

Other specified dissociative disorder (OSDD)

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1. Core Definition and Diagnostic Context

Other specified dissociative disorder (OSDD) is a diagnostic category within the Dissociative Disorders section of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013). OSDD is applied when an individual exhibits clinically significant dissociative symptoms that cause profound distress or functional impairment, but which do not meet the full diagnostic criteria for Dissociative Identity Disorder (DID), Dissociative Amnesia, or Depersonalization/Derealization Disorder.

Unlike the residual category of Unspecified Dissociative Disorder (UDD), the diagnosis of OSDD requires the clinician to precisely specify the reason why the presentation fails to meet the criteria for a more defined dissociative disorder. This commitment to specification ensures that OSDD is not simply a catch-all for minor or vague symptoms, but rather identifies specific, clinically coherent, yet sub-threshold presentations of pathological dissociation. The most common forms of OSDD, particularly those involving identity fragmentation, are strongly associated with histories of severe, chronic trauma.

2. Historical Evolution: From DDNOS to OSDD

The concept of OSDD evolved directly from its predecessor in the DSM-IV, Dissociative Disorder Not Otherwise Specified (DDNOS). DDNOS was frequently diagnosed in clinical settings specializing in dissociation, highlighting that significant pathology often existed outside the boundaries of the primary named disorders. However, DDNOS was criticized for its heterogeneity and lack of specificity.

Clinical researchers identified certain common subtypes under DDNOS, notably DDNOS Type 1 (DDNOS-1), which closely resembled DID but was missing one key diagnostic criterion. These presentations included cases with the presence of distinct alternate identities or "parts," but without recurrent amnesia between them (often termed DDNOS-1a), or cases involving significant amnesia between dissociated states, where the identity states themselves were not sufficiently distinct or complex to meet the full DID threshold (DDNOS-1b).

The transition to DSM-5 aimed to enhance diagnostic clarity. The broad DDNOS category was retired and replaced by two categories: OSDD, which requires specification, and UDD, reserved for cases lacking sufficient information for specification. This restructuring acknowledged the clinical significance of presentations resembling DID but not meeting full criteria, ensuring these individuals receive appropriate recognition and specialized care.

3. DSM-5 Specific Presentations

The DSM-5 provides four explicit examples of presentations that warrant an OSDD diagnosis. These examples represent common and clinically significant patterns of pathological dissociation:

Chronic and recurrent syndromes of mixed dissociative symptoms: This is the most clinically recognized and common subtype, often encompassing the former DDNOS-1 presentations. It is characterized by significant **identity disturbance** or alteration, and/or dissociative amnesia, but the symptoms fall short of the full criteria for Dissociative Identity Disorder. For example, an individual might experience distinct self-states or "modes" that lack the full autonomy required for DID alters, or they may have distinct alters but lack the chronic amnesia for everyday events.

Identity disturbance due to prolonged and intense coercive persuasion: This involves dissociative changes in identity, beliefs, and values following exposure to systematic, coercive techniques, such as those used in brainwashing, thought reform, or prolonged involvement in high-control cults or extremist groups. The core dissociative changes are directly attributable to the manipulative environment.

Acute dissociative reactions to stressful events: This specification applies to transient, intense dissociative states (e.g., stupor, amnesia, depersonalization, or derealization) that occur in immediate response to a significant trauma or stressor. Crucially, these symptoms are time-limited, typically lasting hours to days, and resolving within one month.

Dissociative trance: This involves an acute narrowing or complete loss of awareness of immediate surroundings, manifesting as profound unresponsiveness or insensitivity to environmental stimuli. This state causes significant distress or functional impairment and is specifically defined as **not** being part of a broadly accepted collective cultural or religious practice.

4. Etiology and Structural Dissociation

The etiology of the chronic forms of OSDD (OSDD-1) is overwhelmingly linked to severe and chronic interpersonal trauma, particularly beginning in childhood. This trauma often involves abuse, neglect, or exposure to frightening situations, especially when perpetrated by primary caregivers. This context generates an disorganized attachment pattern, where the child cannot form a coherent strategy for seeking comfort because the source of fear is also the source of potential safety.

The inability to escape overwhelming fear leads the child to adaptively defend through dissociation, compartmentalizing traumatic memories, overwhelming affects, and the perceptions of the self that are incompatible with survival. This process is best conceptualized through the **Theory of Structural Dissociation of the Personality** (TSD), which posits that chronic trauma prevents the

normal integration of self-states into a cohesive personality.

In TSD, the personality remains divided into different prototypical parts: Apparently Normal Parts (ANPs), focused on daily life and coping, and Emotional Parts (EPs), which hold the traumatic experiences and defensive reactions. OSDD-1 is understood as a form of secondary or tertiary structural dissociation where the division is clinically significant but may be less pronounced or elaborate than in Dissociative Identity Disorder. For example, the parts may have more permeable boundaries, leading to increased co-consciousness and reduced amnesia, or the parts may be experienced more as conflicting "modes" or "aspects" rather than fully distinct personalities.

