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Research article

AT THE EDGE OF THE SELF: DISSOCIATION AS A TRANSDIAGNOSTIC MARKER IN YOUTH PSYCHOPATHOLOGY

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SUMMARY

Background: *Dissociative symptoms are increasingly recognised as early indicators of psychopathological vulnerability in adolescence and young adulthood. This study investigates the correlates of dissociation in a sample of youths referred to a psychiatric outpatient service.*

Subjects and methods: *This study was conducted on a sample of 45 patients aged 14–25 referred to the second-level outpatient clinic for adolescent and young adult psychopathology at the University Hospital of Perugia, Italy. Patients were grouped based on their Dissociative Experiences Scale-II (DES-II) scores (≤30% vs. >30%), and data were analysed using bivariate comparisons.*

Results: *Youths with clinically significant dissociation showed earlier psychiatric onset, reduced social connectedness, increased rates of social withdrawal and non-suicidal self-injury, and elevated attentional impulsivity. Higher scores on depressive, cyclothymic, and anxious temperaments were also observed, along with more severe depressive and anxiety symptoms. The high dissociation group reported greater psychological distress and a broader range of psychotic-like experiences on the Prodromal Questionnaire-Brief (PQ-B).*

Conclusions: *These findings suggest that dissociation in youths is linked to two partially overlapping trajectories: one involving emotional dysregulation and behavioural impulsivity, and another marked by cognitive-perceptual anomalies and unreality experiences. Dissociation may thus act as a transdiagnostic risk factor across mood and psychotic-spectrum vulnerability. Early identification and integrated treatment strategies focusing on affect regulation, cognitive control, and interpersonal functioning may help prevent the progression to more severe psychopathological states.*

Key words: *dissociation – adolescents - non-suicidal self-injury (NSSI) - social withdrawal – impulsivity - affective temperaments*

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INTRODUCTION

Dissociative symptoms are increasingly recognised as a core component of early psychopathology in adolescents and young adults, yet their role across diagnostic boundaries remains underexplored. Traditionally associated with post-traumatic stress disorders and dissociative syndromes, dissociation is now understood as a transdiagnostic phenomenon, often manifesting in conjunction with mood, anxiety, personality, and psychotic-spectrum disorders (Lyssenko et al. 2017; Černis et al. 2022). During adolescence - a developmental phase marked by profound neurobiological, cognitive, and affective reorganisation - dissociative experiences such as depersonalisation and derealisation may emerge in response to acute stress or trauma, but in some cases persist and interact with broader vulnerability factors (Ricci et al. 2025; Bhattacharya et al. 2015). Emerging literature suggests that dissociation may act as an early marker of affective and psychotic risk, with implications for onset, clinical severity, and treatment response (Dogan et al. 2025; Longden et al. 2020). Elevated dissociation has been linked to emotional dysregulation, impulsivity, non-suicidal self-injury (NSSI), and impaired social functioning, while also correlating with attenuated psychotic-like experiences and increased subjective distress (Lanius et al. 2011; Melegkovits et al. 2025). These patterns appear to cluster along two partially overlapping trajectories: one associated with affective instability and behavioural dysregulation, the other with cognitive-perceptual anomalies and identity disintegration. Despite its clinical relevance, dissociation remains under-assessed in routine psychiatric evaluations, and its interaction with temperament, symptom expression, and developmental history is often overlooked. The current study aims to investigate the association between dissociation and a broad range of psychopathological dimensions in a clinical sample of adolescents and young adults, with the goal of identifying dissociation-related risk profiles and informing more nuanced, developmentally informed clinical interventions.

