### The BASK Model of Dissociation

#### Bennett G. Braun, M.D.

#### ABSTRACT

The BASK model conceptualizes the complex phenomenology of dissociation along with dimensions of Behavior, Affect, Sensation, and Knowledge. The process of dissociation itself, hypnosis, and the clinical mental disorders that constitute the dissociative disorders are described in terms of this model, and illustrated.

Dissociation as a concept in psychiatry and as a descriptor of phenomena observed in mental disorders is derived from the doctrine of "association," which held that memories are brought to consciousness by way of association of ideas; thus, memories not available to be associated are termed "dissociated." Dissociation is today taken to mean the separation of an idea or thought process from the main stream of consciousness.

The Revised Third Edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1987, p. 269) states that, "The essential feature of these (dissociative) disorders is a disturbance or alteration in the normally integrated functions of identity, memory or consciousness. The disturbance or alteration may be sudden or gradual, and transient or chronic. If it occurs primarily in identity, the person's customary identity is temporarily forgotten, and a new identity may be assumed or imposed (as in Multiple Personality Disorder), or customary feeling of one's own reality is lost and replaced by feelings of unreality (as in Depersonalization Disorder). If the disturbance occurs primarily in memory, important personal events cannot be recalled (as in Psychogenic Amnesia and Psychogenic Fugue)."

Dissociative phenomena include hypnosis, dissociative episodes associated with strong affective states such as fear, and dissociative disorders currently defined in psychiatry. Multiple personality disorder is at the extreme of dissociative phenomena. Post-traumatic stress disorder also may be placed on a continuum of dissociation. Dissociation may be regarded as a coping mechanism.

The term "dissociation" is commonly attributed to Pierre Janet, who used it first in 1889 (Ellenberger, 1970). Having studied hysteria and other forms of psychopathology, he developed a theory of psychological automatism that Kihlstrom (1987) believes anticipated some current concepts of connectionism or parallel distributed processing. Kihlstrom (1987) also states that dissociation may hold important clues to the cognitive unconscious, one of the key concepts of current cognitive psychology.

The conceptualization of dissociation was hindered for decades when Freud rejected dissociation in favor of repression as a central mechanism of the mind's defensive organization. In 1881-82, Breuer had concluded that a splitting of consciousness is present in every hysteriathat a tendency to dissociation and abnormal states of consciousness is the basic phenomenon of hysteria. This explanation for divided consciousness was different from the one that Freud later proposed. Freud eventually stated that the ideas unavailable to consciousness are "repressed" into the unconscious where they are bound up with affective impulses, and enter consciousness indirectly as physical symptoms (Decker, 1986). Breuer's hypothesis was that amnesia occurs because certain memories are not usually available due to a divided consciousness. Breuer had priority of discovery regarding dissociation, but Janet published first. Breuer and Freud at first acknowledged Janet's claim, but later the entire issue of repression and dissociation became controversial and the relationship between Janet and the analysts became acrimonious. Freud's concept of repression finally overrode competing ideas.

Rosenbaum (1980) offered two additional reasons for the rapid fall of concepts of dissociation, multiple personality and hypnosis. These were: (1) Bleuler's introduction in 1911 of the term "schizophrenia" to cover many of the symptoms found in multiple personality disorder; and (2) the growing suspicion that multiple personality disorder and hysteria were artifacts of hypnotic suggestion. Over most of the twentieth century, the central concepts of behaviorist psychology, with its relative disinterest in intrapsychic functions and processes, also deterred interest in dissociation.

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#### DISSOCIATION TODAY

Dissociation is today a powerful concept for looking at human coping mechanisms. The overriding influence of "repression" has dwindled, and no longer stands in the way of scientific investigators' taking a new look at dissociation.

Hilgard (1977) suggested that the major difference between dissociation and repression is in the flow and content of the dissociated and/or repressed material. In a dissociation context, there is an amnestic barrier that prevents the interchange of different memories. In a repression formulation, there is only an amnesia for unacceptable impulses.

Spiegel (1963) proposed a two-directional model of dissociation—e.g., a dissociation/association continuum, whereas repression was seen as unidirectional.