5. Clinical Presentation and Comorbidity

The clinical presentation of OSDD-1 is characterized by a perplexing array of symptoms that often lead to years of misdiagnosis. These individuals struggle significantly with maintaining a cohesive sense of self and managing intense emotional reactions.

Common Symptoms include:

Identity Alteration/Confusion: Feeling like a different person, experiencing unexplained shifts in mood, preferences, or behavior, or intense internal conflict between different self-states or "parts."

Depersonalization/Derealization: Persistent feelings of detachment from one's body, thoughts, or emotions, or from the external world.

Memory Problems: Significant gaps in memory for specific periods of time or important personal information, often referred to as "losing time," though overt recurrent amnesia for everyday events may be absent (distinguishing it from full DID).

Affect Dysregulation: Rapid, intense, and often overwhelming shifts in mood, including intense anxiety, depression, shame, or anger.

Intrusive Symptoms: Flashbacks, intrusive thoughts, or bodily sensations related to past trauma, sometimes experienced as originating from a different internal self-state.

OSDD rarely occurs in isolation, and high rates of co-occurring conditions (comorbidity) complicate diagnosis and treatment. Common comorbidities include Posttraumatic Stress Disorder (PTSD) or Complex PTSD (C-PTSD), Major Depressive Disorder, Anxiety Disorders, Borderline Personality Disorder (BPD), Somatic Symptom Disorder, and Substance Use Disorders.

6. Assessment and Differential Diagnosis

Accurate diagnosis requires comprehensive assessment, utilizing both clinical interviewing and standardized measures, due to the subtlety of dissociative symptoms and the high rate of symptom overlap with other complex disorders.

Assessment Tools include:

Clinical Interview: Detailed inquiry into trauma history, developmental experiences, and explicit questioning about identity alteration, amnesia (including for different time periods), and internal experiences of self-states.

Dissociative Experiences Scale (DES): A widely used self-report screening tool for pathological dissociation.

Multidimensional Inventory of Dissociation (MID): A comprehensive self-report measure providing a detailed profile of dissociative symptoms.

Structured Clinical Interview for DSM-5 Dissociative Disorders (SCID-D): A semi-structured diagnostic interview considered the gold standard for formal diagnosis.

Key Differential Diagnoses:

OSDD vs. Dissociative Identity Disorder (DID): OSDD-1 differs from DID by lacking either the requisite distinctness/autonomy of alternate identities or the recurrent amnesia for everyday events, or both.

OSDD vs. Borderline Personality Disorder (BPD): While both involve identity disturbance and affect dysregulation, the identity disturbance in OSDD-1 involves structured compartmentalization (dissociative parts) linked to trauma, whereas BPD involves an unstable and fragmented sense of self, goals, and values.

OSDD vs. Complex PTSD (C-PTSD): OSDD-1 is often considered part of the severe end of the C-PTSD spectrum. The distinction hinges on whether the dissociative fragmentation of identity and memory is the most defining feature (favoring OSDD) or if it is one aspect of broader disturbances in self-organization alongside core PTSD symptoms (favoring C-PTSD).

OSDD vs. Psychotic Disorders: Dissociative "voices" are usually experienced as internal dialogues or intrusions from self-states, whereas psychotic hallucinations are typically perceived as external. Reality testing generally remains intact in OSDD.

7. Treatment Approaches and Phase-Oriented Therapy

Effective treatment for OSDD, particularly the chronic forms, follows the established principles for treating DID and C-PTSD: a structured, long-term, and trauma-informed phase-oriented approach guided by the International Society for the Study of Trauma and Dissociation (ISSTD) Guidelines.

Treatment goals center on reducing symptom severity, enhancing functional stability, processing trauma, and fostering communication and integration among dissociated self-states.

Phase 1: Safety, Stabilization, and Symptom Reduction: This foundational phase focuses on establishing a secure therapeutic relationship, developing effective coping strategies, and psychoeducation about OSDD and trauma. Interventions include teaching grounding techniques,

affect regulation skills (often utilizing elements of Dialectical Behavior Therapy (DBT)), and gently mapping the client's internal system of parts/modes to facilitate internal communication.

Phase 2: Processing Traumatic Memories: Once stability is achieved, therapy moves to processing the overwhelming traumatic experiences that caused the dissociation. This must be done carefully, using techniques that prioritize titration and pacing to avoid re-traumatization. Modalities frequently adapted for OSDD include **Eye Movement Desensitization and Reprocessing (EMDR)** and **Sensorimotor Psychotherapy**, focusing on the cognitive, emotional, and somatic encapsulation of trauma.

Phase 3: Integration and Rehabilitation: The final phase consolidates gains, focusing on achieving a more unified sense of self. The goal of integration can range from functional integration (harmonious collaboration and co-consciousness between parts) to full fusion (the merging of parts into a single identity), guided by the client's informed choice and capacity. Focus areas include strengthening relational skills, consolidating the personal narrative, and pursuing future life goals.

While medication cannot treat the core dissociative symptoms, it may be used adjunctively to manage common comorbidities such as depression, anxiety, or severe affect dysregulation. Specialized training for the therapist is essential due to the complexity and intensity of treating OSDD.

Further Reading

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