Scientific Research Publishing

Open Journal of Medical Psychology, 2022, 11, 243-253
https://www.scirp.org/journal/ojmp
ISSN Online: 2165-9389
ISSN Print: 2165-9370

Dissociation, Dissociative Disorders and Partial Psychosis

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How to cite this paper: Petric, D. (2022) Dissociation, Dissociative Disorders and Partial Psychosis. *Open Journal of Medical Psychology*, **11**, 243-253.
https://doi.org/10.4236/ojmp.2022.114018

Received: August 7, 2022
Accepted: October 6, 2022
Published: October 9, 2022

Abstract

Background: Dissociation may be defined as a psychopathological process in which an individual's psyche splits into two or more parts. The division of personality is a key element in trauma, especially if the patient is not able to cope with it. At least one part of personality may be relatively able to understand and function in the objective reality, whilst other part(s) of the psyche may be more or less disorganized, dysfunctional and less able to understand the truth. **Methods:** literature review; conceptualization of dissociation, dissociative disorders and partial psychosis from medical and philosophical perspective. **Conclusion:** The core of dissociation and dissociative disorders is usually psychological trauma, especially emotional trauma, although some individuals may experience dissociation without any obvious cause or trigger. Carefully designed trauma-focused psychotherapy and psychosocial support are considered and must be further studied as the cornerstone of multidisciplinary approach in the treatment of dissociative disorders. Dissociative identity disorder in its severe form may resemble characteristics of partial psychosis. Some patients suffering from partial psychosis have narcissistic personality traits, such as shamelessness, magical thinking, arrogance, envy, entitlement, exploitation and bad boundaries, and therefore, developing healthy self-love, which is based on healthy self-criticism, realistic thinking, humility, gratefulness, democratic behavior, altruism and good boundaries, might be helpful for these patients.

Keywords

Dissociation, Dissociative Disorders, Partial Psychosis, Psychological Trauma

1. Introduction

Dissociation may be defined as a psychopathological process in which an indi-

vidual's psyche splits into two or more parts. At least one of these parts is relatively able to understand and function in the objective reality, whilst other part(s) of the psyche is more or less disorganized, dysfunctional and is not able to understand the truth. Dysfunctional part(s) of psyche is usually living in a false reality on the level of mental constructions (unrealistic, obsessive thoughts organized in a false reality with some touch points with the objective reality) or delusions (partial psychosis). Dissociation may occur in the moment of psychological trauma, especially if the patient is not able to cope with it. Inability to cope with the harsh reality may cause dissociation as a consequence of which at least one part of the psyche lives in a more pleasant false reality (pink glasses). Healthy mature defense and adaptive coping mechanisms may be important in preventing and treating dissociation. Defense mechanisms usually occur at the unconscious level, whilst coping mechanisms are conscious and purposeful. Coping styles can be problem-focused (instrumental), which are associated with methods of dealing with the problem in order to reduce stress, or emotion-focused, which can help people handle any feelings of distress that result from the problem. Active coping mechanisms involve an awareness of the stressor and conscious attempts to reduce stress, whilst avoidant coping mechanisms are characterized by ignoring or otherwise avoiding problem. Maladaptive coping methods, such as escape, unhealthy self-soothing (addiction), numbing, compulsions, risk-taking and self-harm, are not effective for a long-term period, whilst adaptive coping strategies, such as support, relaxation, problem-solving, humor and physical activity, are healthy and effective [1]. Culture has a significant impact on the clinical presentation of patients suffering from trauma and dissociation. Dissociative identity disorder is related intrinsically to experiences of self and person-hood, which are culturally constructed. Dissociation may be associated with double consciousness that arises from the difference between self-perception, which is positive, and how others see you, which is negative. This distinction then gets internalized as two alternate and co-existing views of oneself [2]. There is a partial overlap between dissociative symptoms and the positive symptoms of schizophrenia. The process of dissociation (split mind) may be relevant for understanding schizophrenia as well [3]. Results of a study showed that individuals suffering from functional neurological disorder experienced greater susceptibility to dissociation, metacognitive deficits and impaired interoceptive accuracy in comparison with controls after acute dissociation [4]. The division of personality (dissociation) is a key element in trauma and involves the capacity to organize or reorganize the personality into two or more dissociative parts. The maintenance of dissociation is related to the ability to keep two or more parts of the personality and the associated actions and phenomenal mental contents relatively divided. Personality and dissociative parts of the personality can be understood as a dynamic system and dynamic subsystems. Most dissociative parts engage in different mental and behavioral actions across time and context and the interactions among different dissociative parts are not totally fixed [5].

