



DID OR OSDD: DOES IT MATTER?



by Carolyn Spring

Note: DDNOS (dissociative disorder not otherwise specified) was renamed OSDD (other specified dissociative disorder) in the latest update to the psychiatric diagnostic manual, the DSM-5. In this article we're using the terms interchangeably whilst mainly using the term 'OSDD' for brevity.

WHAT IS THE DIFFERENCE BETWEEN DISSOCIATIVE IDENTITY DISORDER (DID) AND OTHER SPECIFIED DISSOCIATIVE DISORDER (OSDD)?

One of the many questions I frequently hear is about OSDD – other specified dissociative disorder. I'll explain technically what OSDD is in a moment, but a quick (although inadequate) definition might be 'dissociative identity disorder without distinct parts of the personality'. Many people with DID struggle with what their

diagnosis means to them – they may resent it or disbelieve it, but there is at least some understanding, and an increasing amount of literature, on the nature of dissociative identity disorder. The same cannot be said for OSDD. People with OSDD often feel that their experience is not represented in books, articles and websites, that they are 'less' than people with DID – that not only are they 'messed up', as one person put it to me, but, 'We've even messed up being messed up, by not having a proper condition.'

OSDD – THE MOST COMMON DISSOCIATIVE DISORDER?

This is a painful position to be in, and yet a variety of studies have regularly found that OSDD is either the most common or among the most common dissociative diagnoses: it is diagnosed, according to O'Neil et al (2008), in 40% of cases. ▶

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of course it is the stand-out feature of DID, but we also recognise that parts develop in response to trauma and disorganised attachment, as do a whole range of other symptoms. So our focus is on living with that entire range of symptoms, and being able to deal with the underlying cause.

THE IMPORTANCE OF VALIDATING OSDD

At the same time, however, it is important to note that there are differences between someone whose constellation of symptoms would identify them as being at the DID end of the spectrum, and someone whose similar but slightly different set of responses might place them at the OSDD end of the spectrum. When there is often a strong emphasis on the dissociative parts of the personality, people with OSDD can feel unheard and unseen, and so I feel that it is very important to validate the reality of the experience of people with the OSDD label.

We have touched on two major differences already – less elaboration or switching to distinct parts, and less amnesia. But people may be diagnosed as OSDD as opposed to dissociative identity disorder simply because their ‘parts’ didn’t show up on cue at a diagnostic interview. Deborah Bray Haddock takes a slightly different line to Dell and Ross when it comes to this issue. She says:

My advice to clinicians is that until they have met an alter, it is not DID. They may suspect that someone has DID and their suspicions may prove to be correct, but each of the four criteria must be met to diagnose someone with DID. Until that time, a diagnosis such as dissociative disorder not otherwise specified (DDNOS) might be more appropriate.

(2001, p.9)

This is a complex area of debate, because as Spiegel et al, in their paper *Dissociative Disorders in DSM-5* (2011, p.839), point out:

According to Kluft and Dell, only 15% of dissociative identity disorder cases regularly manifest easily observable alternate identities during diagnostic interviews. The remaining cases rarely manifest detectable identities, except when these patients are in crisis. Kluft used the term ‘window of diagnosability’ to capture the latent nature of clear-cut switching phenomena in dissociative identity disorder patients.

So for some people, their alters or parts are only obvious to other people during times of crisis. Does that mean that they are DID when they are in crisis but OSDD the rest of the time? Surely not. Many commentators such as Dell and Kluft argue convincingly in a number of places that switching is hard to detect,



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when other parts are 'out'. More common is amnesia for past trauma, although parts often seem to have memory for this. And very few people with apparently diagnosed dissociative identity disorder that I have met claim to have full memory of their past, with no amnesia at any time – which would seem to contradict their diagnosis.

But an interesting point in this concerns the progress of therapy, which is to re-integrate traumatic memories into mainstream consciousness. At what point, when that is happening, could you state that you no longer have amnesia, and should your diagnosis change from DID to OSDD? (And if parts are 'integrating' or 'fusing' during therapy, at what point should you likewise shift along the spectrum and change your diagnostic classification?) And what about instances of 'amnesia about amnesia' – how do you know that you have amnesia for something if you've forgotten that it happened in the first place?! It all seems very muddled.

OSDD: A MATTER OF DEGREE?

In terms of other differences, it seems that as a general rule the degree of the trauma or attachment difficulties leading to OSDD will be less severe than people who are diagnosed with dissociative identity disorder, especially polyfragmented dissociative identity disorder. People with OSDD may for example have had some 'good enough'

attachment experiences, or other mitigating factors. On a neurobiological level, differences can be seen in studies measuring the volumes of the hippocampus, a key component of the brain largely associated with memory formation and retrieval. People with DDNOS were reported to have a 13% reduction in hippocampal volume compared to healthy controls, whereas people with DID showed a reduction in the region of 25% (Ehling, Nijenhuis & Krikke, 2003). This has led clinicians such as Elizabeth Howell (2005) to suggest that the degree of dissociation correlates to the degree of severity of the trauma, which may be true. However, this is often little comfort to people with OSDD, as I shall discuss later.

