The difference between a secondary and tertiary SD

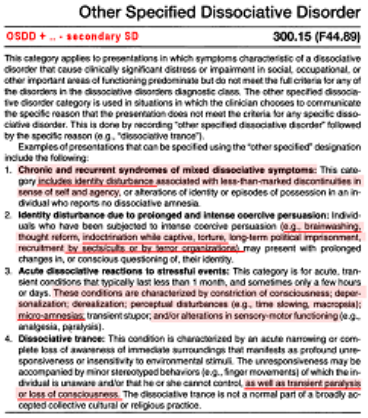
a secondary (OSDD+) and a tertiary (DID) structural dissociation of the personality

Other Specified Dissociative Disorder (300.15) and the Dissociative Identity Disorder (300.14)

As we explained and know already...

DID is a Dissociative Disorder (DD)

A Dissociative Disorder (DD) leads very rarely to a diagnose of a dissociative Identity disorder (DID), more common is a secondary SD.



Other Specified Dissociative Disorder

OSDD + ... - secondary SD 300.15 (F44.89)

This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class. The other specified dissociative disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific dissociative disorder. This is done by recording "other specified dissociative disorder" followed by the specific reason (e.g., "dissociative trance").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Chronic and recurrent syndromes of mixed dissociative symptoms:** This category includes identity disturbance associated with less-than-marked discontinuities in sense of self and agency, or alterations of identity or episodes of possession in an individual who reports no dissociative amnesia.
2. **Identity disturbance due to prolonged and intense coercive persuasion:** Individuals who have been subjected to intense coercive persuasion (e.g., brainwashing; thought reform; indoctrination while captive; torture; long-term political imprisonment; recruitment by sects/cults or by terror organizations) may present with prolonged changes in, or conscious questioning of, their identity.
3. **Acute dissociative reactions to stressful events:** This category is for acute, transient conditions that typically last less than 1 month, and sometimes only a few hours or days. These conditions are characterized by constriction of consciousness; depersonalization; derealization; perceptual disturbances (e.g., time slowing, macropsia); micro-amnesias; transient stupor; and/or alterations in sensory-motor functioning (e.g., analgesia, paralysis).
4. **Dissociative trance:** This condition is characterized by an acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. The unresponsiveness may be accompanied by minor stereotyped behaviors (e.g., finger movements) of which the individual is unaware and/or that he or she cannot control, as well as transient paralysis or loss of consciousness. The dissociative trance is not a normal part of a broadly accepted collective cultural or religious practice.

click Picture to enlarge

And although a trauma related secondary Structural Dissociation, diagnoses OSDD+ in combination with another (personality) disorder such as BPD, **far more often occurs** than a DID, you will find hardly websites that inform you about a OSDD+. It is also a very severe Trauma related disorder which presents itself with a wide range of dissociative symptoms and switching behavior under the influence of EP's (more than one). But its also very often mistaken with DID and diagnosed as a DID - but it isn't a DID.

That alone should ring a bell to the leg of understanding of a trauma related structural dissociation !

Why are there so much websites and blogs about DID and nearly none about OSDD+ (DSM-5 code 300.15 - ICD F44.89 -)

And why are most of the DID related websites focused on, and explaining ANP-EP switching behavior and **not** ANP-ANP switching behavior which is more common to a DID?

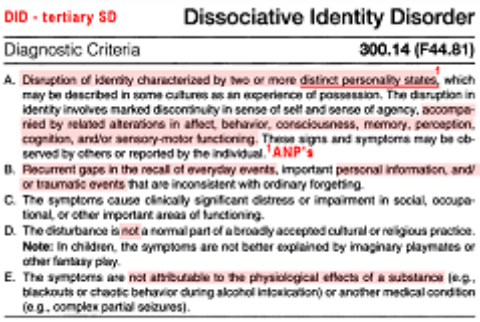
I leave that answer to my readers who are willing to understand the theory of a trauma related structural dissociation of the personality (SD), but I will give you all some theoretically and educational stuff to think over in order to understand even better the difference between a OSDD+ and DID, e.g. the difference between a secondary and a tertiary structural dissociation of the personality.