SUBJECTS AND METHODS

The present cross-sectional study was carried out at the University Hospital of Perugia (Umbria, Italy). Eligible participants were identified among consecutive referrals to the second-level specialist outpatient clinic dedicated to the assessment of psychopathology in adolescence and young adulthood between October 1st, 2024 and May 31st, 2025. The clinic accepts patients aged 14–25 years on referral from another service/specialist. Trained clinicians collected socio-demographic and clinical histories through semi-structured interviews and administered a battery of psychometric instruments. All data were anonymised and entered into

an electronic dataset. Only individuals who completed the Dissociative Experiences Scale-II (DES-II) (Carlson & Putnam 1993) at baseline were included in this analysis. In accordance with the conventional 30% cut-off, participants were stratified into two groups: DES-II – (≤30%), indicating low levels of dissociation, and DES-II + (>30%), indicating clinically significant dissociation (Merckelbach et al. 2017). Variables extracted for analysis comprised socio-demographic characteristics, clinical history, and scores on standardised measures: Barratt Impulsiveness Scale-11 (BIS-11) (Patton et al. 1995), Brief Temperament Evaluation Memphis, Pisa, Paris E San Diego – Munster version (briefTEMPS-M) (Erfurth et al. 2005, Pompili et al. 2013), Beck Depression Inventory-II (BDI-II) (Beck et al. 1996; Steer et al. 1999), State-Trait Anxiety Inventory (STAI-Y) (Spielberg et al, 1983; Pedrabissi et al. 1989), and the Prodromal Questionnaire-Brief (PQ-B) (Fonseca-Pedrero et al. 2009). Statistical analyses were conducted using IBM SPSS Statistics, version 26. Descriptive statistics were computed to examine the distributional properties of all variables. The Kolmogorov-Smirnov test was conducted for assessing normality. Continuous variables were reported as means ± standard deviations, while categorical variables were presented as counts and percentages. Bivariate comparisons between the DES-II – and DES-II + subgroups were performed with independent-samples Student's t-tests for continuous variables and Pearson's χ^2 test or Fisher's exact test categorical variables ($p<0.05$).

RESULTS

Of the 45 participants, most were females (n = 27, 60.0 %) with a mean age of 18.80±3.04 years; nearly half (n = 22, 48.9 %) were classified as DES-II +. Significant variations in clinical and anamnestic features across dissociation groups are reported in Figure 1. The DES-II + subgroup presented an earlier age at onset of psychopathology than the DES-II – subgroup (11.00±2.88 vs. 13.65±5.03 years, p = 0.036). Social functioning also differed: absence of meaningful relationships (60.0 % vs. 18.2%, p = 0.005) and social withdrawal (68.8 % vs. 21.7 %, p = 0.035) were both more common in the DES-II + group. Non-suicidal self-injury (NSSI) was markedly more prevalent among DES-II + participants (71.4% vs. 31.8%, p = 0.005). Psychotic-spectrum symptoms (18.2% vs. 0%, p = 0.049) and childhood/adolescent impulse-dysregulation symptoms (23.8% vs. 0%, p = 0.049) were likewise confined to the DES-II + group. Previous antipsychotic treatment was reported by 45% of DES-II + participants versus 17.4 % of DES-II – participants (p=0.049), and prior benzodiazepine use by 40.0% versus 13.0% respectively (p = 0.043). Psychometric profiles differed markedly between groups, with the DES-II + subgroup showing consistently higher scores across the examined instruments as detailed in Figure 2. The DES-II + participants outscored their DES-II – peers on the BIS-11 total (75.70±8.59 vs. 67.86±10.70; p = 0.014) and on the attentional-impulsivity subscale (21.75±3.35 vs. 18.68±4.36; p = 0.015). Regarding temperament (b-TEMPS), they displayed higher depressive (29.60±2.30 vs. 21.85±6.22; p = 0.001), cyclothymic (29.50±3.16 vs. 20.92±8.04; p = 0.010) and anxious scores (25.83±3.43 vs. 18.38±5.78; p = 0.010). Depressive symptom severity was greater as reflected by the BDI-II (32.67±15.08 vs. 21.09±20.29; p = 0.039). Anxiety levels were likewise elevated: STAI-Y-1 (state) 56.48±15.52 vs. 50.95±15.87 (p = 0.046) and STAI-Y-2 (trait) 62.67±12.01 vs. 53.95±11.47 (p = 0.019). Finally, the PQ-B indicated higher distress (43.00±21.47 vs. 14.18±19.41; p = 0.006) and a greater number of distressing items endorsed (7.22±3.93 vs. 2.45±4.01; p=0.016) in the DES-II + group.

