

THE BASK MODEL OF DISSOCIATION:

Part II- Treatment

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ABSTRACT

This article is a continuation of the BASK Model of Dissociation: Part I, which discussed the phenomena and theory of dissociation. It uses the previously described BASK Model (Behavior, Affect, Sensation, Knowledge levels within a time continuum) and applies it to treatment. Since treatment is a dynamic concept and knowledge is a static term, BASK is changed to BATS, wherein the active term "thought" is substituted for "knowledge." The interrelationship of the various dimensions of the BATS model is demonstrated and described. The BASK format is used to describe how a behavior, affect, thought and/or sensation clue is used to track down and synthesize the BASK/BATS components in psychotherapy through work with different personalities and/or fragments. A main thesis is that congruence of the BASK/BATS levels across the space/time continuum is required for healthy functioning. It is hoped

from this discussion that the reader will get a sufficient understanding of the practical use of the BASK model and that he/she might apply it to her/his school and practice of psychotherapy.

The therapist's intention in treating a patient with a dissociative disorder is to help the patient reshape the dissociative experience and make it congruent with regard to Behavior, Affect, Sensation, and Knowledge (BASK), as well as space/time (i.e., *here and now* vs *then and there*). If this goal is to be achieved under therapeutic guidance, the patient should be able to restore the dissociated aspects to the ongoing flow of consciousness and reestablish its integrity. The purpose of this paper is to use the BASK model of dissociation to propose an explanation of the dissociative process and offer illustrations of its application in therapy.

In the BASK model (Figure 1) the main stream of consciousness is conceptualized as made up of four processes — Behavior, Affect, Sensation (including perception) and Knowledge — functioning along a time continuum represented by arrows. When the integral BASK components are consistently congruent over time, consciousness is stable and the mental processes are healthy. If dissociation is defined as the separation of an idea or thought process from the ongoing flow of

Bask Model

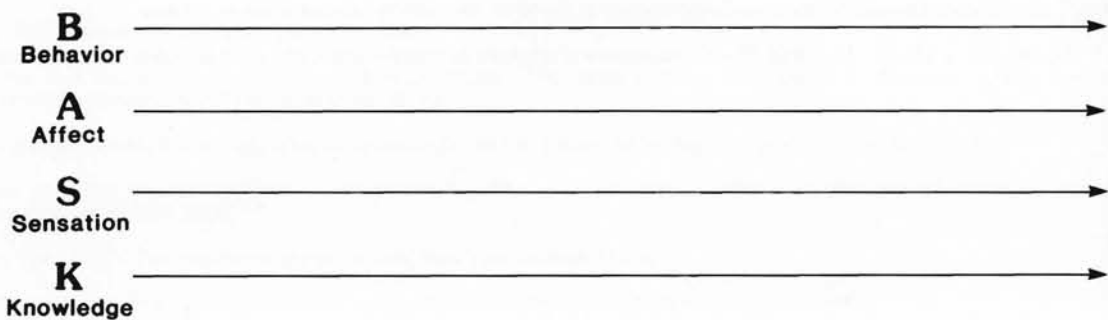


Figure 1: The BASK Model of Dissociation. Dissociation can occur at any level, i.e., any BASK component may be separated from any other(s) at a given point in time and congruent at others. The arrows represent the passage of time.

consciousness, the BASK model may be used to illustrate dissociation occurring on any one or more of these four processes or levels. Automatism is an example of dissociation on a single level, Behavior. Multiple personality disorder is the most extreme example of dissociation and separate association across all levels.

The BASK concept is placed in different perspective by a brief discussion of the proposal made by Braun and Sachs (1985) regarding the development of multiple personality disorder. A model for understanding the genesis of MPD was established on the basis of predisposing, precipitating and perpetuating factors: the 3-P model (Figure 2). It takes account of the theoretical proposal made in 1984 (Braun, 1984a) regarding the etiology of multiple personality and dissociation and the apparent role played by state-dependent learning and neuropsychophysiologic (NPP) states — a view summarized in Part 1 of this paper (Braun, 1988).

