Indian Journal of Clinical Psychiatry
An Official Journal of **Association of Clinical Psychiatry**
(Indian Psychiatric Society- Uttar Pradesh State Branch (IPS-UPSB))

CASE SERIES
doi: 10.54169/ijocp.v6i01.09

Dissociative Disorders in Pediatric Males from Industrial Worker Families: Clinical Presentation and Treatment Challenges - A Case Series

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Abstract

Dissociative disorders disrupt consciousness, emotions, and behavior integration. Sociocultural factors, childhood experiences, and socioeconomic stressors influence their development in children and adolescents, especially in industrial and labor sectors. Dissociative disorders are more common in females, but boys may show atypical/externalizing symptoms, causing diagnostic delays and misattribution to other disorders. We present a case series of four male patients (9–12 years) at a tertiary psychiatric service in an industrial area. All cases showed mixed dissociative symptoms, complex stressors, and delayed psychiatric evaluation. Treatment was impacted by gender-role-based emotional suppression, mental health stigma, and limited family awareness. Findings highlight the need for culturally informed, developmentally appropriate, and gender-responsive strategies for pediatric males with dissociative presentations.

ARTICLE INFO

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Dates:
Received: 09-03-2026
Accepted: 05-06-2026
Published: 26-06-2026

Keywords:
Dissociative disorders

How to Cite:
Jain K, Kaur A, Kumar M. Dissociative Disorders in Pediatric Males from Industrial Worker Families: Clinical Presentation and Treatment Challenges - A Case Series. Indian Journal of Clinical Psychiatry. 2026;6(1):58-62.
doi: 10.54169/ijocp.v6i01.09

Introduction

Dissociative disorders disrupt consciousness, identity, perception, and motor control.[1] Mixed dissociative disorder features two or more symptom types in the same individual that fluctuate in intensity and presentation. Indian literature shows female predominance, but boys often present with motor symptoms or trance states.[2] In boys (0–12 years), academic pressures, externalizing behaviors, and gender norms hinder emotional expression, delaying psychiatric help[3].

Faridabad, Haryana, is a major industrial hub of North India, with many small to large-scale industrial units. A significant portion of the workforce includes migrant laborers, many of whom are semi-skilled or unskilled. Employment is marked by daily-wage work, long hours, and job insecurity. Most families are lower or lower-middle socioeconomic strata. Housing includes crowded colonies with limited space and shared sanitation. Parental education is low to moderate, with both parents often working. Long, irregular hours and family conflict limit supervision and emotional engagement with children.[4]

Children in these homes are often first-generation learners facing academic

and financial challenges. Chronic financial instability, parental conflict, migration-related isolation, and overcrowded living environments add to their psychosocial vulnerability.[3]

In this socioeconomic and industrial context, psychological distress in children may show as somatic and dissociative symptoms, especially where service awareness and availability are low and stigma exists. Cultural beliefs, developmental overlap, and complex therapy are contributing factors. These stressors likely contributed to the clinical presentation and treatment challenges in this case series.

Cases

Case A: Dissociative Convulsions

A 9-year-old boy presented with frequent episodes of fainting and generalized seizure-like movements lasting for 20 to 30 minutes, occurring multiple times daily for the past 2 months. Neurological examination, imaging, and electroencephalography were normal. The onset coincided with the birth of a younger sibling, following which maternal attention toward the child reduced. Further exploration revealed school avoidance and bullying in the guitar class due to the inability to purchase a guitar, owing to poor family finances. Family understanding remained limited. Treatment consisted of medications (SSRI and Benzodiazepines), family psychoeducation, relaxation sessions and cognitive behavior therapy. Despite ongoing treatment, continued reinforcement of secondary gains was seen, including purchasing a guitar in response to peer bullying. Minimal improvement was noted, and the family opted for premature discharge. Emphasis was made to continue both pharmacological and psychological interventions, along with school involvement. Subsequent follow-ups were irregular, with persistence of symptoms and minimal change in family behavior.

Case B: Mixed Dissociative Disorder

An 11-year-old boy presented with multiple bodily complaints for the past 2 months. It started with abdominal pain and progressed to headache, chest pain, breathlessness, and eventually inability to walk, resulting in wheelchair dependence. Extensive investigations across all systems were normal. The child was noted to have academic difficulties. His mother was a known case of dissociative illness, whose symptoms he appeared to model. The mother's prolonged illness and the father's long working hours led to inconsistent parenting at home. Highly expressed emotions in the form of overinvolvement were prominent. A plan consisting of medications and an intensive psychological engagement was considered. Special attention was given to parenting approaches, expressed emotions and modeling of the mother's symptoms. Although partial improvement occurred with inpatient treatment, relapse followed when an attempt was made to normalize functioning. Parents rejected the psychological model and discontinued treatment in favor of faith-based interventions. Suggestions were made to continue allopathic treatment alongside faith healing practices. The child was lost to follow up and further status could not be ascertained.

Case C: Dissociative Trance and Possession Disorder

A 10-year-old boy presented with trance-like episodes for the last 1-month. It was characterized by aggressive behavior, unresponsiveness, and acting like his deceased grandfather. He refused to go to school and initially denied any stressors. All investigations were unremarkable. The child was started on SSRI, SOS benzodiazepines and psychotherapeutic interventions. During admission, episodes continued, and it came to notice that the father was simultaneously giving faith-based treatment to the child while he was admitted. The child later disclosed that he had to depend on his father for the daily commute to school, which embarrassed him in front of his peers, and stated he could "manage" his episodes only if he received a bicycle. The family was encouraged to reduce secondary gains, establish boundaries and respect the autonomy of the child. Despite ongoing treatment and advice to the contrary, the demand was met. Poor parental cooperation continued, which led to premature discharge. Recommendations were made to continue psychiatric and psychological interventions with faith healing practices. Inconsistent follow-ups, per-

sisting symptoms with reinforcement of secondary gains were seen.

