Exploring Dissociative Symptoms, Self-harm, and Somatisation in Kashmiri Children: Insights from a Hospital-Based Analysis

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Abstract

Background: Children and Adolescents in conflict-affected regions like Kashmir face heightened mental health risks, including dissociative symptoms, somatisation, and deliberate self-harm (DSH), often driven by trauma, academic stress, and social challenges. There is limited clinical data on adolescent mental health in Kashmir. This study investigates key psychological presentations and their socio-demographic associations in a hospital setting.

Objectives of the Study: 1. To assess the prevalence and predictors of dissociation, self-harm, and somatisation in Kashmiri children. 2. Identify the frequency of dissociation, self-harm, and somatic complaints. 3. Examine associations with socio-demographic factors. 4. Determine predictors of dissociative symptoms

Methodology: A hospital-based cross-sectional study was conducted with 167 children. Data were analysed using SPSS v27. Age comparisons were made using the Mann–Whitney U test, while associations with categorical variables were assessed using Fisher's Exact test. Predictors of dissociation were identified through backward stepwise logistic regression.

Results: The sample consisted of 89.8% females with a mean age of 14.1 years. **Dissociative symptoms** were observed in 29.9% of participants, **somatic complaints** in 49.1%, and **self-harm/suicidal behaviours** in 21.6%. The most common method of self-harm was **organophosphate poisoning** (20.4%). Psychological symptoms, particularly dissociation and panic attacks, were significantly associated with self-harm. Logistic regression showed that adolescents in **9th–12th standard** were 3.48 times more likely to exhibit dissociative symptoms compared to those in lower grades (p=0.003). Children whose parents were in skilled/professional jobs were less likely to report dissociation (OR=0.3, p=0.034). The presence of **somatic complaints** and **self-harm behaviours** significantly predicted dissociative symptoms (both p<0.001).

Conclusion: Dissociation and self-harm are prevalent among Kashmiri children, especially in secondary school girls. School-based screening and context-sensitive interventions are urgently needed.

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Introduction

The formative years of childhood and adolescence are characterised by fast biological, psychological, and social change as well as increased susceptibility to mental health issues, particularly somatisation, dissociative symptoms, and deliberate self-harm (DSH). Trauma or extreme stress is frequently followed by dissociation, which is characterised as a disturbance in consciousness, memory, identity, or perception[1]. Clinical and longitudinal studies show that teenage dissociation serves as a risk indicator for suicidality and self-harming behaviours[2]. In children and adolescents, somatisation, the presentation of psychological distress as physical symptoms, often co-occurs with affective and dissociative psychopathology, especially in situations where cultural norms prevent the expression of emotions [3].

Cumulative adversities (political instability, exposure to violence, disruptions in education, and economic precarity) presumably increase these risks in conflict-affected areas like Kashmir[4] Research from the area and similar South Asian contexts shows that adolescents have higher rates of anxiety and depression symptoms [5], dissociative presentations, and suicidal behaviours, with stress from school and family strife serving as frequent triggers[6] [7]. However, there is still a dearth of systematic, hospital-based clinical data on the co-occurrence and correlates of DSH, somatisation, and dissociation in Kashmiri children, which limits the development of trauma-informed, context-sensitive interventions and service planning.

Aims and Objectives

Aim. To assess the prevalence and predictors of dissociation, self-harm, and somatisation among Kashmiri children attending a tertiary-care hospital.

Objectives:

1. To estimate the frequency of dissociative symptoms, self-harm behaviours, and somatic complaints.
2. To examine associations between these symptoms and socio-demographic factors (age, sex, schooling level, family structure, residence, parental occupation/education).
3. To identify predictors of dissociative symptoms using multivariable modelling.

Methodology

A descriptive cross-sectional study was conducted at the 500-bedded Children's Hospital, Srinagar, Jammu & Kashmir, India, from January to June 2024. Participants were recruited from adolescents referred by the Department of Paediatrics for psychological evaluation.

Sampling and recruitment

Consecutive sampling was employed: all eligible referrals during the study window were assessed for inclusion. Importantly, paediatricians first evaluated each case and excluded organic causes before referral to the psychiatric/psychological team.