2. Dissociative Disorders

Dissociative disorders may be defined as conditions in which disruptions or breakdowns of memory, awareness, identity, or perception are present. People suffering from dissociative disorders use dissociation as a pathological defense mechanism. Some dissociative disorders are triggered by psychological trauma, whilst depersonalization disorder may be preceded by stress, use of psychoactive substances, or there may be no identifiable trigger at all [6]. Dissociative disorders include dissociative identity disorder, dissociative amnesia, dissociative fugue, depersonalization disorder, dissociative seizures and other specified or unspecified dissociative disorders [7].

Dissociative identity disorder (DID) is the alternation of two or more distinct personality states with impaired recall among them. In extreme cases, the host personality is unaware of the other, alternating personalities [8]. DID is etiologically associated with a complex combination of developmental and cultural factors, including severe childhood relational trauma. The prevalence of DID appears to be highest in the emergency psychiatric settings and affects approximately 1% of the general population. Characteristic features of DID include a complex array of co-existing symptoms associated with psychosis, mood, anxiety, affect regulation and personality functioning. DID is characterized by amnesia, identity confusion and coexistence of dissociative identities. It seems that childhood attachment-based trauma is an universal factor of DID development. Orbitofrontal, cortico-limbic and temporal anomalies are reported to be present in DID. Amnesia between identities may be produced by metacognitive processes, which are processes used to plan, monitor and assess one's understanding and performance [9]. Neurobiological evidence regarding the etiology of DID supports clinical observations that it is a severe form of post-traumatic stress disorder (PTSD). A smaller hippocampal volume is the most consistently reported neuroanatomical correlate of childhood traumatization [10]. Several studies have confirmed that DID is related to childhood trauma based on the negative correlation between hippocampal volumes and childhood traumatization [11]; decreased cortical thickness in the insula, anterior cingulate and parietal regions; and reduced cortical surface area in temporal and orbitofrontal cortices in the comparison with matched healthy controls [12]. The evidence from the available scientific literature demonstrates that carefully staged trauma-focused psychotherapy for DID results in improvement, whereas dissociative symptoms persist when not specifically targeted in treatment [13]. Psychotherapy is considered to be the cornerstone of a multidisciplinary treatment plan for dissociative disorders, including DID, and other trauma-related disorders. It must be incorporated into the interventional strategy, whether the mode of psychotherapy is supportive or psychodynamic in nature, or some combination of various approaches. The treatment must be based on the quality and acuity of the patient's symptoms [14].

Dissociative disproportionate retrograde amnesia with or without identity loss

happens in the context of psychological trauma. Evidence from metabolic imaging studies have reported functional alterations, particularly in the bilateral hippocampus, right temporal regions and inferolateral prefrontal cortex, despite normal morphological imaging [15]. Dissociative amnesia may be defined as an inability to consciously recall autobiographical information in the absence of significant brain damage detectable by conventional structural neuroimaging [16], although the abnormal findings in metabolic imaging studies may be present. Dissociative amnesia is characterized by temporary loss of recall memory, specifically episodic memory, due to a traumatic or stressful event. It may occur abruptly or gradually and may last minutes to years depending on the severity of the trauma [17] and personality traits of a patient (including defense and coping mechanisms).