In brief summary, I proposed (Braun 1984a, 1985) that multiple personality disorder (MPD) is the extreme end of a continuum of dissociative phenomena that includes hypnosis, repression, ego states, and atypical dissociative disorder (see upper section of Figure 4, below). The MPD patient and the easily hypnotized person share the characteristic of being *dissociation prone*, but MPD is not explained merely by the ability to dissociate. MPD is the result of repeated dissociative episodes that occur under extreme stress — usually the stress of severe and inconsistently administered child abuse. Dissociation is a defense mechanism for the *dissociation prone* victim who must escape from some untenable conflict — e.g., severe, unpredictable abuse from an otherwise *loving* mother. The dissociative episodes frequently have similar NPP affective states that pro-

mote the linking together of the episodes in a chaining of congruent, stable behavior patterns, memories, ranges of emotion and response patterns. Over time, an alter personality/fragment with its own behavioral repertoire, life history, and range of affect is formed, shaped and expressed.

Although independently derived, the 3-P model (Braun & Sachs 1985) bears significant similarity to Kluft's (1984) 4-factor theory of MPD. In the 3-P proposal, the two major predisposing factors for MPD are (1) a natural, inborn capacity to dissociate, and (2) exposure to severe, overwhelming trauma such as frequent, unpredictable and inconsistently alternating abuse and love, especially during childhood. Both of the factors, taken together, are hypothesized as a necessary cause of MPD, but neither cause is sufficient to cause the disorder. There is documentation now in more than one thousand patients to demonstrate that severe child abuse is a predisposing factor in 95% to 98% of MPD (Putnam, Guroff, Silberman, Barban, & Post, 1986; Schultz, Braun, & Kluft, 1985; Schultz, Kluft & Braun, 1986; Braun & Gray, 1986; Braun & Gray, 1987; Braun, 1984b).

The most common events linked to precipitation of MPD is some form of abuse that triggers defensive dissociative episodes. When such events are related by a common NPP or adaptational theme, the dissociated elements begin to develop a life history and behavioral style of their own, and an alternate personality begins to develop.

Perpetuating factors are personal, interpersonal and situational. The personal perpetuating factor may be the patient's repeated use of dissociation as a defense against stress; interpersonal factors usually relate to family dynamics and may include ongoing abuse; situational variables include societal attitudes, such as a family's literal interpretation of "spare the rod and spoil the child".

MPD develops most easily when the fragments/segments that are lost were congruent for BASK. Polyfragmented atypical dissociative disorder and polyfragmented multiple personality disorder appear to develop when the incongruence is not only on the time continuum, but also in the levels of BASK (Figure 3). This usually occurs when the incident causing the