DID versus OSDD and again I start with writing . . .

Switching behavior caused and under the influence of Emotional personality **parts ANP-EP's switching** is not a phenomenon that occurs most commonly as a symptom of a dissociative identity disorder (DID) - a Tertiary Structural Dissociation of the Personality. Indeed it is **more common** to a **Secondary** Structural Dissociation of the personality OSDD in combination with a Borderline Personality disorder.

There are also other disorders that have symptoms of identity problems, or which causes switching behavior, such as a theatrical personality disorder, a Borderline personality disorder, a Bipolar disorder, Schizophrenia etc..

A Dissociative Disorder (DD) has a wider range of being a co-morbidity disorder.



DID - tertiary SD Dissociative Identity Disorder

Diagnostic Criteria 300.14 (F44.81)

A. Disruption of identity characterized by two or more distinct personality states,[1] which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.[1] ANP's

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

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Take notice:

a tertiary Structural Dissociation - a trauma related Dissociative Identity disorder (DID) - is a poly-symptomatic condition which is characterized by a hidden presentation (Boon/Daijer). Diagnoses of a 'trauma related' structural dissociation of the personality can only be done by an experienced clinical trauma psychologist/psychotherapist which is specially taint to do so.

It's hard to accept a diagnose of a mental disorder

I know that most of us who suffer mentally problems don't like to be lined out with a Personality disorder or another mentally disorder diagnose which we don't like to accept or were we don't want to hear about. I'm no different to that. I also walked the way rejection. I also rejected every mental disorder diagnose for years – I wanted to be accepted as 'Neuro typical without any mental problems'. I didn't want to hear or know about it, I didn't suffer a mental disorder, I also didn't want to hear about my history or about the past. I was strong, nothing was wrong with me because I could survive everything, it had to be a physical problem – but it was a big lie, told by my own misleading mind. I hated to be diagnosed or to accept 'I have problems and I need help'. So I know how hard it is to accept a diagnose of a mental disorder .

Especially a diagnose which is so painful and hard to understand, and which carries a very stigmatizing character. But I did accept eventually and I also will beat the monster inside of me.

So a diagnose will never be something to please or pleasure, and in a way it will always hurt until you learn to accept who you are and which problems you need to face and fight. So I don't write to please, pleasure or hurt someone. **I write to explain something**. Because the diagnose of a tertiary and also secondary "structural dissociation" - is still very misplaced, misunderstood, unknown and very often wrongly explained.
And likewise, there are DID sufferers misdiagnosed with a personality or other mentally disorder,
there are also OSDD sufferers misdiagnosed with a the diagnose MPD or DID

Suffering a DID

In my previous column ***the diagnostically reality of a SD-DID sufferer*** I wrote:

Are all DID diagnoses a tertiary structural dissociation?
And I answered to it:
Technically and to the theory of a Structural Dissociation: ***YES***
Realistic and to the present time of a global diagnostically acceptance and understanding of a Structural Dissociation: ***NO***
Until this moment a level 2 and 3 of the structural dissociation of the personality are a diagnostically mess and you also get easily misinformed about a level 3 SD-DID. Because there is still no suitable diagnostically DSM category to define a Complex Trauma (CPTSD) with severe dissociative symptoms. And there is also still a big leg of understanding to the SD theory and diagnosticians who can proper diagnose a trauma related structural dissociation of the personality.
Result: Level 2 and 3 of a Structural Dissociation are totally mixed up as a Dissociative Identity Disorder. And DID sufferers still get stigmatized by a global a populistic presentation of unrealistic switching behavior which isn't a realistic match to someone who suffers a Tertiary Structural dissociation of the personality.
In reaction someone commented to it:
The diagnosis of MPD (multiple personality disorder) was renamed as DID
but the DSM criteria barely changed, so that part I don't follow

The DSM - DID criteria A holds:

Disruption of identity characterized by **two or more distinct personality states.** ANP states !
Here the biggest misunderstanding starts already. Lots of people mess up the explanation and understanding of the EP and ANP (alters, hosts, personality parts or personality state, etc.):

An Emotional personality Part (EP)
An Apparently Normal Personality state (ANP)

1. **Emotional Personality part (EP)**
   Every human being is gifted with emotions and a personality.
   So everyone can also develop EP's during live (no age boundaries) – Emotional parts of the personality. ***But an EP is NO autonomic functioning personality state*** that takes care of daily life events (its not task oriented). Also EP's **aren't** a realistic match to the present time and they don't take care of everyday life (the present time). EP's are emotional personality **Parts** which are stocked in a traumatizing experience, a memory in the past. And EP's react to everything that (could) trigger a traumatizing memory or a part of that nasty memory - they go in contact with that memory.