Case D: Mixed Dissociative Disorder with Selective Mutism

A 12-year-old boy presented with headache, leg pain, inability to walk, and mutism for a period of 2 weeks. Extensive evaluation done by the Otolaryngology and Orthopedics departments was within normal limits. Similar episodes in the past had been resolved with placebo injections of multivitamins and antacids. In this admission, he also reported possession-like episodes attributed to an external entity ("The Spirit"). Ward observation revealed a lack of distress, excessive secondary gains in terms of exemptions from academic work and activities of daily living, and increased screen time. Overprotective caregiving by the mother was noted. In repeated interviews, the child admitted disinterest in studies and aspirations of becoming a YouTuber. The treatment plan consisted of pharmacotherapy, psychotherapy and behavioural modifications. Focussed sessions to address the overprotective caregiving, reducing secondary gains and screen time were conducted. Demands for injections were politely declined. The child was encouraged to carry out all his activities on his own with minimal support and communicate verbally while discouraging other forms of communication. Gradual improvement was seen with treatment; however, persistent reinforcement and poor acceptance of psychological causation led to loss to follow-up. On discharge, the psychological basis and the need for a comprehensive treatment plan and regular follow-ups were emphasised; however, the child was lost to follow-up and further status could not be ascertained.

Discussion

Across the four cases, the symptoms were influenced by individual vulnerabilities, family dynamics, sociocultural influences, and systemic barriers. Maternal unavailability, socioeconomic constraints, peer bullying, academic difficulties, and embarrassment related to caregiver dependence contributed to psychological distress. Difficulty in identifying, acknowledging, and communicating emotions was prominent. Dissociation functioned as a means to manage stress, avoid responsibilities, and communicate unmet emotional needs.

Poor family understanding of the illness, resistance to psychological explanations, inconsistent and overprotective parenting, high expressed emotions, reinforcement of the sick role maintained the disorder.[5] Symptom modeling from a parent with dissociative illness was noted. In our society, cultural beliefs shape explanatory models, with reliance on faith healers and possession-state attributions.[2] Concurring with the available data, children in our sample were engaged in traditional faith-healing practices, which legitimised symptoms and strengthened dissociative presentations.

Gender norms were central across cases. Social expectations discourage emotional expression in boys, pressures toward independence and self-reliance, and intensified shame around vulnerability. Hence, psychological distress was acceptably expressed through physical symptoms, motor manifestations, trance states, or possession-like episodes[6], which mimicked organic illness and prompted medical rather than therapeutic exploration. Concerns about social reputation and masculinity norms made caregivers reluctant to acknowledge emotional stress, equating vulnerability to weakness, reducing treatment acceptance and adherence.[7]

Treatment engagement was limited due to therapy resistance, partial family involvement, early discharge, stigma, and systemic barriers. Parenting stress in Indian settings adversely affects children's psychological well-being.[8] Psychiatric consultation occurs later after multiple physician visits.

Trauma and stress response research demonstrates that persistent stress alters affect regulation, predisposing to dissociative symptoms.[9,10] In industrial worker families, parental unavailability creates sustained stress. Dissociation initially functions as an affect-regulation strategy, becoming maladaptive through reinforcement.

Insufficient self-integration and oscillation between normal functioning and dissociative states trigger trance or possession-like states, consistent with the Theory of Structural Dissociation.[11] Cognitive-behavioral models explain symptoms

by negative reinforcement (reduction of internal distress) and positive reinforcement (environmental responses).[12,13]

Attachment theory links insecure attachment to impaired emotional regulation[14,15], increasing dissociative distress expression. Observational learning and reinforcement explain symptom modeling and maintenance.[16] Developmental models emphasize that psychopathology emerges from cumulative interactions over time.[17] In this population, dissociation is a developmental adaptation to chronic adversity, reinforced by limited emotional skill acquisition.

Early psychiatric liaison is crucial to prevent prolonged diagnostic cascades. Non-stigmatizing psychoeducation, addressing parental concerns and attributing symptoms to a biopsychosocial model is essential. Gender and masculinity norms should be addressed. School collaboration to minimize secondary gains is imperative. Development of male-sensitive therapeutic techniques may enhance engagement. Clinicians should adopt a respectful and integrative approach when families consult faith healers, negotiating care plans that allow parallel ritual practices while continuing evidence-based treatment. Improving mental health service availability, accessibility, and affordability is fundamental for early identification and effective intervention.

Limitations

These vignettes illustrate clinically relevant patterns and gender barriers, not epidemiologic

prevalence or causal inference. The sample excludes pediatric female cases, aiming to describe

male dissociative symptomatology, not to compare. Long-term outcomes in mixed dissociation

require months of staged therapy and observation; this study had a short follow-up period.

Conclusion

The role of industrial or occupational stress on children's mental health, especially dissociative pathology, is underexplored. More qualitative work is needed to understand how male vs. female children conceptualize their dissociative symptoms, especially in culturally specific contexts. There is a need for interventions tailored to gender-specific stress profiles.

Author Contributions

Dr Kudrat Jain: conceptualising the idea, data collection, preparation of the manuscript, review and approval. Dr Aashmeen Kaur: conceptualising the idea, data collection, preparation of the manuscript, review and approval. Dr Manoj Kumar: data collection, preparation of the manuscript, review and approval

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