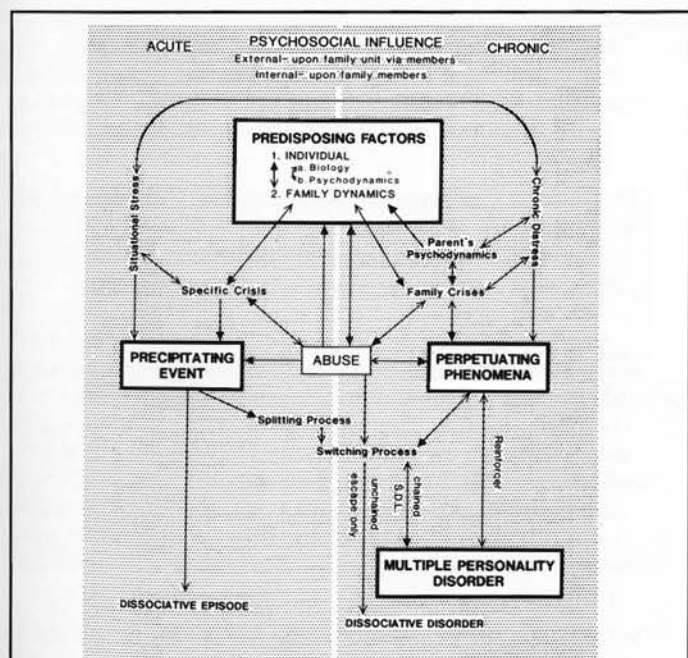


Figure 2: The influence of the three P's (Predisposing factors, Precipitating Events, Perpetuating Phenomena) on the creation of Multiple Personality Disorder. Solid arrowheads indicate a greater degree of influence than do open arrowheads. (From page 53 in R. Kluft, M.D., (Ed.) *Childhood Antecedents of Multiple Personality*. American Psychiatric Press, Inc., Washington D.C., 1985. Reprinted with permission.)

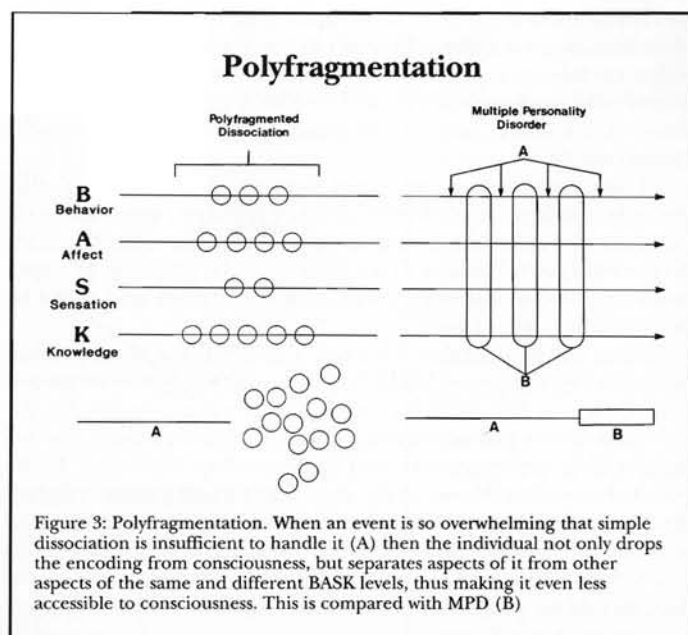


Figure 3: Polyfragmentation. When an event is so overwhelming that simple dissociation is insufficient to handle it (A) then the individual not only drops the encoding from consciousness, but separates aspects of it from other aspects of the same and different BASK levels, thus making it even less accessible to consciousness. This is compared with MPD (B)

dissociation is so traumatic as to severely, rapidly, and repeatedly overwhelm not only the congruence in time, but the congruence between and within each of the BASK levels as well. Such a situation will be illustrated in Case 1 - Behavioral Clue, below. In Figure 4, the continuum of dissociation is adapted to display aspects of treatment of MPD (Braun 1986). Issues 3 through 8 are adapted for the treatment of the patient with atypical dissociative disorder, called Dissociative Disorder NOS in the new DSM-III-R (1987).