Frankel (in press) pointed out that the unpleasant side effects of dissociation such as amnesia, depersonalization, and derealization make it less than an ideal protective mechanism. Frankel noted that it is nevertheless clear that in multiple personality disorder, fugues, and conversion symptoms, dissociation provides some escape from conflict. The escape is often maladaptive, and that leads the patient to the therapist, to prison, or to a life of misery.

The therapist hopes to help the patient reshape the dissociative experience, and provide the patient with a helpful way to deal with an untenable conflict. Helping the therapist to help the patient is the aim of a proposal for a new model of dissociation that provides an explanation of the dissociative process and a methodology for the therapist.

In 1984, I proposed a speculative concept of multiple personality and other dissociative phenomena. It brought together a number of approaches to understanding dissociation under the rubric of neuropsychophysiologic (NPP) state-dependent learning (SDL). In that paper, I proposed that multiple personality disorder represents an extreme point on a continuum of response patterns that includes hypnosis, repression, ego states, and dissociative disorders. Although multiple personality disorder has its place on the continuum, neither hypnosis nor dissociation alone can create multiple personality. Multiple personality disorder is created by means of repeated dissociations that occur under extreme stress, usually the extreme stress of child abuse. These dissociations often have similar NPP affective states that allow them to be linked together, permitting the association of facts, the development of congruent, stable memories, ranges of emotion, and response patterns. Central to the proposal is that the linked affective states are NPP-based. The inclusion of NPP is what differentiates this concept of dissociation from those that are solely psychological.

The NPP state is central to the concept of memory linked to state-dependent learning. The basic tenet of state-dependent learning is that something that is learned in one NPP state is most expeditiously retrieved under the same NPP state. Personalities are formed, shaped, and expressed through the individual's continuous interaction with the environment. Behaviors are expressed, and shaped by environmental responses. If the reinforcement of behavior occurs in a sufficiently disparate, dissociated NPP state, the effects of that interaction will not be available under the usual NPP state. If the NPP states are too disparate, retrieval is not possible.

If enough environmental interactions occur under similar NPP states, as in circumstances in which a child endures abuse frequently but also experiences more positive interactions (Braun & Sachs, 1985), the informations learned under the NPP state of abuse will be linked together. This chaining of knowledge, memory and interactive patterns forms an alter personality with its own response patterns, life history, and range of affect.

The dissociation model presented in this paper is a further development of the theoretical proposals of 1984. Later in this paper, the model is extended to discussion of multiple personality disorder and its treatment.

#### THE BASK MODEL

The complex phenomena of dissociation can be conceptualized in a BASK (B-A-S-K) model. The four letters of the acronym represent Behavior, Affect, Sensation and Knowledge, processes that function in parallel on a time continuum represented by the arrows in Figure 1. If we continue to define dissociation as the separation of an idea or thought process from the main stream of consciousness, then we may use the BASK model (Figure 1) to illustrate that dissociation can occur on any one or more of the levels — e.g., on Behavior as it might in automatism, on Affect and Sensation as when hypnosis is used to create an anesthesia. Dissociation may occur in all the processes at once for a greater or lesser period of time. In this model, mental health is the congruence over time of the BASK components.

Before proceeding to use of the BASK model to formulate models of dissociative disorders, the phenomenon of dissociation may be brought into sharper focus. Dissociation can be shown as one extreme on a continuum of awareness (Figure 2). The continuum runs from full awareness-through suppression, which is a conscious putting-out-of-mind of something we don't want to think about-through denial, which is a mechanism we use until we have the capacity to cope in other ways-through repression, which Freud identified as being due to pathological psychological conflict-to dissociation itself, which I believe includes repression, but unlike the classical definition of repression, has a major NPP component. Although there is a vertical bar in the Figure at each point where we name a successively severe diminution of awareness, the progression

from left to right should be seen as the gradual shadings of a true continuum.

A static model of the dynamic continuum of dissociation also is useful to comprehension of the BASK model (Figure 3). As with maps of the world, not everyone will agree with where the lines are drawn; some will agree, some disagree with the placement of "repression" as a "dissociative episode." I also propose that, on the horizontal axis between "dissociative disorder and "atypical dissociative disorder," we should place "post traumatic stress disorder." A strong case can be made for identifying post traumatic stress disorder (PTSD) as a dissociative disorder, and this line of reasoning will be discussed later under PTSD.