Participants

Inclusion criteria

- Patients aged 7–18 years referred by paediatricians after clinical assessment had excluded organic causes of the presenting symptoms.
- First index presentation to the study team during the study period.
- Provision of written informed consent from the parent/guardian and assent from the adolescent, as applicable.

Exclusion criteria

- Patients with confirmed medical/neurological conditions explaining their symptoms (e.g., epilepsy, traumatic brain injury, metabolic/endocrine disorders).
- Patients with severe intellectual disability or communication impairment precluding reliable assessment.
- Patients with acute intoxication or delirium at the time of evaluation.
- Patients declining consent/assent or withdrawn by guardians.
- Repeat presentations of the same patient during the study period.

Assessment and study tools

Dissociative symptoms were evaluated through structured clinical interviews by psychiatrists using DSM-IV-TR criteria[1]. A structured diagnostic instrument such as the Structured Clinical Interview for DSM Disorders (SCID-I) was not employed; this is acknowledged as a limitation. Somatic and psychological complaints were identified through structured interviews with adolescents and guardians, supplemented by clinical observation. Self-harm behaviours were recorded if intentional self-injury or self-poisoning occurred, irrespective of suicidal intent, and details of the method and intent were documented. Clinicians screened for common comorbid psychiatric conditions (e.g., depression, anxiety, obsessive-compulsive symptoms) during evaluation. These were not systematically assessed with standardised instruments, which may have led to underreporting. Data quality safeguards included standardised case-record forms, consensus meetings within the psychiatric team for atypical cases, and de-duplication checks.

Variables and operational definitions

- Primary outcome: presence of dissociative symptoms as per DSM-IV-TR criteria.
- Secondary outcomes: self-harm behaviour (yes/no; method; stated intent) and somatic complaints (yes/no; type).
- Explanatory variables: age, sex, schooling level, family structure, residence (urban/rural), parental occupation, and parental education.

Statistical analysis

Data were analysed in IBM SPSS v27. Age (non-normally distributed) was summarised as median (IQR) and compared with the Mann–Whitney U test. Categorical variables were analysed using Chi-square or Fisher's Exact tests. Backward stepwise binary logistic regression identified predictors of dissociative symptoms. Diagnostics included multicollinearity checks (variance inflation factors) and goodness-of-fit (Hosmer–Lemeshow test). Adjusted odds ratios with 95% confidence intervals were reported, with significance set at $p < 0.05$.

Ethics

The study was approved by the Institutional Ethics Review Board, Government Medical College Srinagar (Ref. No.: IRBGMC-SGR/Pedia/845). Written informed consent/assent was obtained prior to participation.

Results

The study included 167 adolescents aged between 7 and 18 years, with a mean age of 14.1 ± 1.7 years and a median age of 14 (IQR: 13–15). The sample was predominantly female (89.8%). Most participants were in middle (43.1%) or secondary school (40.1%), and a large majority lived in urban areas (62.9%) and belonged to nuclear families (78.4%). Parental literacy levels were low, particularly among mothers, with 78.9% being illiterate. Nearly half of the participants (49.1%) had parents working in unskilled occupations (Table 1).

Table 1: Socio-demographic Characteristics of the studied Cases (N=167)

Characteristic	Description	N (%)
Age (year)	min - max	7 - 18
	Mean ± SD	14.1 ± 1.7
	Median (P25 - P75)	14 (13 - 15)
Sex	Female	150 (89.8%)
	Male	17 (10.2%)
Child's literacy status	Primary School Level (Ist-5th Standard)	17 (10.2%)
	Middle School Level (6th to 8th)	72 (43.1%)
	Secondary School Level (9th to 10th)	67 (40.1%)
	Higher Secondary School Level (11th to 12th)	11 (6.6%)