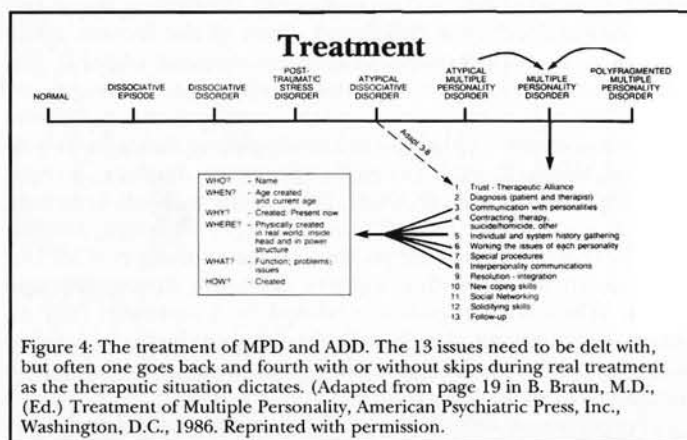


Figure 4: The treatment of MPD and ADD. The 13 issues need to be dealt with, but often one goes back and forth with or without skips during real treatment as the therapeutic situation dictates. (Adapted from page 19 in B. Braun, M.D., (Ed.) *Treatment of Multiple Personality*, American Psychiatric Press, Inc., Washington, D.C., 1986. Reprinted with permission.

In the treatment of MPD, trust is the first and essential basis for all that follows. Trust is the critical first step to establishing contact, and trust is the critical bond that must be maintained to make continuing therapy possible. If trust breaks down, reasons must be sought within the therapist, within the patient, or within the always tenuous therapist/patient relationship. Specifically, but certainly not exhaustively: (1) the therapist may be judged unworthy of trust because he is missing salient issues in the lives of the personalities; (2) the therapist may create actual mistrust by his actions, words or omissions; (3) the patient may be unable to trust himself enough to grant trust to the therapist, perhaps because the patient does not understand the *switching* that occurs within himself; and (4) the patient may be on the edge of taking a positive therapeutic step and/or about to reveal and work on a *secret*, so the reduction of trust serves as a form of resistance. Also, (5) the patient may mobilize a negative transference.

Trust is not merely an initial first step. It is a first step that must be made over and over again as therapy progresses with the known personalities and as contact is made with the newly discovered personalities. Trust must never be taken for granted, for it is constantly being tested and withdrawn and must be reestablished repeatedly.

After the foundation for trust is laid and the therapist has made the diagnosis of MPD, he/she must share the diagnosis with the patient. Timing is crucial. If the therapist withholds the information at the beginning of therapy for too long, the patient will become restless and seek another therapist. If the diagnosis is shared too early, the patient will panic and bolt from therapy. When the diagnosis is shared and accepted by the patient, the patient may be overjoyed because finally things make sense and she/he feels understood. However, the therapist should be prepared to face a therapeutic crisis. Very soon

there will be significant acting out because the *discovery* of MPD also is the discovery of its psychic rationale, secrecy, and thereby threatens to reveal past experiences of child abuse, which is always a secret that must be kept from both the internal and external worlds. The discovery of the secret often causes psychic chaos.

When trust is established and the diagnosis shared, the door to the beginning of therapy for MPD is finally opened. Next, the therapist must find out how this constellation of personalities works. He must establish communication with the personalities and obtain a history of each. For issues 3 through 8 of Figure 4, the following questions and concepts can help to gather the necessary information for treatment:

- **Who are you?** A personality may be defined as a set of thought processes with concomitant behavior and psychophysiology. *Who* or *Name* or descriptor is the address, in computer terms, where a specific set of thought processes with their concomitant neuropsychophysiology and behaviors may be accessed and called forth. Later, the therapist will return to this *address* to do psychotherapy around specific issues — e.g., shoplifting behavior.
- **When were you created?** *When* is an essential clue to the age of the personality and how long it has existed; Knowing *when* also is a clue to the possibility of a significant trauma at that time and to other personalities who may be related in some way. If a personality does not know its age, it still will have an earliest memory that may be retrieved; e.g., if the earliest memory is of junior high school, the personality may have been created at the patient's biological age of 12 to 14 years.
- **Why were you created?** In seeking *why*, the therapist is looking for precipitating and perpetuating events associated with this personality's development, and why this alter is present at this specific time in life and/or in therapy. Other personalities may be able to furnish important *why* information about this personality that it is unable to provide.
- **Where were you created?** Where was the body when you were created? Where are you in the power structure of personalities (who do you control and who controls you)? *Where do you live in the patient's head?* is a projective technique and obviously the therapist would not accept as reality the personality's response "behind the right eye". Nevertheless, the response is an important clue to location of this personality in a system of personalities and their functions. As therapy progresses, the patient may be asked to draw a map of his psyche, charting out the system of personalities. Over time the map will change and help to document progress in therapy (Braun, 1986b; Braun & Sachs, 1986). Other special techniques serving similar uses include sand tray therapy (Sachs & Braun 1986) and art therapy.
- **What are your functions?** What do you do that aids or balances the system of personalities? What are your issues and problems?
- **How were you created?** How were your elements put together? Are you an original, or do you believe you were put together from parts of other previous personalities?