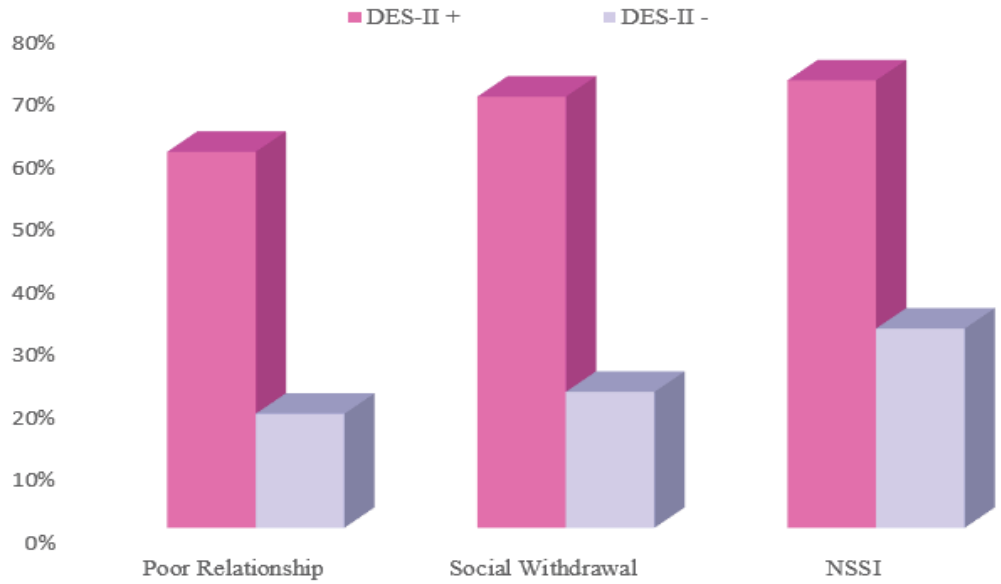

Figure 1. Interpersonal, Social, and Self-Injurious Behaviors by DES-II Group

Psychometric Measures	DES-II + Mean	DES-II – Mean	p-value
BIS-11 Total	75.70	67.86	0.014
BIS-11 Attentional Impulsivity	21.75	18.68	0.015
b-TEMPS Depressive	29.60	21.85	0.001
b-TEMPS Cyclothymic	29.50	20.92	0.010
b-TEMPS Anxious	25.83	18.38	0.010
BDI-II Total	32.67	21.09	0.039
STAI-Y 1 (State Anxiety)	56.48	50.95	0.046
STAI-Y 2 (Trait Anxiety)	62.67	53.95	0.019
PQ-B Distress Score	43.00	14.18	0.006
PQ-B Distressing Items	7.22	2.45	0.016