Occupation of Parents	Unskilled	82 (49.1%)
	Semi-skilled	41 (24.6%)
	Skilled	40 (24.0%)
	Professional	3 (1.8%)
	Household	1 (0.6%)
Type of family	Nuclear	131 (78.4%)
	Non-nuclear	36 (21.6%)
Family Status	Intact	154 (92.2%)
	Broken	13 (7.8%)
Residence District	Anantnag	11 (6.6%)
	Bandipora	7 (4.2%)
	Baramullah	12 (7.2%)
	Bijbehara	1 (0.6%)
	Budgam	35 (21.0%)
	Ganderbal	5 (3.0%)
	Kulgam	6 (3.6%)
	Kupwara	12 (7.2%)
	Other	7 (4.2%)
	Pulwama	23 (13.8%)
	Ramban	1 (0.6%)
	Shopian	4 (2.4%)
	Srinagar	43 (25.7%)
Dwelling	Rural	62 (37.1%)
	Urban	105 (62.9%)
Father's Education	Illiterate	88 (56.8%)
	Primary School Level (8th-9th)	8 (5.2%)
	Secondary Level (10th to 12th)	42 (27.1%)
	Higher Education (Graduation, M.A, D. Pharma)	17 (11.0%)
Mother's Education	Illiterate	112 (78.9%)
	Primary School Level (8th-9th)	1 (0.7%)
	Secondary Level (10th to 12th)	25 (17.6%)
	Higher Education (Graduation, M.A, D. Pharma)	4 (2.8%)

Clinically, **somatic complaints** were reported by 49.1% of participants, with anxiety and body ache being the most common symptoms. **Psychological symptoms** were present in 35.3% of the adolescents, with **dissociative symptoms** accounting for the majority (29.9%). Self-harm or suicidal behaviours were reported in 21.6% of the sample, with **organophosphate poisoning** being the most common method (20.4%) (Table 2).

Table 2: Symptoms and Chief Complaints in the studied Cases (N=167)		
Characteristic	Description	N (%)
Somatic/Physical Complaints		82 (49.1%)
Number of Somatic/Physical Complaints	One	73 (43.7%)
	Two	9 (5.4%)
Somatic/Physical Complaints type	Anxiety	14 (8.4%)
	Body Ache	14 (8.4%)
	Palpitation	11 (6.6%)
	Headache	10 (6.0%)
	Breathlessness	6 (3.6%)
	Aggression	5 (3.0%)
	Stomach Ache	4 (2.4%)
	Abdomen Pain	3 (1.8%)
	Chest Discomfort	3 (1.8%)
	Seizures	3 (1.8%)
	Chest Pain	2 (1.2%)
	Ticks	2 (1.2%)
	Hematemesis	2 (1.2%)
	Joint Pain	1 (0.6%)
	Leg Pain	1 (0.6%)
	Vomiting	1 (0.6%)
	Heart Palpitation	1 (0.6%)
	Bipolar Disorder	1 (0.6%)
	Coughing	1 (0.6%)
	Pain	1 (0.6%)
	Pain in lower limb	1 (0.6%)
	Anemia	1 (0.6%)
	Blood With Stool	1 (0.6%)
	Esophageal Reflex Grade A	1 (0.6%)
	Enuresis	1 (0.6%)
Psychological Symptoms		59 (35.3%)
Number of Psychological Symptoms	One	54 (32.3%)
	Two	4 (2.4%)
	Three	1 (0.6%)

Psychological Symptom type	Psychological Symptoms-Depression	1 (0.6%)
	Mood Swings	1 (0.6%)
	Forgetfulness	1 (0.6%)
	Dissociation	50 (29.9%)
	Panic Attack	5 (3.0%)
	Lost Consciousness	5 (2.4%)
	OC Symptoms	1 (0.6%)
	Low I.Q	1 (0.6%)
Self-harm/Suicidal Behavior		36 (21.6%)
Number of Self-harm/Suicidal Behavior	One	36 (21.6%)
Self-harm/Suicidal Behavior type	OP poisoning	34 (20.4%)
	Poisoning (Rat Poision)	1 (0.6%)
	Suicide (Hanging)	1 (0.6%)

Early childhood trauma (ECT) was reported by 17.4% of participants. The most frequent causes were family conflict (20.7%), bullying (17.2%), and child sexual abuse (17.2%). Among those reporting self-harm, 67.3% indicated intent to die, while others reported a desire to inflict pain or were unable to articulate their intent. The most frequent methods of deliberate self-harm (DSH) included poisoning (57.1%) and self-inflicted cuts (38.8%) (Table 3).