How may provide some early clues to possibilities for integration especially if the therapist also detects indications of co-presence — i.e. as one personality interacts with the therapist, another one observes at the same time. The given personality may not know the answers to the *how* questions any more than one may know the reason for her/his conception. However, someone else in the system of personalities may know this, and the information will yield a clue to the thinking process of the individual.

The question of integration must be approached with great caution. Some personalities will see integration as tantamount to death. They need to be reassured that they will not disappear, but will continue to contribute to one, unified, whole person. A useful analogy is that of red paint and white paint joining to make a greater amount of pink paint. The therapist also must be absolutely sure regarding *who* to integrate. A meek and submissive personality is probably not a good candidate for integration with a rageful one or a martial arts expert unless all individual issues and integration issues have been processed carefully and resolved.

Psychotherapy for MPD is a dynamic process. While the BASK model is useful in describing MPD, the understanding of the therapeutic process requires a dynamic model. That model is outlined in the next section.

BASK/BATS in Psychotherapy

The reason that knowledge in BASK is changed to thought in BATS is that the BATS model is a dynamic one rather than static and descriptive. Thought is an active term, as in therapy, and knowledge is a passive one. BATS attempts to look at the results of congruence or noncongruence of the BASK levels of the individual's thought processes.

Psychotherapy uses the Test-Operate-Test-Exit (TOTE) principle to bring the elements of BASK into congruence. We saw earlier, in illustration of identity (Braun, 1988), that when behavior, affect and thought are congruent, we experience a sensation of satisfaction or calm that all is well. When behavior, affect, thought and/or sensation are incongruent, we suffer an error signal or anxiety. I believe that congruence is the major goal of psychotherapy especially in patients with dissociative disorders.

The dynamic BATS process model (Figure 5) brings all BASK ele-

ments into active congruence. The congruence of some, but not all, of the BATS elements may yield a variety of results, some of which may be desired and some not. Congruence of all of the BATS elements, especially in continuous relation to space/time, yields a healthy individual.

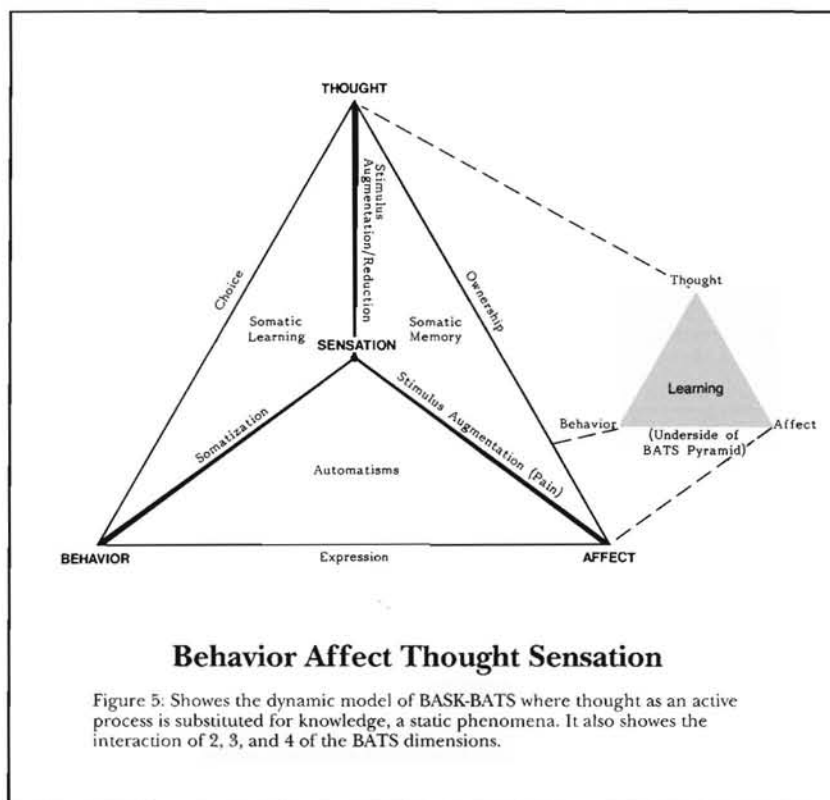
Congruence & Outcome:

- Behavior/Affect = Expression
- Behavior/Thought = Choice
- Behavior/Sensation = Somatization
- Affect/Thought = Ownership
- Affect/Sensation = Stimulus Augmentation (i.e., pain)
- Thought/Sensation = Stimulus Augmentation or Reduction
- Sensation/Affect/Thought = Psychophysiologic or Somatic Memory
- Sensation/Thought/Behavior = Disorder of Feeling (i.e., alexithymia)
- Behavior/Affect/Thought = Learning
- Behavior/Affect/Sensation = Automatism
- Congruence (of all BATS over time) = Mental Health

Five illustrative uses of the BATS model involving patient material will be presented and should make its utility apparent. In each of the following five cases, hypnotherapy was used to assist psychotherapy in (1) recovering lost material, and (2) chaining together the BASK/BATS elements that were not congruent. When congruence was achieved the episode was brought to an end and suffering reduced.

The case examples below will be used to illustrate how one uses the BASK/BATS concepts to chain together information

that was unavailable to the consciousness of the host personality to help gain congruence of BASK/BATS on the space/time continuum. The patient is taught to use full knowledge of *both* similarities and differences to differentiate here and now from then and there, and to bring present reality and thinking to bear on the previously incongruent BASK to modify it and make a new, more adaptive, congruent BASK. In each of the examples, as in all psychotherapy, information known before the clue was noted was used as a basis for the exploration and chained together with information obtained from the various personalities, fragments, etc.



Case 1. BEHAVIORAL CLUE (Figure 6):

The patient was a 32-year-old single white female with MPD who was diagnosed as suffering from migraine headaches which were usually right-sided, often accompanied by an erythematous area on the right temple, and preceded by flashing lights, tinnitus, and nausea. She was found staring into space and rocking (behavioral clue) shortly after a loud noise caused by another patient dropping a heavy book on the floor. When she was able to talk she complained of a severe right-sided headache. A quarter-size erythematous area was noted above the lateral aspect of her right eye. She said that she had experienced the usual aura for a very short duration as the rocking started. She said she had been terrified by the noise. It was noted that she was again dissociated, staring into space, and was wringing her hands in an unusual manner. I asked her if her hands felt sticky, and she replied "Blood — blood, blood — blood, blood, blood." With some prodding, the following story was pieced together from various alters using new information and previously known information.