Moving from the far left side of the continuum, we see that some dissociative phenomena are quite normal. Hypnosis is an interactive dissociative phenomenon in the case of heterohypnosis: one person, the subject, responds to suggestions offered by another person, the hypnotherapist, for experiences involving alterations in perception, memory and action.

Returning to the BASK model, we can look at the functioning of the model in describing the relatively simple phenomenon of hypnotic anesthesia. Figure 4 illustrates the process of hypnotic induction, whereby the hypnotherapist's use of an hypnotic ceremony induces the subject to focus attention very narrowly, and alter awareness. For the purposes of surgical anesthesia, the hypnotherapist and subject separate the subject's Affect and Sensation from his/her ongoing Behavior and Knowledge that a surgical procedure is taking place. Kihlstrom (1987) believes that hypnosis represents a special case of the cognitive unconscious, saying that "post-hypnotic suggestion seems to expand the domain of nonconscious mental processes" and "hypnotic analgesia and posthypnotic amnesia appear to expand the domain of nonconscious structures." As conceptualized in the BASK model, hypnotic induction focuses the subject's attention and then proceeds to decrease his/her General Reality Orientation (GRO) by creating an illusion that the subject can agree with and incorporate into the hypnotic process (Shor, 1970). This further focuses attention and decreases GRO. As attention is focused on an aspect of BASK-e.g. sensation of muscle contraction and relaxation-there is progressive relaxation induction. One can see that as trance is achieved attention is focused on Sensation over the other elements of BASK, and the foundation of dissociation is constructed.

In the BASK model presentation of repression as a dissociative episode, there is a break of all BASK processes across the time continuum, although the physiologic component is less evident (Figure 5). We see, represented by double-ended arrows at the bottom of the Figure, that in relation to actual elapsed time the patient has the perception of having been in a condition of total awareness. Certain memories, however, are not available to conscious recall. They may be retrievable in psychotherapy. In the traditional Freudian model of repression, it is affect-loaded conflict which causes the loss. In this model, affect effects the NPP state but its effect is less obvious than in other classic cases of dissociation.

A dissociative disorder is characterized by a disruption of memory (Figure 6) and a disruption of identity (Figure 7). It is differentiation between memory of knowledge that is often a critical factor in making or missing the diagnosis of multiple personality. The creation of memory requires the dynamic involvement of all four BASK processes. We see in Figure 6 a representation of what may occur in the instance of a multiple personality. Along the time continuum of Behavior, we see two phenomena occurring: ongoing, external Behavior represented by the digital-like vertical bars, and physiological Behavior by the sine wave. We can look at the disruption in the BASK continuum at the left side of the Figure as a representation that "something happened" to cause activity in Affect, Behavior, Sensation and Knowledge which is encoded. This flurry of activity is the BASK representation of "memory encoding." Two types of retrieval, memory and knowledge, are represented on the right. The multiple personality who is "covering his tracks," so to speak, may be able to present Knowledge so convincingly that it appears to be memory. The alter personality who was not present during encoding of an event may still be able to report the facts that constitute Knowledge, but altogether lacking will be the demonstrative Affect, Sensation, and to a lesser extent the Behavioral components that accompany a recalled memory of a significant event. An example might be the civilian who can tell you very knowledgeably about an event in the Vietnam War, but has no true memory of the event because he was never in Vietnam.

The reporting of knowledge may be misperceived by the therapist as memory, and the diagnosis of dissociative disorder will be missed. The reporting of knowledge as memory may occur intentionally, to cover up and keep the secret of multiple personality disorder (MPD), or because the distinction between memory and knowledge has never been made by the patient or the therapist.

One's perception of one's own identity depends on the congruence of one's image of self and one's behavior. You may check this for yourself by saying aloud "My name is (your name)," and noting both your psychological and physiological responses. Next say as if you mean it, "My name is John Fitzgerald Kennedy," and note your responses. Most people have a reaction to the "lie," usually some kind of anxiety response. This is in essence an error signal or a mismatch in TOTE, an acronym for Test-Operate-Test-Exit in computer terminology.

