.75	0	3	0	1	17.4	1	2	2	25	[illegible]
1	2	18.75	0	3	2	2	30.43	4	4	4	60	[illegible]
3	3	37.5	2	3	1	2	34.7	4	2	2	40	[illegible]
1	2	18.75	1	2	3	1	30.43	2	4	2	40	[illegible]
3	3	37.5	1	2	3	3	36.1	2	5	3	50	[illegible]
2	3	31.25	3	2	1	4	43.48	3	3	4	50	[illegible]
1	2	18.75	1	3	2	1	30.43	1	4	2	30	[illegible]
2	1	18.75	3	2	1	0	26.08	2	4	3	45	[illegible]
2	2	25	1	3	3	2	36.1	2	4	3	45	[illegible]
3	2	31.25	2	1	3	2	34.7	5	2	3	50	[illegible]
2	3	31.25	3	2	1	2	34.7	2	4	1	35	[illegible]
1	1	12.5	2	1	1	3	30.43	1	3	4	40	[illegible]
1	3	25	2	3	1	4	43.48	3	5	4	60	[illegible]
1	3	25	4	1	2	0	30.43	4	5	2	55	[illegible]
2	4	37.5	2	1	2	4	39.1	2	4	3	45	[illegible]
3	1	25	1	3	0	1	21.74	1	3	4	40	[illegible]
1	2	18.75	3	0	3	1	30.43	2	4	4	50	[illegible]
1	3	25	3	2	2	2	36.1	3	2	5	50	[illegible]
2	2	25	3	2	2	3	43.48	3	4	1	40	[illegible]
1	4	31.25	1	4	3	3	47.8	5	3	2	50	[illegible]
3	2	31.25	1	1	3	2	30.43	3	4	1	40	[illegible]
1	2	18.75	2	3	2	2	36.1	2	1	4	35	[illegible]
3	1	25	1	1	0	4	26.08	2	2	4	40	[illegible]
1	3	25	2	3	2	2	36.1	3	4	1	40	[illegible]
1	2	18.75	3	1	1	1	26.08	1	3	4	40	[illegible]
2	1	18.75	4	0	2	0	26.08	5	3	2	40	[illegible]
3	1	25	1	3	2	4	43.48	2	4	3	45	[illegible]
2	3	31.25	2	1	2	3	34.7	4	1	3	40	[illegible]
4	1	31.25	2	3	2	1	34.7	1	3	5	45	[illegible]
2	3	31.25	3	2	4	3	52.17	2	4	2	45	[illegible]
1	2	18.75	2	4	1	31	43.48	4	3	1	40	[illegible]
2	1	18.75	4	1	0	3	34.7	4	3	2	45	[illegible]
2	3	31.25	1	3	3	0	30.43	3	4	3	50	[illegible]
3	2	31.25	2	3	1	2	34.7	3	1	4	40	[illegible]
2	1	18.75	2	0	1	4	30.43	2	4	1	35	[illegible]
1	1	12.5	4	3	2	1	43.48	2	2	5	45	[illegible]
3	2	31.25	1	2	3	3	36.1	4	3	1	40	[illegible]
1	3	25	2	1	3	0	26.08	2	5	1	40	[illegible]