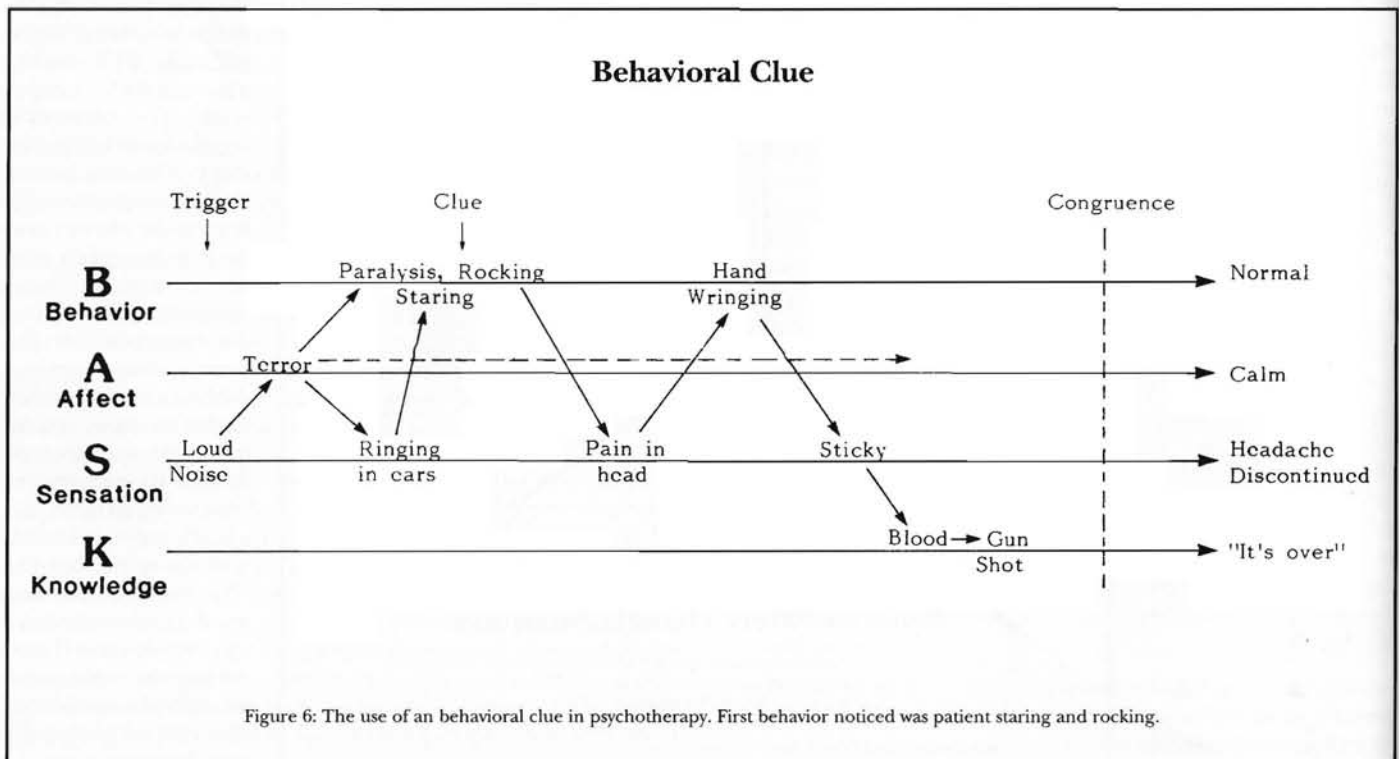
When the patient was five years old, her father and uncle got into a fight in her home. She was afraid and ran to hide under the basement stairs. Shortly her father and uncle came tumbling down the stairs and landed near where she was hiding. The two men separated; her father picked up a revolver from the workbench and shot her uncle six times, blowing off part of his head and killing him. She crawled out and attempted to put her uncle's head back together. Her hands were covered with blood and she froze. Her father put the hot gun to her head and snapped the trigger while she was staring at her uncle, causing further dissociation. Her father made her help him dismember the uncle's body with a hatchet, and when she struck the chest the corpse moaned due to air expelled from his lungs by the blow. Her father used this to prove to her that she had killed her