We carry a BASK monitor image that is a template of experience, and we feel quite comfortable when this expectation matches experience. At the top of Figure 7 we see the BASK representation of the monitor image of self in concert with the image of immediate action to the statement of one's name. No error signal occurs because of the match of the expected name and the stated name.

At the bottom of Figure 7 we see images becoming separated, resulting in an error signal, or a changed identity. The TOTE principle is based upon work done by Bernstein in the 1930s, published in 1967; the work was further cited and developed by Pribram (1971).

In a dissociative disorder the error signal becomes overwhelming. There may be a loss of encoded information, or an inability to retrieve encoded information (Braun, 1984), as in psychogenic amnesia. In psychogenic amnesia there is a sudden inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. The disturbance is not due to an organic disorder such as blackouts during alcohol intoxication. The amnesia is of sudden onset, and is generally of localized or systematized form. Generalized and continuous amnesia are less common. The patient is usually aware of a disturbance of recall, but may be indifferent to the recall failure.

The four types of amnesia may be conceptualized on the BASK model (Figure 8). In LOCALIZED amnesia, all events for a period of time are lost. In GENERALIZED amnesia almost everything before a given event is lost, although some memory for very fundamental activities such as how to eat is usually retained; there is encoding of memory for everything after the given event. In SYSTEMATIZED amnesia information for a very specific and related event is lost, such as memory of several clandestine meetings because of unacceptable memories of other events or persons that are associated with the events; however, some memories of events that occurred in the same period of time are available. CONTINUOUS amnesia is most commonly organic, and each successive event is forgotten as it occurs. At the very bottom of Figure 8, we see a representation of total time covered by available memories in relation to actual elapsed time, for each type of amnesia.

Psychogenic fugue (Figure 9) is characterized by:

 Sudden, unexpected travel away from home or customary place of work, with inability to recall one's past.

Assumption of a partial or complete new identity.

• Absence of any organic mental disorder, although heavy alcohol use may be an associated factor.

 Conflicts over sexuality, aggression or money may be present.

In fugue we see a condition in which a person becomes overwhelmed by life experience. The person "splits" psychologically and in the colloquial sense of leaving home. In the BASK model, fugue is represented by dislocation of the middle portion of the continuum. Actual time elapsed is represented by the double-headed arrow. Perceived Time A represents memories available for the periods on both sides of the dislocation; perceived Time B represents memories for time during the fugue itself. Ultimately, all or nearly all memories are available to retrieval. In many ways, psychogenic fugue is closer to multiple personality disorder than to psychogenic amnesia.

Any discussion of depersonalization disorder (Figure 10) requires a caveat: many adolescents experience a condition that is probably akin to depersonalization disorder as a normal event of adolescence. The characteristics of depersonalization disorder are:

 One or more episodes of depersonalization sufficient to produce significant impairment in social or occupational functioning;

• The symptom is not due to any other disorder, such as schizophrenia, affective disorder, organic mental disorder, anxiety disorder, or epilepsy.

The clinical features of depersonalization disorder include:

•Alteration of the perception or experience of the self, with a loss of a sense of one's own reality, and with associated changes in body image (such as a perception that "this arm is not mine.").

Rapid onset and disappearance.

• Feeling of loss of control of one's actions and speech.

• Episodes last for many minutes to hours and recur frequently.

 Derealization (loss of feeling of the world's reality) and perceived changes in size and shape of external objects.

In the BASK model of depersonalization, Behavior, Affect and Knowledge are unperturbed. However, Sensation, in regard to Self, is distorted; for example, "this arm does not belong to me." This may result in anxiety and/or other disturbances in affect.

In derealization, it is Sensation with regard to the world that is altered, and that may also ultimately cause a disturbance in Affect.

Posttraumatic stress disorder (PTSD) is characterized as a dissociative disorder on the continuum of dissociation disorders (Figure 3). PTSD is represented as being farther from "normal" dissociation than the amnesias, fugue and depersonalization. Since there are many sub-types of PTSD, I have not yet been able to develop a satisfactory BASK representation.