Table 3: Early Childhood Trauma and DSH in the studied Cases (N=167)

Characteristic	Description	N (%)
Early Childhood Trauma		29 (17.4%)
Cause for Early Childhood Trauma	Accident on Scooty	1 (3.4%)
	Bullying	5 (17.2%)
	chased by dogs which caused her head injury	1 (3.4%)
	Child Sexual Abuse	5 (17.2%)
	Dissociation has given her trauma	1 (3.4%)
	Family Conflict	6 (20.7%)
	Father had passed away	2 (6.9%)
	Had to leave old school	1 (3.4%)
	Mother Died	4 (13.8%)
	Parents divorced	2 (6.9%)
	Separation from parents in Childhood	1 (3.4%)
Only Having thoughts or actions also	DSH	49 (29.3%)
	Only self harm thoughts	45 (26.9%)
	None	73 (43.7%)

Intent of DSH	To kill herself	33 (67.3%)
	To harm & inflict pain	11 (22.4%)
	Didn't Reveal	3 (6.1%)
	Not Known	2 (4.1%)
Mode of DSH	Poisoning	28 (57.1%)
	Cuts	19 (38.8%)
	Burns	1 (2.0%)
	Jumped from Waranda	1 (2.0%)
	Tried hanging	1 (2.0%)

When stratified by self-harm risk, adolescents who had engaged in DSH were significantly older (mean age = 14.8 years) than those with only self-harm thoughts (14.3 years) or no self-harm (13.4 years) ($p < 0.001$). Educational level was also significantly associated with self-harm status ($p < 0.001$), with the majority of DSH cases found among students in secondary school. No significant associations were found between self-harm and gender, family structure, dwelling type, or parental education. However, psychological symptoms, especially dissociation, were significantly more prevalent in the DSH group ($p = 0.003$), while somatic complaints were more common in the self-harm thoughts group ($p = 0.016$) (Table 4).

Table 4: DSH and Self harm in association with the studied factors

Characteristic	Description	None	Self-harm thoughts	DSH	p-value
		N = 73 (43.7%)	N = 45 (26.9%)	N = 49 (29.3%)	
Age (year)	min - max	7 - 17	11 - 18	12 - 17	<0.001
	Mean ± SD	13.4 ± 1.9	14.3 ± 1.4	14.8 ± 1.3	
	Median (P25 - P75)	14 (12 - 15)	14 (13 - 15)	15 (14 - 16)	
Sex	Female	64 (87.7%)	41 (91.1%)	45 (91.8%)	0.716
	Male	9 (12.3%)	4 (8.9%)	4 (8.2%)	
Child's literacy status	Primary School Level (Ist-5th Standard)	14 (19.2%)	3 (6.7%)	0 (0.0%)	<0.001
	Middle School Level (6th to 8th)	34 (46.6%)	23 (51.1%)	15 (30.6%)	
	Secondary School Level (9th to 10th)	21 (28.8%)	16 (35.6%)	30 (61.2%)	
	Higher Secondary School Level (11th to 12th)	4 (5.5%)	3 (6.7%)	4 (8.2%)	
Occupation of Parents	Unskilled	35 (47.9%)	23 (51.1%)	25 (51.0%)	0.316
	Semi-skilled	17 (23.3%)	8 (17.8%)	16 (32.7%)	
	Skilled/Professional	21 (28.8%)	14 (31.1%)	8 (16.3%)	

