

Dissociative Identity Disorder as a "Not to Know Strategy"

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In the September/October 1999 issue of the ISSD (International Society for the Study of Dissociation) newsletter, ISSD president Peter Barach lists 10 changes in the treatment of DID that have occurred in the past 10 years. Number 3 is "Focusing on the dissociative patient as a whole." He writes, "Along these lines, I have found that referring to DID as the 'not to know strategy' can facilitate this shift in focus."

Some of my patients and I like this and find it useful in treatment because it is non-pathological, describing a strategy rather than a disorder. DID in adulthood is, of course, a disorder, causing much difficulty and dysfunction in daily living. It should stay in the DSM and should be treated as a psychological problem. But the etiology of DID in childhood, engendered in experiences of abuse, suggests that it arose originally as a strategy, as a way to avoid full conscious experiencing of something intolerable.

Calling it the "not to know strategy" emphasizes the functionality of the dissociative splits. They were, in effect, a way not to know everything all at once. "Not to know" includes not knowing actual events, and also their attendant emotions, cognitions and behaviors. Blocking all or part of this knowing allows a child to function.

This title also puts less emphasis on the separateness of the parts, and more on the functionality and reason for the separateness. Along these lines, I am sometimes calling parts "knowing areas." I talk about them more as areas of knowing certain things rather than as separate entities. For instance, one knowing area can know part of what happened, and others can know other parts. This is helpful for some patients who have a sense of wholeness at times -- it doesn't imply that they aren't whole.

When I think this way, I don't use the term integration as much, when referring to processes of unification or removal of the dissociative barriers. While I do believe that integration should be the goal of treatment, I think of it more as a gradual process of increasing the sharing of knowing among parts, than as a discrete event. I am substituting "increasing self knowing and self tolerance" for the term "integration." When I work this way, the work often feels more fluid and gentle, and there is more empowerment for the patient. If it serves them, they can choose to share knowing between areas. I notice that more of the work of therapy is done with co-consciousness when we think this way.

Example: A patient I will call Jody had been feeling very anxious for a week, and could not discover the reason, no matter how much we explored it. The anxiety was becoming intolerable. Using the "not to know" framework, I asked if the knowledge about the source of the anxiety was located in a knowing area, and asked if she wanted to increase knowing between herself and this area, in order to decrease her anxiety. She agreed. She simply asked herself where the knowing about the anxiety was, and if that "knowing area" was willing to share with her. She became aware of hearing the information being shared within her, and, by understanding the reasons for the anxiety, was able to take steps to diminish it.

In summary, I propose that thinking and talking about DID in treatment (not in terms of the DSM) can be helpful in focusing on the wholeness of the patient, de-pathologizing the origin of DID, and facilitating improved daily life through increased co-consciousness.