QUALITY OF LIFE

PHYSICAL HEALTH					PSYCHOLOGICAL HEALTH					SOCIAL RELATIONS					ENVIRONMENT				
RAW SCORE	TRANSFORMED SCORES 4 TO 20	0 TO 100	INTERPRETATION	QUALITY OF LIFE: P DT	RAW SCORE	TRANSFORMED SCORES 4 TO 20	0 TO 100	INTERPRETATION	QUALITY OF LIFE: PSY DT	RAW SCORE	TRANSFORMED SCORES 4 TO 20	0 TO 100	INTERPRETATION	QUALITY OF LIFE: S DT	RAW SCORE	TRANSFORMED SCORES 4 TO 20	0 TO 100	INTERPRETATION	QUALITY OF LIFE: E DT
11	6.3	[illegible]	POOR	1	12	8	[illegible]	MODERATE	2	6	8	[illegible]	MODERATE	2	24	12	[illegible]	GOOD	3
20	11.4	[illegible]	GOOD	3	16	10.7	[illegible]	GOOD	3	9	12	[illegible]	GOOD	3	30	15	[illegible]	VERY GOOD	4
15	8.6	[illegible]	MODERATE	1	11	7.3	[illegible]	MODERATE	2	9	12	[illegible]	GOOD	3	22	11	[illegible]	GOOD	3
16	9.1	[illegible]	MODERATE	2	14	9.3	[illegible]	MODERATE	2	9	12	[illegible]	GOOD	3	23	11.5	[illegible]	GOOD	3
24	13.7	[illegible]	VERY GOOD	4	17	11.3	[illegible]	GOOD	3	9	12	[illegible]	GOOD	3	30	15	[illegible]	VERY GOOD	4
21	12	[illegible]	GOOD	3	20	13.3	[illegible]	GOOD	3	10	13.3	[illegible]	GOOD	3	27	13.5	[illegible]	GOOD	3
15	8.6	[illegible]	MODERATE	2	14	9.3	[illegible]	MODERATE	2	9	12	[illegible]	GOOD	3	28	14	[illegible]	VERY GOOD	4
16	9.1	[illegible]	MODERATE	2	14	9.3	[illegible]	MODERATE	2	9	12	[illegible]	GOOD	3	26	13	[illegible]	GOOD	3
17	9.7	[illegible]	MODERATE	2	13	8.7	[illegible]	MODERATE	2	6	8	[illegible]	MODERATE	2	21	10.5	[illegible]	GOOD	3
24	13.7	[illegible]	VERY GOOD	4	20	13.3	[illegible]	GOOD	3	12	16	[illegible]	VERY GOOD	4	24	12	[illegible]	GOOD	3
14	8	[illegible]	MODERATE	2	14	9.3	[illegible]	MODERATE	2	7	9.3	[illegible]	MODERATE	2	20	10	[illegible]	MODERATE	2
15	8.6	[illegible]	MODERATE	2	9	6	[illegible]	POOR	1	6	8	[illegible]	MODERATE	2	21	10.5	[illegible]	GOOD	3
14	8	[illegible]	MODERATE	2	10	6.7	[illegible]	POOR	1	3	4	[illegible]	POOR	1	15	7.5	[illegible]	MODERATE	2
16	9.1	[illegible]	MODERATE	2	14	9.3	[illegible]	MODERATE	2	10	13.3	[illegible]	GOOD	3	17	8.5	[illegible]	MODERATE	2
14	8	[illegible]	MODERATE	2	9	6	[illegible]	POOR	1	4	5.3	[illegible]	POOR	1	19	9.5	[illegible]	MODERATE	2
23	13.1	[illegible]	GOOD	3	19	12.7	[illegible]	GOOD	3	10	13.3	[illegible]	GOOD	3	26	13	[illegible]	GOOD	3
27	15.4	[illegible]	VERY GOOD	4	23	15.3	[illegible]	VERY GOOD	4	9	12	[illegible]	GOOD	3	29	14.5	[illegible]	VERY GOOD	4
11	6.3	[illegible]	POOR	1	12	8	[illegible]	MODERATE	2	7	9.3	[illegible]	MODERATE	2	14	7	[illegible]	POOR	1
27	15.43	[illegible]	VERY GOOD	4	21	14	[illegible]	VERY GOOD	4	10	13.3	[illegible]	GOOD	3	30	15	[illegible]	VERY GOOD	4
14	8	[illegible]	MODERATE	2	14	9.3	[illegible]	MODERATE	2	9	12	[illegible]	GOOD	3	20	10	[illegible]	MODERATE	2
27	15.43	[illegible]	VERY GOOD	4	24	16	[illegible]	VERY GOOD	4	10	13.3	[illegible]	GOOD	3	28	14	[illegible]	VERY GOOD	4
23	13.1	[illegible]	GOOD	3	19	12.7	[illegible]	GOOD	3	9	12	[illegible]	GOOD	3	25	12.5	[illegible]	GOOD	3
21	12	[illegible]	GOOD	3	18	12	[illegible]	GOOD	3	10	13.3	[illegible]	GOOD	3	27	13.5	[illegible]	GOOD	3
20	11.4	[illegible]	GOOD	3	14	9.3	[illegible]	MODERATE	2	11	14.7	[illegible]	VERY GOOD	4	26	13	[illegible]	GOOD	3
19	10.86	[illegible]	GOOD	3	20	13.3	[illegible]	GOOD	3	12	16	[illegible]	VERY GOOD	4	27	13.5	[illegible]	GOOD	3
24	13.7	[illegible]	VERY GOOD	4	21	14	[illegible]	VERY GOOD	4	10	13.3	[illegible]	GOOD	3	28	14	[illegible]	VERY GOOD	4