>2 SD above general population norms

Figure 2. Psychometric Measures between High and Low Dissociation (DES-II) Group

DISCUSSION

Results from the present study underline that adolescents and young adults with clinically significant dissociation present earlier psychiatric onset, supporting dissociation as an evolutionary vulnerability marker that may precede the onset of more structured psychopathological conditions (Ricci et al. 2025). Prior studies encourage the notion that dissociative phenomena during childhood and adolescence are predictive of more severe clinical trajectories, particularly when associated with neurobiological dysfunctions such as alterations in Default Mode Network (DMN) connectivity (Bhattacharya et al. 2007; Pecoraro et al. 2025). Individuals exhibiting marked dissociative symptoms frequently report the absence of close interpersonal relationships, indicating a disruption in social bonding processes. This is in line with previous evidence, suggesting that dissociation interferes with relational capacity and attachment security (Heriot-Maitland et al. 2024). The literature identifies shame and deficits in emotional expressiveness as contributing mechanisms, potentially inhibiting vulnerability and intimacy in interpersonal contexts (Dorahy et al. 2023; Mauss et al. 2011). Consequently, young people with significant dissociative symptoms may develop behavioral strategies characterized by social withdrawal and avoidance, further isolating them from protective social environments (Schafer et al. 2006). This dynamic, observable in both adolescents and young adults, can initiate a self-reinforcing cycle in which reduced social connectedness exacerbates affective dysregulation and reinforces avoidance behaviors. The experience of being disconnected from a meaningful social network - an essential protective factor during adolescence - may mediate the relationship between dissociation and broader psychopathological outcomes. Difficulties in establishing or maintaining emotionally significant bonds contribute to feelings of insecurity, rejection sensitivity, and perceived inadequacy, thereby fueling a relational retreat. Such a trajectory increases vulnerability to internalizing disorders and compromises resilience in the face of environmental stressors (Heriot-Maitland et al. 2024). The high prevalence of NSSI in the subgroup of participants with DES-II scores >30% further underscores the clinical salience of dissociation. These data are consistent with a growing body of evidence supporting a robust link between dissociative symptoms and self-injurious behaviors (Longden et al. 2020). In clinical terms, dissociation is frequently understood as a maladaptive affect regulation strategy, typically emerging in response to overwhelming internal states or developmental trauma. For individuals with high dissociative tendencies, self-injury may function as a mechanism for restoring control, mitigating inner turmoil, or regaining perceptual clarity over one's body or affective experience (Lanius et al. 2011; Lyssenko et al. 2017). Moreover, dissociative youths often demonstrate impairments in social cognition and emotion regulation. These deficits can further intensify their vulnerability to NSSI, particularly during adolescence and young adulthood, critical periods for affective development and identity consoledation. This constellation of symptoms - dissociation, impulsivity, and NSSI - suggests an underlying failure in self-regulatory processes that may represent an early marker of more severe psychopathological conditions. The present findings also corroborate the association between dissociation and heightened impulsivity, especially in its attentional component. Individuals with marked dissociative features exhibit significant deficits in executive functions, including sustained attention, behavioral inhibition, and cognitive flexibility. These impairments are likely mediated by dysfunctional prefrontal circuitry, as evidenced by neuroimaging studies that implicate the medial and dorsolateral prefrontal cortex in both dissociative phenomena and impulse dysregulation (Krause-Utz et al. 2017). Within this framework, dissociation may undermine the individual's capacity to anticipate, evaluate, and modulate their responses in emotionally charged contexts, thereby increasing the likelihood of impulsive behaviors (Hoptman et