Type of family	Nuclear	54 (74.0%)	40 (88.9%)	37 (75.5%)	0.134
	Non-nuclear	19 (26.0%)	5 (11.1%)	12 (24.5%)	
Family Status	Intact	66 (90.4%)	43 (95.6%)	45 (91.8%)	0.708
	Broken	7 (9.6%)	2 (4.4%)	4 (8.2%)	
Dwelling	Rural	28 (38.4%)	15 (33.3%)	19 (38.8%)	0.826
	Urban	45 (61.6%)	30 (66.7%)	30 (61.2%)	
Father's Education	Illiterate	38 (55.9%)	26 (61.9%)	24 (53.3%)	0.666
	Primary School Level (8th-9th)	5 (7.4%)	1 (2.4%)	2 (4.4%)	
	Secondary Level (10th to 12th)	15 (22.1%)	12 (28.6%)	15 (33.3%)	
	Higher Education (Graduation, M.A, D. Pharma)	10 (14.7%)	3 (7.1%)	4 (8.9%)	
Mother's Education	Illiterate	52 (81.3%)	31 (75.6%)	29 (78.4%)	0.668
	Primary School Level (8th-9th)	0 (0.0%)	1 (2.4%)	0 (0.0%)	
	Secondary Level (10th to 12th)	10 (15.6%)	7 (17.1%)	8 (21.6%)	
	Higher Education (Graduation, M.A, D. Pharma)	2 (3.1%)	2 (4.9%)	0 (0.0%)	
Number of Somatic/ Physical Complaints	None	37 (50.7%)	16 (35.6%)	32 (65.3%)	0.053
	One	33 (45.2%)	25 (55.6%)	15 (30.6%)	
	Two	3 (4.1%)	4 (8.9%)	2 (4.1%)	
Somatic/Physical Complaints	No	37 (50.7%)	16 (35.6%)	32 (65.3%)	0.016
	Yes	36 (49.3%)	29 (64.4%)	17 (34.7%)	
Number of Psycho-logical Symptoms	None	53 (72.6%)	33 (73.3%)	22 (44.9%)	0.007
	One	17 (23.3%)	12 (26.7%)	25 (51.0%)	
	Two	2 (2.7%)	0 (0.0%)	2 (4.1%)	
	Three	1 (1.4%)	0 (0.0%)	0 (0.0%)	
Psychological Symptoms	No	53 (72.6%)	33 (73.3%)	22 (44.9%)	0.003
	Yes	20 (27.4%)	12 (26.7%)	27 (55.1%)	
Self-harm/Suicidal Behavior	No	51 (69.9%)	36 (80.0%)	44 (89.8%)	0.069
	Yes	22 (30.1%)	9 (20.0%)	5 (10.2%)	
Early Childhood Trauma	No	64 (87.7%)	35 (77.8%)	39 (79.6%)	0.309
	Yes	9 (12.3%)	10 (22.2%)	10 (20.4%)	

In comparing adolescents with and without dissociative symptoms, those with dissociation were significantly older (mean = 14.8 years) and more likely to be in 9th–12th grade (69.4%) ($p < 0.001$). They

also had higher rates of psychological symptoms (55.1% vs. 27.1%, $p < 0.001$) and were more likely to report self-harm ($p = 0.023$). In contrast, somatic complaints were significantly more common among adolescents without dissociation ($p = 0.018$). No significant associations were found between dissociation and gender, family structure, residence, or parental education (Table 5).

Table 5: Dissociative Symptom in association with the studied factors

Characteristic	Description	Non-DSH N = 118 (70.7%)	DSH N = 49 (29.3%)	Total	p-value
Age (year)	min - max	7 - 18	12 - 17	7 - 18	<0.001
	Mean ± SD	13.8 ± 1.8	14.8 ± 1.3	14.1 ± 1.7	
	Median (P25 - P75)	14 (13 - 15)	15 (14 - 16)	14 (13 - 15)	
Sex	Female	105 (89)	45 (91.8)	150 (89.8)	0.78
	Male	13 (11)	4 (8.2)	17 (10.2)	
Child's literacy status	Upto 8th	74 (62.7)	15 (30.6)	89 (53.3)	<0.001
	9th to 12th	44 (37.3)	34 (69.4)	78 (46.7)	
Occupation of Parents	Unskilled	58 (49.2)	25 (51)	83 (49.7)	0.118
	Semi-skilled	25 (21.2)	16 (32.7)	41 (24.6)	
	Skilled/Professional	35 (29.7)	8 (16.3)	43 (25.7)	
Type of family	Nuclear	94 (79.7)	37 (75.5)	131 (78.4)	0.553
	Non-nuclear	24 (20.3)	12 (24.5)	36 (21.6)	
Family Status	Intact	109 (92.4)	45 (91.8)	154 (92.2)	>0.999
	Broken	9 (7.6)	4 (8.2)	13 (7.8)	
Dwelling	Rural	43 (36.4)	19 (38.8)	62 (37.1)	0.776
	Urban	75 (63.6)	30 (61.2)	105 (62.9)	
Father's Education	Illiterate	64 (58.2)	24 (53.3)	88 (56.8)	0.746
	Primary School Level (8th-9th)	6 (5.5)	2 (4.4)	8 (5.2)	
	Secondary Level (10th to 12th)	27 (24.5)	15 (33.3)	42 (27.1)	
	Higher Education	13 (11.8)	4 (8.9)	17 (11)	
Mother's Education	Illiterate	83 (79)	29 (78.4)	112 (78.9)	0.701
	Primary School Level (8th-9th)	1 (1)	0 (0)	1 (0.7)	
	Secondary Level (10th to 12th)	17 (16.2)	8 (21.6)	25 (17.6)	
	Higher Education	4 (3.8)	0 (0)	4 (2.8)	