I have proposed that PTSD should be reclassified as a dissociative disorder in the next revision of the Diagnostic and Statistical Manual of Mental Disorders. This proposal is made on the basis that many major and essential symptoms of PTSD are dissociative symptoms.

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Because good research is lacking on this point, there was insufficient data to allow the reclassification of PTSD for DSM III-R (American Psychiatric Association, 1987).

Horowitz (1986) authoritatively discusses intrusion and denial symptoms in PTSD. DSM III-R (American Psychiatric Association, 1987) also lists intrusion and denial symptoms, which for the purposes of this paper, are marked either with a double asterisk (\*\*) as definitely dissociative, or with a single asterisk (\*) as probably dissociative or seen in almost all dissociative disorder patients:

#### **INTRUSIVE SYMPTOMS:**

 Recurrent and intrusive, distressing recollections of the event.\*\*

Recurrent distressing dreams of the event.\*

Sudden acting or feeling as if the event was

recurring\*

•Intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including the anniversary of the trauma.\*

#### **DENIAL SYMPTOMS:**

•Efforts to avoid thoughts or feelings associated with the trauma.\*

•Efforts to avoid activities or situations that arouse recollections of the trauma.\*

 Inability to recall important aspects of the trauma (psychogenic amnesia)\*\*

Markedly diminished interest in significant activities.\*

Feelings of detachment from others.\*

Restricted range of affect.\*

Sense of a foreshortened future.\*

#### SYMPTOMS OF INCREASED AROUSAL NOT SEEN BEFORE THE TRAUMA:

Difficulty falling asleep.\*

Irritability or outpouring of anger.\*

Difficulty concentrating.\*

Hypervigilance.\*

Exaggerated startle response.\*

•Physiologic reactivity upon re-exposure to events that symbolize or resemble an aspect of the traumatic event.\*\*

With this background in place, it is possible to discuss the proposal that PTSD should be reclassified as a dissociative disorder. The proposal is made on the basis that the major and essential features of PTSD are dissociative symptoms: Intrusion symptoms include intrusive thoughts, nightmares, hypervigilance, and episodes of strong emotion; Denial symptoms include inattention, amnesia, constriction of thought processes, and emotional numbing. Both intrusion and denial symptoms may be interpreted as breakdowns in the ongoing flow of mental processes, and thus are dissociative.

Before proceeding to models of atypical dissociative disorder and to multiple personality disorder, some definitions are required and will be drawn from a recent contribution (Braun, 1986).

#### **Personality/Personality State:**

 Consistent behavior to given stimuli (such as one's behavior upon the sudden appearance of a rat—i.e. attack it, or run, or stand on a chair; whatever the behavior, it probably will be repeated under the same circumstances at another time).

 Life history (relatively continuous); no one remembers everything that happened to him or her since birth, but a personality has a significant life history of chained (associated) memories.

3. Affect; each personality has a range of affect and a range of intensity of the given affect.

#### **Personality Fragment:**

1. Consistent behavior to given stimuli.

But, there are two kinds of fragments:

a. One has a continuous life history, but minimal range of Affect—the fragment may express anger and deal with authority figures, for example.

b. Another type of fragment has a short life history, but has a full range of Affect; is often created for special occasions such as dealing with in-laws, holidays, weddings and funerals.

Special Purpose Fragment:

1. Consistent behavior to given stimuli.

2. A minimum life history.

3. Very limited Affect: an example is a patient who baked chocolate chip cookies in a certain special-purpose fragment, because Daddy loved chocolate-chip cookies. In this patient, another fragment baked other delicacies.

Memory Trace Fragment:

1. Minimum behavior.

2. Memory for circumscribed periods of time—often very tiny snippets of time because events were so overwhelming, such as being present at the murder of one parent by another; the event may have been of sufficient impact to cause the creation of several memory trace fragments to deal with parts of the event i.e., the argument, the shooting, questioning by the police, etc.

#### Little or no Affect.

Figure 11 indicates what Dissociative Disorder NOS (DSM III—Atypical Dissociative Disorder) might look like in the BASK model. Automatisms include conditions such as sleepwalking: Behavior is confluent and ongoing, but out of awareness; Affect is not associated with Behavior, and Knowledge of ongoing events is missing, but Sensation is probably continuously present.