Dissociative fugue is described as reversible amnesia for personal identity, usually involving unplanned travel or wandering, sometimes accompanied by the establishment of a new identity. This state of mind is typically associated with stressful life circumstances, and may last for a shorter or longer period of time [8]. A case report of a thirty-year-old woman with secondary education, married and employed, that had left the maternity ward with her baby unnoticed on the fourth day after giving birth was published. The patient did not remember this fact after being found by the police. The patient had suffered head injury in her childhood. Her mother lost two of her siblings and the patient miscarried her first pregnancy. The second pregnancy was at risk, the labor was premature and the infant was born with *palatoschisis.* In the maternity ward, the patient had difficulties with feeding the baby. She experienced fear about the infant's life, as well as the feeling of being neglected by the staff. In the psychiatry ward, the patient did not reveal any symptoms of mental illness, but the tendency to use immature defense mechanisms, as well as mild cognitive dysfunctions, were observed in psychological testing. She was diagnosed with dissociative fugue. Authors concluded that the interaction of past and present traumatic experiences with cognitive dysfunctions and immature defense mechanisms could influence the patient's ability to cope with fear about the child negatively, all of which together led to the dissociative loss of memory with disintegration of perception, identity and conscious control over the behavior in the fugue [18].

Depersonalization disorder (DPD) is characterized by periods of detachment from self or surrounding which may be experienced as unreal while retaining awareness that this is only a feeling and not a reality [7]. It is a complex chronic disorder which affects young people, who often tend to suffer in isolation because of lack of knowledge about the disorder among mental health professionals as well as the laity. Despite DPD being more common than schizophrenia, it is poorly recognized, researched and resourced. Psychotherapy is usually useful in the treatment of DPD, particularly because of the significant rate of trauma and childhood abuse [19]. The results of a study aimed to examine the co-occurrence of PTSD and dissociation in a clinical sample of trauma-exposed adolescents by

evaluating evidence for the depersonalization/derealization dissociative subtype of PTSD, showed that model A, the depersonalization/derealization model, had five classes, which are dissociative subtype, high PTSD, anxious arousal, dysphoric arousal and a low symptom class, and that model B, the expanded dissociation model, identified an additional class characterized by dissociative amnesia and detached arousal. Authors concluded that these two models provide new information about the specific ways PTSD and dissociation co-occur. Dissociation co-occurs with PTSD commonly among adolescents and therefore, assessments of dissociative symptomatology, along with the assessment for PTSD, should be included in the diagnostic and treatment process. Dissociation should be conceptualized broadly and assessed comprehensively. Dissociative amnesia and dissociative avoidance may be considered as important symptoms. There was a unique subgroup of adolescents in the study who were symptomatic for dissociation, particularly dissociative amnesia, and less symptomatic for PTSD and behavioral symptoms, but who still benefit from trauma-specific treatment [20]. Results of another study aimed to examine associations between suicide attempts, suicidal ideation, depression, dissociative symptoms, emotional, physical and sexual abuse, showed that emotional abuse was linked to dissociation, which in turn was related to depression, which was predictive of suicide ideation. Depression had a full mediating effect between dissociation and suicide ideation in the community sample, and a partial mediating effect in the group of patients diagnosed with depression (DG). Sexual abuse had a direct effect upon depression and suicide ideation in the DG. Authors concluded that this study supports the phenomenon of a dissociative depression subtype and confirms that dissociation should be added to the list of the more commonly accepted and studied risk factors for suicidal ideation. Researchers proposed that dissociation should be regularly screened for when working with patients suffering from depression, as well as with individuals that attempted suicide. The experience of possible childhood abuse should be evaluated [21].

Dissociative seizures (psychogenic non-epileptic seizures, PNES) are seizures that are often mistaken for epilepsy, but are actually another form of dissociation [7]. PNES are paroxysms of altered subjective experience, involuntary movements and reduced self-control that can resemble epileptic seizures, but have distinct clinical characteristics and a complex neuropsychiatric etiology. PNES account for over 10% of seizure emergencies and around 30% of cases in tertiary epilepsy units, but the diagnosis is usually missed or delayed. Common risk factors are considered to be trauma and acute stress, whilst common comorbid disorders are dissociative and functional disorders, PTSD, depressive and anxiety disorders, personality disorders, comorbid epilepsy, head injury, cognitive and sleep problems, migraine, pain, and asthma [22]. When the diagnosis of dissociative seizures has been made, psychotherapy is indicated, possibly in combination with psychoactive medication, in the setting of long-term treatment provided in collaboration by the neurologist, psychiatrist, psychotherapist, and fam-

ily physician [23].