Somatic/Physical Complaints	No	53 (44.9)	32 (65.3)	85 (50.9)	0.018
	Yes	65 (55.1)	17 (34.7)	82 (49.1)	
	No	86 (72.9)	22 (44.9)	108 (64.7)	<0.001
	Yes	32 (27.1)	27 (55.1)	59 (35.3)	
	Yes	31 (26.3)	5 (10.2)	36 (21.6)	
	Yes	19 (16.1)	10 (20.4)	29 (17.4)	

A backward stepwise binary logistic regression identified four significant predictors of dissociative symptoms. Adolescents in higher grades (9th–12th) were 3.48 times more likely to report dissociation ($p = 0.003$). Those whose parents had skilled or professional occupations were significantly less likely to report dissociation (OR = 0.3, $p = 0.034$). Additionally, the presence of somatic complaints (OR = 0.11, $p < 0.001$) and self-harm/suicidal behavior (OR = 0.11, $p < 0.001$) were both inversely associated with dissociative symptoms (Table 6).

Table 6: Backstep logistic regression analysis predicting association of Dissociative Symptom with the Child's literacy status, Occupation of Parents, Somatic/Physical Complaints, and Self-harm/Suicidal Behavior in the final 10th step of the modal.

Variable(s) entered on step 1: Age (year), Sex, Child's literacy status, Occupation of Parents, Type of family, Family Status, Dwelling, Father's Education, Mother's Education, Somatic/Physical Complaints, Psychological Symptoms, Self-harm/Suicidal Behavior, Early Childhood Trauma.

	Characteristic	Description		OR (LL UL)	p-value
Step-01	Age (year)	min - max		1.05 (0.87 1.26)	0.606
	Sex	Female	Reference		
		Male		0.48 (0.07 3.23)	0.451
	Child's literacy status	Up to 8th	Reference		
		9th to 12th		4.41 (1.4 13.87)	0.011
	Occupation of Parents	Unskilled	Reference		
		Semi-skilled		1.6 (0.5 5.08)	0.427
		Skilled/Professional		0.15 (0.03 0.9)	0.038
	Type of family	Nuclear	Reference		
		Non-nuclear		0.98 (0.28 3.38)	0.974
	Family Status	Intact	Reference		
		Broken		2.46 (0.3 20.15)	0.402
	Dwelling	Rural	Reference		
		Urban		0.74 (0.28 1.98)	0.553
	Father's Education	Illiterate	Reference		
		Primary School Level (8th-9th)		0.86 (0.07 10.85)	0.904
		Secondary Level (10th to 12th)		3.31 (0.68 16.21)	0.139
		Higher Education		6.94 (0.81 59.84)	0.078

	Mother's Education	Illiterate	Reference		
		Primary School Level (8th-9th)		0 (0)	1.000
		Secondary Level (10th to 12th)		1.17 (0.26 5.3)	0.838
		Higher Education		0 (0)	0.999
	Somatic/Physical Complaints	No	Reference		
		Yes		0.04 (0 0.45)	0.009
	Psychological Symptoms	No	Reference		
		Yes		0.27 (0.03 2.91)	0.282
	Self-harm/Suicidal Behavior	No	Reference		
		Yes		0.03 (0 0.46)	0.011
	Early Childhood Trauma	No	Reference		
		Yes		1.56 (0.37 6.6)	0.547
Step-10	Child's literacy status	Up to 8th	Reference		
		9th to 12th		3.48 (1.54 7.85)	0.003
	Occupation of Parents	Unskilled	Reference		
		Semi-skilled		1.25 (0.49 3.24)	0.641
		Skilled/Professional		0.3 (0.1 0.91)	0.034
	Somatic/Physical Complaints	No	Reference		
		Yes		0.11 (0.05 0.28)	<0.001
	Self-harm/Suicidal Behavior	No	Reference		
		Yes		0.11 (0.03 0.34)	<0.001