Polyfragmented atypical dissociative disorder must be differentiated from polyfragmented multiple personality. In polyfragmented atypical dissociative disorder (ADD) one sees a person who dissociated frequently, for various periods of time, but the dissociation periods and thought processes are not chained together as one sees in ADD with features of multiple personality. One can see patients with ADD with features of MPD who are also polyfragmented due to very, very, severe abuse.

In atypical dissociative disorder with features of MPD, the in-and-out dissociative episodes are chained, but the chained and intermittent life experiences do not qualify as full personalities. They qualify only as fragments. This differentiates ADD with features of multiple personality from typical MPD. This is a polyfragmented individual who may look like a multiple upon first encounter, but who really has one relatively full personality and multiple fragments.

Multiple personality disorder is characterized by:

- The existence within the individual of two or more distinct personality states, each of which is dominant at a particular time;
- The personality state that is dominant has executive control over the individual's behavior;

 Each personality state is complex and integrated with its own unique behavior patterns and social relationships.

• I argue also that these three criteria should be observed consistently, over time before a diagnosis of MPD can be made; an alter personality can be faked in a single or a few encounters.

Clinical features of MPD include:

1. Domination of the patient by one of two or more distinct personalities at any one time.

2. Each personality has a full or nearly full range of different, frequently opposite mental characteristics.

Transition from one personality to another is either sudden or gradual.

 Amnestic barriers are found between personalities, and there may be co-consciousness of personalities.

The presentations must be consistent and repeated over time.

On the continuum of dissociation (Figure 3), atypical MPD precedes MPD as read from left to right. Follow-

ing the continuum of dissociation, then, Figure 12 is a BASK-model characterization of atypical MPD.

These are patients who do not, at first encounter, appear to suffer MPD because there is no disruption in the Knowledge element of BASK. They appear to have unbroken memory. They create the unbroken Knowledge of events during sleep, when all of the personalities exchange information among themselves.

In Figure 12 there are two personalities and two fragments: Personality A, the host, represented by the thin line, Fragment B the black box above the line, Fragment C the black and grey below the line, Personality D the black and grey straddling the ling. Grey areas represent periods of co-consciousness, when one personality is observing, or "looking through" while another (indicated by black) is holding executive control of the body. Thus, the time of existence of Personality D represents the time of co-consciousness plus the time in executive control. The same is true of Fragment C. Personality A does not have co-consciousness and represents a relatively typical host.

In typical or true MPD (Figure 13), even Knowledge is fragmented. All elements of BASK are encoded as elements of discrete personalities.

Here we see the host personality A who has no coconsciousness, and D who has periods of both executive control and co-consciousness. Also present are Fragment C with co-consciousness, and Fragment B without co-consciousness. In the total system of available memories, the memories sum to more time than actually elapsed. The explanation for this is co-consciousness, and what one might call the "Rashomon phenomenon" where two personalities view an event from different perspectives. Sometimes a multiple can be identified because of these incongruent memories.

The polyfragmented multiple personality is a person who qualifies as having MPD by having at least two personalities and many fragments. These are the patients who have in the past astonished physicians and the public with their large number of personalities. Reports about them are so unbelievable that the entire principle of MPD is brought into question by skeptics. The polyfragmented multiple personality patient is best thought of, and treated, as what he/she is- a person with a few personalities and many fragments. The fragments require less intensive therapeutic work to achieve integration.

#### CONCLUSION

This article has explored the BASK model of dissociation and demonstrated its utility in the conceptualization and description of a wide range of clinical phenomena. It appears to have considerable value in clarifying the characteristics of a number of mental disorders, and has the potential to facilitate the resolution of certain differential diagnostic issues. In a subsequent contribution, the relevance of the BASK model to pragmatic psychotherapeutic interventions will be explored.

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Figure 1. The BASK Model of Dissociation. Dissociation can occur at any level, i.e., any BASK component may be separated from any other(s) at a given point in time and congruent at others. The arrows represent the passage of time.