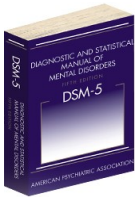
2. **Apparently Normal Personality state (ANP)**
   ANP's are very **ingenious Personality states**. Survival oriented personality states. They function fully autonomic and they stay fully in contact with the present time. Their **main function** is 'not remembering traumatizing experiences at all'. They **act** Apparently **Normal**. They take care of everyday life emotions and tasks. And they don't leave a lot of room to EP's to take over or to react on situations which could trigger EP's (remembering the past or a part of the personality that goes in contact with that experience in of the past). If you don't know the person who suffers a DID very well, you probably wouldn't notice their switching behavior. This also causes difficulties to diagnose a DID because very often it's the same ANP which will present itself to a diagnostician. DID is poly-symptomatic condition which is characterized by a hidden presentation. Someone who suffers a DID very often also suffers a very superficial emotional life. Their life is very often tasks oriented and not emotional oriented. A very common pronunciation of someone who suffers a DID is: *I wear the feeling as if I'm only able to function like a robot.*

Thinking this over, you could ask yourself at the same time:

- Is someone who suffers acting-out behavior, impulsive behavior, etc. able to live a life of a DID sufferer? A very stable, emotional superficial, task oriented life?
- The second question you could ask yourself is;
  Would someone who suffers a DID present oneself on a vulnerable way – by the presentation of an emotional personality part? Or is the life of someone who suffers a DID more task oriented with a constantly avoiding of being vulnerable on any way (a hidden presentation)?
- The third question you could ask yourself is;
  Does someone who suffers DID shows unstable behavior that is strongly influenced and inflicted by emotional personality parts? Does someone who suffers DID know how to live an emotionally life? Or are they only acquainted with a superficial emotional and Surviving task oriented life style?
- The fourth question you could ask yourself is;
  Would you be able to diagnose someone with DID who you know barely and who you didn't observe over a reasonable time expand, and where you have no knowledge of development and behavior history, and were you have no excess to an extensive hetero case history etc.. Could you diagnose someone with DID just within a couple of clinical diagnostically meetings / appointments with filling out some questionnaire lists?

To all the professionals out there I would like to say, please…..
Don't take it lightly if you are up to diagnose someone who suffers Switching behavior. Switching behavior is not a phenomenon that only occurs as a symptom of a dissociative identity disorder (DID), likewise hearing voices or having interrupting thoughts, or suffering amnesia to a Traumatic Experience (a partial or full dissociation - ANP to EP) and or a general micro amnesia. Please inform yourself very extensively about a Trauma related Structural Dissociation of the

personality before you diagnose someone with it.



General diagnostically information:

DSM-5 300.14 - ICD F44.81 diagnostically criteria A, B, C, D and E;

A)

Disruption of identity characterized by two or more distinct personality states. The disruption in identity involves marked discontinuity in sense of self and sense of agency accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

Here we are talking about ANP's (and not about EP's). The Apparently Normal Personality state. Living the present time, taking care of daily tasks, having their own distinct behavior, thinking and feelings about their environment and oneself. Daily life emotion and task oriented personality parts – the ANP's.

for example:

ANP 1 would also wear a skirt
ANP 2 would never wear a skirt

ANP 1 has a soft and warm voice
ANP 2 has a clear but cold voice

ANP 1 can't read without reading glasses
ANP 2 read without them and doesn't need reading glasses

ANP 1 drinks coffee with sugar and milk
ANP 2 drinks only black coffee

ANP 1 loves to cook
ANP 2 doesn't know how to cook and also doesn't like to cook

ANP 1 has parents or a parent
ANP 2 has no parents, was adopted and doesn't know her own parents
etc.