22	12.57	[illegible]	GOOD	3	15	10	[illegible]	MODERATE	2	10	13.3	[illegible]	GOOD	3	28	14	[illegible]	VERY GOOD	4
21	12	[illegible]	GOOD	3	17	11.3	[illegible]	GOOD	3	10	13.3	[illegible]	GOOD	3	24	12	[illegible]	GOOD	3
12	6.9	[illegible]	POOR	1	12	8	[illegible]	MODERATE	2	9	12	[illegible]	GOOD	3	22	11	[illegible]	GOOD	3
15	8.6	[illegible]	MODERATE	2	16	10.7	[illegible]	GOOD	3	8	10.67	[illegible]	GOOD	3	20	10	[illegible]	MODERATE	2
23	13.1	[illegible]	GOOD	3	21	14	[illegible]	VERY GOOD	4	11	14.7	[illegible]	VERY GOOD	4	26	13	[illegible]	GOOD	3
28	16	[illegible]	VERY GOOD	4	22	14.7	[illegible]	VERY GOOD	4	12	16	[illegible]	VERY GOOD	4	28	14	[illegible]	VERY GOOD	4
14	8	[illegible]	MODERATE	2	13	8.7	[illegible]	MODERATE	2	9	12	[illegible]	GOOD	3	21	10.5	[illegible]	GOOD	3
24	13.7	[illegible]	VERY GOOD	4	19	12.7	[illegible]	GOOD	3	10	13.3	[illegible]	GOOD	3	26	13	[illegible]	GOOD	3
27	15.43	[illegible]	VERY GOOD	4	24	16	[illegible]	VERY GOOD	4	11	14.7	[illegible]	VERY GOOD	4	30	15	[illegible]	VERY GOOD	3
23	13.1	[illegible]	GOOD	3	14	9.3	[illegible]	MODERATE	2	10	13.3	[illegible]	GOOD	3	28	14	[illegible]	VERY GOOD	4
24	13.7	[illegible]	VERY GOOD	4	22	14.7	[illegible]	VERY GOOD	4	12	16	[illegible]	VERY GOOD	4	27	13.5	[illegible]	GOOD	3
17	9.7	[illegible]	MODERATE	2	16	10.7	[illegible]	GOOD	3	9	12	[illegible]	GOOD	3	25	12.5	[illegible]	GOOD	3
18	10.29	[illegible]	MODERATE	2	17	11.3	[illegible]	GOOD	3	13	17.3	[illegible]	EXCELLENT	5	32	16	[illegible]	VERY GOOD	4
23	13.1	[illegible]	GOOD	3	21	14	[illegible]	VERY GOOD	4	11	14.7	[illegible]	VERY GOOD	3	30	15	[illegible]	VERY GOOD	4
14	8	[illegible]	MODERATE	2	15	10	[illegible]	MODERATE	2	11	14.7	[illegible]	VERY GOOD	3	28	14	[illegible]	VERY GOOD	4
28	16	[illegible]	VERY GOOD	4	20	13.3	[illegible]	GOOD	3	10	13.3	[illegible]	GOOD	3	27	13.5	[illegible]	GOOD	3
24	13.7	[illegible]	VERY GOOD	3	16	10.7	[illegible]	GOOD	3	12	16	[illegible]	VERY GOOD	4	34	17	[illegible]	EXCELLENT	5
15	8.6	[illegible]	MODERATE	2	15	10	[illegible]	MODERATE	2	7	9.3	[illegible]	MODERATE	2	22	11	[illegible]	GOOD	3
27	15.43	[illegible]	VERY GOOD	4	22	14.7	[illegible]	VERY GOOD	3	12	16	[illegible]	VERY GOOD	3	30	15	[illegible]	VERY GOOD	3
28	16	[illegible]	VERY GOOD	4	24	16	[illegible]	VERY GOOD	4	6	8	[illegible]	MODERATE	2	28	14	[illegible]	VERY GOOD	4
27	15.43	[illegible]	VERY GOOD	4	19	12.7	[illegible]	GOOD	3	13	17.3	[illegible]	EXCELLENT	5	28	14	[illegible]	VERY GOOD	4

Nishanth Reddy

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CURRICULUM VITAE

PRIMARY GUIDE BIO-DATA

Name : Dr. SANTOSH RAMDURG

Age (in years) : 44 years

Date of birth : 25/06/1980

Educational Qualification:

Degree	Name of the College	Name of the University	Year of Passing
MBBS	JN MEDICAL COLLEGE, BELGAUM	RAJEEV GANDHI UNIVERSITY OF HEALTH SCIENCES, BANGALORE	2003
M.D. PSYCHIATRY	AIIMS DELHI	AIIMS DELHI	2009

Present position : PROFESSOR AND HEAD

K.M.C Registration No : 69081

Teaching Experience : 13 YEARS

P.G Guide : 3 YEARS

U.G teacher : 7 YEARS 10 MONTHS

Publications: 30 published articles in international, national and state journals.

Research projects: 4 projects are ongoing.

BIO-DATA

INVESTIGATOR

Name : Dr. NISHANTH REDDY

Age : 27 years

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Qualification : M.B.B.S

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Medical Council number : KMC 144490