### CONTINUUM OF AWARENESS



Figure 2. The Continuum of Awareness. "Full" has quotation marks around it because due to the action of the nervous system, especially the reticular activating system, we are never completely aware of everything.



Figure 3. The Continuum of Dissociation. The lower section is an attempt to demonstrate parallels between dissociative episodes and dissociative disorders and more common physiplogic and medical phenomena.



gure 4. Hypnotic Anesthesia. For hypnotic anesthesia to be obtained, affect and sensaon must be dissociated from behavior and knowledge.

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Figure 5. Repression as portrayed by the BASK Model. The actual passage of time and the second set of four lines, the subject's perception of time, are the same. However the consciously available memories are less due to repression.

## MEMORY vs. KNOWLEDGE



Figure 6. The differentiation of Memory and Knowledge by the BASK Model. A true memory has at least the ASK component of BASK and must be differentiated from the reporting of knowledge. (Q stands for question or stimulus.)

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..... Image of Action

Figure 7. BASK representation of testing behavior Monitor Image (MI) against Image of Action (IA). TOTE = Test: does MI = IA? Operate—check MI against IA; Test—check your vork and if so, Exit, go on to next behavior. If not, go on to error signal.

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s		and related events lost.
K		
Continuous		
B	·····»	
A	·····»	Each successive event is forgotten
S	·····	as it occurs.
к		

Figure 8. The BASK representation of the four types of amnesia.

### 15

# **PSYCHOGENIC AMNESIA**





Figure 11. The BASK representation of Atypical Dissociative Disorder. The ADD is the same chaining as in MPD, but the duration of history is only sufficient to qualify for B, C, and D as fragments.

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### Figure 13. The BASKL representation of Multiple Personality Disorder. The grey areas indicate periods of co-consciousness. Therefore, it can be seen that the histories of Fragments B and C, when added to the histories of Personalities A and D, create a summated life experience greater than the actual passage of time.

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Figure 14. The influence of the three P's (Predisposing Factors, Precipitating Events, Perpetuating Phenomena) on the creation of Multiple Personality Disorder. Solid arrowheads indicate a greater degree of influence than do open arrowheads. (From page 53 in R. Kluft, M.D., (Ed.) Childhood Antecedents of Multiple Personality, American Psychiatric Press, Inc., Washington, D.C., 1985). Reprinted with permission).

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Figure 15. The Treatment of MPD and ADD. The 13 issues need to be dealt with, but often one goes back and forth with or without skips during real treatment as the therapeutic situation dictates. (Adapted from page 19 in B. Braun, M.D., (Ed.) Treatment of Multiple Personality, American Psychiatric Press, Inc., Washington, D.C., 1986. Reprinted with permission).

POST-

TRAUMATIC

STRESS

DISORDER

DISSOCIATIVE

DISORDER

DISSOCIATIVE

**EPISODE** 

NORMAL



TREATMENT

ATYPICAL

DISSOCIATIVE

DISORDER

ATYPICAL

MULTIPLE

PERSONALITY

DISORDER

MULTIPLE

PERSONALITY

DISORDER

POLYFRAGMENTED

MULTIPLE

DISORDER

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**BASK MODEL** 



# Behavior Affect Thought Sensation

(TOTE using old BASK)

Figure 16 shows the dynamic model of BASK-BATS where Thought as an active process is substituted for knowledge, a static phenomenon. It also shows the interactions of 2, 3, and 4 of the BATS dimensions.

**BEHAVIORAL CLUE** 



# Patient staring and rocking.

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## AFFECT CLUE



; Figure 18. The use of an affect clue is psychotherapy. Rage and agitation reported and observed.

## SENSATION CLUE (Somatic Memory)



igure 19. The use of a sensation clue is a somatic memory, in psychotherapy. Clue observed by therapist: burn blister on left arm as well as blister on right arm without thermal injury.

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# SENSATION CLUE (Psychosomatic Illness)



Figure 20. The use of a sensation clue, a psychomatic illness, in psychotherapy. Clue reported to therapist: stuffy nose and nausea.

**KNOWLEDGE CLUE** 



Figure 21. The use of a knowledge clue in pychotherapy. The knowledge was report of the dream.

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