al. 2025). Furthermore, there appears to be a robust inverse correlation between emotion regulation self-efficacy and both impulsivity and risk-taking behaviors. This reinforces the conceptualization of dissociation as a transdiagnostic mediator that disrupts self-regulatory functions and facilitates maladaptive behavioral patterns (Zhang et al. 2025). These findings highlight the importance of identifying dissociative symptoms in clinical populations presenting with behavioral dysregulation, particularly in adolescence and early adulthood. The integration of targeted interventions focused on improving executive functioning - such as attention training, affect regulation strategies, and behavioral inhibition techniques - may yield significant clinical benefits for this subgroup. Moreover, consistent evidence from neuroimaging and cognitive research underscores the need for longitudinal studies to explore the causal mechanisms underlying these associations (Liu et al. 2025). The relationship between dissociation and affective temperaments further elucidates its role in shaping psychopathological trajectories. In the present study, individuals with high dissociative scores reported significantly elevated levels on the depressive, cyclothymic, and anxious subscales of the briefTEMPS, confirming prior research that has linked these temperamental traits with increased risk for mood disorders (Favaretto et al. 2024). Dissociation appears to amplify the expression of temperamental vulnerabilities, serving as a modulatory factor in the emergence and maintenance of affective symptoms. Depersonalization and derealization have been shown to exacerbate depressive and anxious symptomatology, likely through mechanisms involving heightened affective sensitivity and impaired emotional processing (Černis et al. 2025). These findings support integrative models that conceptualize dissociation not merely as a byproduct of affective dysregulation but as a core psychopathological dimension that interacts dynamically with temperamental dispositions. Further reinforcing this model is the consistent association between dissociation and internalizing psychopathology. The literature identifies dissociation as both a risk factor for the development of depressive and anxiety disorders and as a maintaining factor that contributes to symptom chronicity and severity (Guan et al. 2025; Pini et al. 2025). Dissociative symptoms have also been associated with elevated rates of suicidal ideation, particularly in individuals with comorbid anxiety disorders or affective instability (Pini et al. 2025). The interaction between dissociation, low self-efficacy, and hyper-reactivity to emotional stimuli constitutes a high-risk profile that demands careful monitoring and early intervention. Results from the PQ-B contribute further evidence to the conceptualization of dissociation as a vulnerability marker for subclinical psychotic symptoms. The subgroup of individuals with elevated DES-II scores reported significantly higher levels of both distress and breadth of psychotic-like experiences. These findings resonate with previous studies indicating that dissociation enhances not only the subjective impact of anomalous experiences but also their phenomenological variety (Calciu et al. 2025; Melegkovits et al. 2025). Two dimensions of the PQ-B - the Distress Score and the Distressing Items Score - offer complementary insights into the clinical profile of dissociative individuals. While the former captures the emotional intensity of symptoms, the latter reflects the range of perceived anomalies. Both dimensions are clinically relevant, as they may reflect different pathways toward psychopathological vulnerability. For instance, the presence of a broad array of mildly distressing symptoms may indicate diffuse cognitive-perceptual instability, whereas fewer but highly distressing experiences may reflect intense affective reactivity or sensory disintegration (Capizzi et al. 2024). The link between dissociation and psychotic-like experiences is well-documented in both clinical and subclinical populations, particularly among individuals with a history of early adversity or developmental trauma (Longden et al. 2020; Melegkovits et al. 2025). The present data suggest that dissociation may act as an amplifying mechanism, increasing both the quantity and severity of psychotic-like symptoms. Such a profile warrants close clinical attention, as the transition from subthreshold symptoms to formal psychosis often involves interacting cognitive, affective, and neurodevelopmental vulnerabilities. It is critical, however, to distinguish between dissociative phenomena that are transient and reactive, and those that are structurally embedded within emerging psychotic syndromes. In psychotic disorders, dissociation often presents as a pervasive and enduring disturbance, characterized by significant impairment in agency, identity coherence, and reality testing. These cases may evolve toward hallucinations or delusional thinking, especially in the context of sustained stress and deteriorating functional status (Ricci et al. 2025). In contrast, dissociation observed in emotional dysregulation is generally more transient and situational, frequently linked to acute affective overload rather than chronic disintegration of the self. While distressing, these episodes typically remit and do not escalate into full-blown psychosis. Nonetheless, they indicate a fragile regulatory system that requires stabilization and support (Vatanparast et al. 2024). Overall, the data support a dimensional and developmental view of dissociation as a core feature that intersects with multiple domains of psychopathology. By contributing to impulsivity, affective instability, and cognitive-perceptual disturbances, dissociation may serve as a transdiagnostic catalyst, shaping diverse clinical trajectories. Limitations of this study include its cross-sectional and retrospective design, which precludes causal inferences and limits the assessment of developmental progression; sample size restricts stratified analyses; key cognitive-neurobiological markers were not directly measured; and reliance on self-report (DES-II) may bias dissociation estimates.

CONCLUSIONS

This study reinforces the role of dissociation as a transdiagnostic vulnerability factor in youth. Elevated dissociative symptoms were linked to earlier onset, poor social functioning, impulsivity, severe affective temperaments, and distressing subthreshold psychotic experiences. Two partially overlapping trajectories emerged: one affective-impulsive, the other psychotic-like. Clinically, dissociation should be assessed beyond trauma contexts, especially in the presence of internalising symptoms or social withdrawal. Its association with poorer treatment outcomes the need for early detection and targeted interventions, including grounding, emotion regulation, and cognitive control strategies, particularly in early intervention settings.

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Ethics compliance: The study was conducted in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments. Ethical approval was obtained from the local ethics committee of the University Hospital of Perugia.

Conflict of interest: None to declare.

Contribution of individual authors:

Francesca Scopetta: conceptualization, methodology, formal analysis, writing – original draft.

Marta Barbi: data curation, writing – review and editing.

Gianmarco Cinesi: conceptualization, methodology data curation, writing – review and editing.

Filippo De Giorgi: data curation, writing – review and editing.

Giulia Menculini: data curation, formal analysis, writing – review and editing, supervision.

All authors approved the final manuscript.

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