Discussion

This study investigates the prevalence and correlates of dissociative symptoms, self-harm behaviours, and somatisation in children at a hospital in Kashmir. Of the 167 participants, 29.9% reported dissociative symptoms, while 29.3% revealed a history of deliberate self-harm, and 49.1% reported somatic complaints. Our regression analysis indicated that higher education levels (OR = 3.48, p = .003), somatic complaints (OR = 0.11, p < .001), and self-harm behaviour were significantly associated with dissociative symptoms

These findings are in line with an emerging body of research positioning dissociation as an important marker of psychopathological risk in adolescence. For example, in a large-scale cohort study, Tanaka et al. showed that persistent dissociative symptoms predicted future self-harm (OR = 2.61[8], thus underlining the concept of dissociation being an antecedent rather than a consequence of self-injurious behaviour. Correspondingly, in a study on adolescents with a history of childhood sexual abuse, it was found that dissociation was a strong predictor of non-suicidal self-injury NSSI, with higher parent-reported levels of dissociation scores independently associated with both NSSI and suicide attempts.

Somatisation was a prevailing condition and strongly associated with dissociative symptoms in our sample, which corroborates the findings of Raffagnato et al. (2020), who demonstrated that adolescents characterised by alexithymia

and somatic complaints show more severe psychopathological profiles and a higher risk for self-injurious behaviours[9]. The overlap between bodily symptoms and emotional distress was also reflected in the current sample, with headaches, palpitations, and psychogenic seizures being outstanding in this respect. This suggests that in an emotionally repressive or trauma-exposed environment, the somatic expression becomes a surrogate for unresolved psychological pain.

Moreover, the current study provides further confirmation of the association of early trauma with the development of dissociative and self-injurious behaviour. While only 17.4% of our subjects reported identifiable early childhood trauma, this subgroup disproportionately displayed psychological symptoms and DSH. Luoni et al. (2018) found that children exposed to complex trauma were more likely to present with dissociation, somatic complaints, and mood or psychotic disorders, further supporting a trauma-symptom linkage [10]

Interestingly, higher levels of education, for the 9th–12th-grade category, were significantly associated with dissociative symptoms, with an odds ratio of 3.48, perhaps reflecting greater academic and social pressures faced by older children and adolescents. Previous Indian studies also reported school-related stress as a common precipitant for dissociative episodes. Moyon et al., (2021), in their results, indicate that in the absence of well-structured school-based mental health systems, the academic environment is likely to inadvertently emerge as a source of psychological distress.

The observed gender distribution, with females constituting nearly 90% of the sample, is in keeping with previous studies that have reported a higher prevalence of dissociative and self-harming behaviours among girls. Cultural scripts about emotional expression, internalised distress, and social role expectations might explain this gendered vulnerability.

While the majority of participants indeed came from urban areas and were raised in intact, nuclear families, such protective structural factors failed to significantly buffer them in the development of dissociative symptoms and self-harm. This strongly confirms the need to explore not only family structure but also aspects of emotional climate and relational dynamics within families—areas often neglected by the more common assessment tools

Limitations

This study has several limitations. First, it was conducted in a hospital-based referral sample; therefore, the prevalence estimates may not be generalisable to adolescents in the wider community. Second, while dissociative symptoms were evaluated using DSM-IV-TR based structured clinical interviews, standardized diagnostic instruments such as the SCID-I were not employed, which may affect diagnostic reliability. Third, although comorbid psychiatric conditions (e.g., depression, anxiety, obsessive-compulsive symptoms) were clinically screened, they were not systematically assessed with validated tools, leading to possible underreporting. Fourth, the cross-sectional design prevents establishing causal relationships between dissociation, somatisation, and self-harm. Fifth, an *a priori* sample size calculation was not conducted because the study was exploratory in nature and based on consecutive hospital referrals during the study period. As such, the sample size was determined by the flow of eligible cases rather than statistical power considerations. Finally, the relatively small and female-predominant sample limits subgroup analyses; future research should include larger, community-based, and more gender-balanced cohorts.

Conclusion

Our findings highlight dissociation as a critical transdiagnostic marker linked with both self-harm and somatisation in children. These symptoms likely reflect latent emotional dysregulation shaped by early trauma, academic pressure, and limited avenues for emotional expression. Integrating trauma-informed approaches and school-based mental health interventions may be crucial for early identification and support in high-risk populations like Kashmiri children & adolescents

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