All of these points present certain issues for people with the OSDD label. Most strikingly perhaps, people labelled as OSDD may not feel that their condition is taken as seriously as dissociative identity disorder. Some people with DID may resent the 'multiple personalities' connotation, but at times it is the easiest way of explaining it to other people when time is short or openness limited. But how do you describe OSDD? The temptation might be to describe it in terms of what it is lacking – 'It's sort of DID except not quite' or 'It's like PTSD but with more dissociation.' I wonder how many people with OSDD therefore feel short-changed, as if somehow they are not deemed worthy of a 'proper' condition, only a 'residual' one, which



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complex DDNOS patients would meet diagnostic criteria for DID.

So one option, favoured by many people that I have been in contact with, is to merge the categories and to count the condition as 'DID/OSDD' and leave it at that. Certainly where private therapy is being sought and there is no need for a definitive statement on some official piece of paper or medical record, this may be the preferable option for a large number of people.

But some people do justifiably feel the need for an 'official diagnosis' – for a number of reasons, including the pursuit of treatment on the NHS (although a diagnosis of either DID or OSDD is never a guarantee of appropriate therapy); in order to receive better care from the NHS than the pejorative catch-all 'personality disorder' label will elicit; to justify or at least corroborate a claim for welfare benefits; to negotiate appropriate support from an employer; or to determine the pathway of treatment, amongst other reasons. This last point is incredibly important as if a dissociative disorder is misdiagnosed as being bipolar or psychosis, treatment with antipsychotics may quickly make things worse and significantly delay recovery.

But there are a range of difficulties in gaining a diagnosis at all, not least the fact that very few NHS staff are trained to spot dissociative symptoms,

let alone administer the 'gold standard', the SCID-D assessment tool. And in the UK, medical staff tend to prefer the diagnostic manual known as the ICD-10 (International Classification of Diseases, version 10) published by the World Health Organisation which is notoriously backward in addressing dissociative disorders. Indeed Spiegel et al (2011, p.826) in their incisive critique say:

Importantly, the ICD-10 describes dissociative disorders as primarily acute disorders that usually remit within a few weeks or months, and that have an onset in the immediate context of events that are highly stressful, traumatic, and/or that involve intolerable, insoluble problems. In contrast, the DSM-IV-TR conceptualises several dissociative disorders as long-term, chronic disorders, including dissociative identity disorder and some forms of depersonalisation disorder, dissociative amnesia, and DDNOS.

They further state:

The ICD-10 description of dissociative identity disorder is not based on an understanding of DID as a childhood-onset, complex, posttraumatic developmental disorder. Rather, this description is based on the literature that pre-dates the body of research on dissociative disorders since the publication of DSM-III.



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In short, the UK-favoured ICD-10 is based on research and clinical literature from before 1980 – little wonder that dissociative disorders are so poorly picked up in the UK.

And even successfully obtaining a diagnosis can cause difficulties – in work situations, in applying for life insurance or even travel insurance, and in the stigma that surrounds so many mental health conditions. Each person needs to weigh up the pros and cons on an individual basis and do what is right for them.

OSDD AND DISSOCIATIVE IDENTITY DISORDER: SURVIVAL STRATEGIES

So what is the solution? I wish ‘the answer’ were easy to find, and equally easy to put into practice. In the harsh reality of the state of awareness of dissociative disorders in the UK today, we have to just keep moving in the right direction and not be dispirited at the challenges that still lay ahead. People with OSDD need to understand that their experiences are valid and real and not inferior in any way to people with dissociative identity disorder. And whilst recognising the differences, we can also recognise the underlying similarities. In the words of Sue Richardson (2011):

Both OSDD and DID are the result of the spontaneous action of the brain in response to trauma. Both contain different self-states, holding shards of

memory and ‘unformulated experience’ (Stern, 1997). Both can be helped by similar approaches to therapy which encourage neuronal repair and result in brain growth such as increased hippocampal volume. Above all, all forms of dissociation need to be validated for their unique contribution to survival.

It may be important for some people with OSDD to distinguish their experience from that of people with dissociative identity disorder and it would be good for people in this category to come forwards and write about their experience to help people, clinicians in particular, understand the unique characteristics of life with OSDD. For others, it may be validating to recognise that the distinguishing line between OSDD and DID is largely arbitrary, and to subsume the diagnosis of dissociative identity disorder into their own self-definition of being a dissociative survivor.

The important thing is that the labels people give themselves are helpful to them, to meet their specific needs. For some people, that means rejecting labels altogether. For others, that means fighting to have their own particular label recognised and acknowledged. As long as we have a pragmatic and even utilitarian view of diagnosis that leads people towards recovery and health, I think we’re near enough on the right tracks. ●