3. Partial Psychosis

Partial psychosis may be defined as a delusional disorder characterized by at least one month of delusions without other psychotic symptoms. Ongoing behavior can be influenced by delusional content, but impairments in psychosocial functioning are less severe than those seen in other psychotic disorders, and behavior is not obviously bizarre. Delusions are defended in an intelligent way and person can still function in the reality. One part of the individual's psyche is in accord with objective reality, but other part has well-organized delusions that are fixed and continuous [24].

In his textbook from 1838, French psychiatrist Jean-Étienne Dominique Esquirol (1772-1840) made the first comprehensive psychopathological description of paranoia, which he labeled as partial psychosis and described it as a condition with encapsulated, well organized, and persistent delusions, which are defended with a great deal of emotions and sharp argument. The individual appears quite convincing, especially because of otherwise rational behavior. The intellectual capacity is used to achieve defined goals according to the delusional content. This condition is difficult to uncover because of dissimulation and adaptation. The person suffering from partial psychosis is often characterized by egocentric, autophilic and self-overrated arrogance; negative suspicious attitude to the outside world, which is perceived as hostile, and from which the patient isolates oneself; tendency to misinterpretations and misjudgments; and diminished capacity for social adjustment and flexibility because of the above-mentioned points [25].

Dissociation identity disorder in its severe form, in which one part(s) of a psyche is delusional, whilst other part is relatively able to understand and function in the objective reality, may be understood as a type of partial psychosis. It seems that some individuals who suffer from partial psychosis may have narcissistic personality traits, such as egocentrism and arrogance, which gives them the ability to defend their delusions in an intelligent way. Narcissism may be defined as the pursuit of gratification from vanity or egotistic admiration of one's idealized self-image and attributes, which includes self-flattery, perfectionism, and arrogance [26]. Four dimensions of narcissism as a personality variable have been delineated as leadership/authority, superiority/arrogance, self-absorption/self-admiration, and exploitativeness/entitlement [27]. Psychiatrist Hotchkiss identified the seven deadly sins of narcissism: shamelessness, magical thinking, arrogance, envy, entitlement, exploitation and bad boundaries [28]. It might be useful for individuals suffering from partial psychosis and with narcissistic personality traits to be made aware during the psychotherapy about their narcissism and to be supported in a way to change their personality towards the other side of the spectrum: healthy self-love and empathy. Narcissistic self-love is not true love towards oneself, but it is rather a distortion of healthy self-love based on

narcissistic magical picture about oneself. Narcissists are not able to give true love to others either. Opposite to seven deadly sins of narcissism, seven virtues of healthy self-love and empathy are healthy constructive self-criticism, realistic thinking, humility, gratefulness, democratic behavior (everybody is equal before the law, there is no need for special treatment), altruism and good boundaries. Narcissists might also experience a narcissistic self-satisfaction, which may be defined as an exaggerated pleasant feeling following self-accomplishment that is associated with narcissistic self-love, ungratefulness and egoism. Opposite to that, healthy self-satisfaction is a pleasant feeling following self-accomplishment that is associated with healthy self-love, gratefulness and altruism. Learning how to feel healthy self-love and healthy self-satisfaction might be useful for individuals caught in their egoistic, almost autistic narcissistic world, in which they may experience partial psychosis, especially after the trauma, and might help them to broaden their views, and heal from delusional disorder using healthy constructive self-criticism, and practicing realistic thinking, humility, gratefulness and altruism.

4. Discussion

Dissociation may be defined as a psychopathological process in which an individual's psyche splits into two or more parts with at least one part of the psyche being relatively able to understand and function in the objective reality, whilst other part(s) of the psyche is more or less disorganized, and dysfunctional on the level of mental constructions or delusions. It has been recognized that the core problem of dissociation is usually psychological trauma, especially if the patient is not able to cope with it. As a consequence of dissociation, at least one part of the psyche lives in a more pleasant false reality (pink glasses). Therefore, healthy mature defense mechanisms, such as altruism, anticipation, humor, sublimation and suppression, and adaptive coping mechanisms, such as support, relaxation, problem solving, and healthy physical activity, may be important in prevention and treatment of dissociation before, during and after the traumatic event. Maladaptive coping mechanisms, such as escape (social isolation), addiction, numbing, compulsions, risk-taking, and self-harm, should be avoided as these may represent a risk factor for dissociation. Culture and social context may be an important factor of dissociation, especially if the person is being traumatized and then perceived as negative by the society (for example, racism), which causes the coexistence of two opposite views of oneself (one is positive related to self-consciousness and the other is negative related to the social construct). As a consequence of psychopathological process of dissociation various forms of dissociative disorders may develop. People suffering from dissociative disorders use dissociation as a pathological defense mechanism that causes disruptions and breakdowns of memory, awareness, identity, or perceptions. Dissociative identity disorder (DID) is defined as the alternation of two or more distinct personality states with impaired recall among them. In extreme cases the host personality is unaware of the other,