B)

Recurrent gaps in the recall of every day events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

For example:

If ANP 1 is out, ANP 2 doesn't take in the memory of that daily life tasks. The task which where done by ANP 1. Likewise the other way around. Sometimes an ANP has some recognition (can recall memories) about doing tasks done by another ANP but then it still doesn't recognize it as something done by the own self (someone else did it, not me). Both (and very rarely even three) ANP's have different memories of doing tasks in the present time and they have also a different recognition/memories of a past. The ANP's don't have a autobiographically memory that fits the reality of the own past (a autobiographically memory that fits one main healthy personality).

C)

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The amnesia, the different life styles and also living a very superficial emotional life which is task and survival oriented causes severe insecurity, loneliness and suppressed emotional chaos. Someone who suffers a DID is without self-knowing, constantly living a high alert state. They get easily confused and exhausted because they are ongoing on a wake to avoid being vulnerable to the outside and also inside world. It's also not uncommon that someone who suffers a DID slips in to an isolated life style (a very pour social life) because they can't keep up the different preferences of each ANP. The pour emotional life causes very often a severe inner loneliness. Emotions are likely experienced as a fragile state and the ANP's don't like a fragile state so they avoid those feelings by an automatically switching back and forward between the different ANP states. This causes memory gaps during daily life (broken time and chaotic memory fragments) which mess up daily life. The presence of more than one ANP also causes ongoing conflicting thoughts: did I do this already, no I didn't do this, yes you did, no I didn't etc. And also new experiences, new life events or new daily life tasks causes conflicting situations and chaotic thoughts as; do I like or need to do this, no I don't, yes I do, no I don't and I won't do this, yes I would like or need to do this (etc.). Also trusting someone is very chaotic and causes severe inner conflicts; can I trust this therapist, no you can't, yes you can, you need help, no I don't need help, etc..

I by myself always say:

someone who suffers DID, suffers the loneliness of surviving the own inner self (oneself) and no longer a traumatic event or the past. There was a time our instinct created this survival mode because it was needed, but it also caused that we didn't learn how to feel and live life – we only learnt how to survive and that's not living, it's surviving! Our inner self which is constantly on the run, trying to escape from the own autobiographical memory.

D)

The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E)

The symptoms are not attributable to the physiological effects of a substance (e.g. blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

I want to close this column with a very personal note:

I don't switch at all to personality states which loose contact with the reality of daily life. The ANP's which are a part of my whole personality, are very stable daily life task oriented. Lots of people don't understand at all if we talk about our switching behavior. And very often there goes a big misunderstanding to the difference between ANP to ANP switching behavior, and ANP under the influence of EP switching behavior.

I suffer, I suffer a lot by the switching behavior back and forward between more than one ANP state. A specific symptom that comes with a Tertiary Structural dissociation of the personality and which is common to the Dissociative Identity Disorder - a A typical diagnostically criteria. A very typical symptom to the third level of a SD.
Within a therapeutically frame and only within a therapeutically frame, and with the help of an experienced clinical psychologist and (hypno-) therapist we bring the phobic ANP's step by step in contact with each other and

each experiences (the ANP's and EP's) in order to learn recognizing, working together (the ANP's) and handling our own autobiographically being (one personality state). So we hopefully can learn to feel and functioning as one personality. And although I'm very aware of the even more severe agony someone suffers diagnosed with OSDD+ and the switching behavior that comes with it, I want to write: you will not find us switching to a vulnerable ANP sate that goes under the influence of an EP part. We will avoid that on all times, which is also very common to DID sufferers.

Understanding and even healing doesn't come with rejecting or denial. It only comes with the acceptance of our own being and recognizing what causes our own behavior and suffering that comes with it. *A secondary structural dissociation of the personality is also a very severe 'Trauma related' disorder witch causes even more and very severe agony in life. The co-morbidity of this disorder is far too much under exposed, accepted and recognized. It should even get more attention and research than DID.*

Kopie of website colomn:

▶ Trauma, BPD and Dissociation ◀