alternating personalities, which may become delusional and therefore, can be understood as a form of partial psychosis, a condition in which the behavior may be influenced by delusional content, but impairments in psychosocial functioning are less severe than those seen in other psychotic disorders, behavior is not obviously bizarre and delusions are defended in an intelligent way. It seems that childhood attachment-based trauma is an universal factor of DID development with orbitofrontal, cortico-limbic and temporal anomalies being present; as well as the reduction of hippocampal volume; decreased cortical thickness in the insula, anterior cingulate and parietal regions; and reduced cortical surface area in temporal and orbitofrontal cortices. Therefore, carefully staged trauma-focused psychotherapy for DID results in improvement of dissociative symptoms and psychotherapy is considered to be the cornerstone of a multidisciplinary treatment plan for dissociative disorders and other trauma-related disorders. Other forms of dissociative disorders, such as dissociative amnesia and dissociative fuga have been also associated with psychological trauma and stressful life conditions. Depersonalization disorder, which is characterized by periods of detachment from self or surrounding, usually affects young people, who tend to suffer in isolation, and social isolation may worsen that suffering, closing the vicious circle of dissociation, psychosocial trauma, depression, anxiety, and even suicidal ideation. Dissociative depression may be recognized as a subtype of dissociative-depressive disorder. Dissociation, especially when combined with depression and when associated with PTSD, must be considered and further studied as a risk factor for suicidal ideation.

5. Conclusion

The core of dissociation and dissociative disorders is usually psychological trauma, especially emotional trauma, although some individuals may experience dissociation without any obvious cause or trigger. Carefully designed trauma-focused psychotherapy and psychosocial support are considered and must be further studied as the cornerstone of multidisciplinary approach in the treatment of dissociative disorders. In addition to that, practicing healthy mature defense mechanisms and adaptive coping styles, such as support, humor, and problem-solving, could be useful in the prevention and treatment of dissociation. Dissociation, social isolation, depression, anxiety, various types of psychological traumas, suicidal ideation and suicidal attempt, are shown to be interrelated, and therefore, dissociation may be considered as an important risk factor for suicidal ideation. People suffering from various types of dissociative disorders, especially young adolescents may benefit from trauma-focused psychotherapy even in the absence of obvious behavioral and other symptoms typical for PTSD. Dissociation depressive subtype should be recognized as an important mixed dissociative-depressive entity and further studied, especially because co-occurrence of dissociation and depression might increase the risk of suicidal ideation and suicidal attempts. Dissociative identity disorder, in its severe form, in which one part of a psyche is

delusional, whilst other part is relatively able to function in the objective reality, may be understood as a type of partial psychosis. French psychiatrist Jean-Étienne Dominique Esquirol recognized association of partial psychosis with narcissistic personality traits in some patients. Therefore, such individuals may benefit from becoming aware of their narcissism and being supported using the knot psychotherapy to learn how to become more empathic, feel healthy self-love and healthy self-satisfaction, instead of narcissistic self-love which is rutted in magical thinking (distorted, illusional thinking) that as such may be understood as a risk factor for the development of delusion. Contrary to that, constructive self-criticism, realistic thinking and humility may help an individual to maintain the understanding of objective reality even in the case of severe psychological trauma. Disentanglement of mind knots related to trauma may be helpful in the treatment of dissociation, dissociative disorders and partial psychosis using positive emotions and realistic positive thoughts about oneself and surrounding social environment, but further clinical research on this subject is mandatory.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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