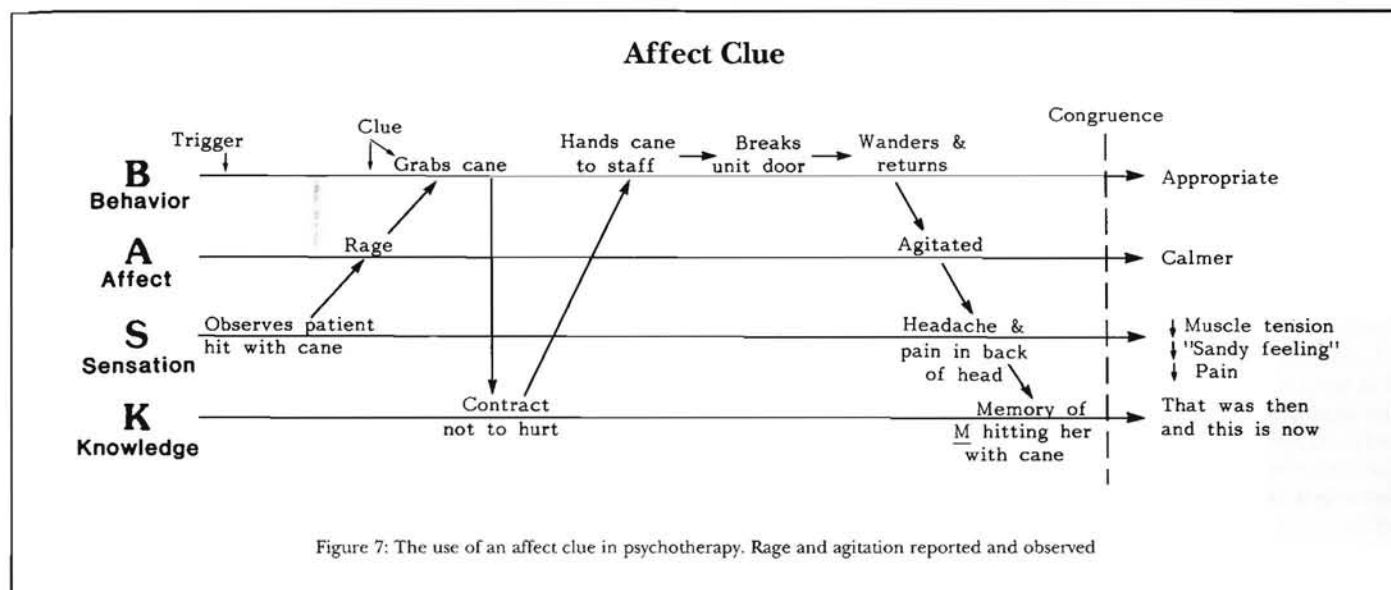
uncle, and thus assured her keeping of their mutually-held secret. This prevented her from processing the incident until she did so in psychotherapy. The polyfragmentation was frozen in time and kept separate via multiple dissociations (see Figure 3).

The patient suffers polyfragmented MPD. This incident was so traumatic that it was encoded or filed in many different special purpose and memory trace fragments which had to contribute their pieces before the full chain of events and their meaning could be appreciated. For example, one special purpose fragment just rocked, another wrung her sticky hands, while other memory trace fragments knew about the fight, hiding, the gunshots, etc. When this was finally pieced together the host personality could understand, say "It's over," and relax. Her behavior became normal, she felt calm, and her headaches dissipated. It appears that the headaches were caused by rapid switching between fragments and special-purpose fragments that she created to cope with the panic and the overwhelming experience. This was all reactivated through intrapsychic association which was stimulated by the loud noise.

From the above description one can see how symptoms of her migraine headaches were caused by her polydissociated memory. The aura of flashing lights were the flashes of the gunshots in the dark basement. The ringing in her ears was originally created by the loud retorts of the gun's firing. The nausea was secondary to the revulsion of looking at her uncle's dead body and what she was forced to do. The rocking behavior was similar to what she had done under the stairs, and the erythematous area was a psychophysiologic memory of where her father had pressed the hot gun to her head.

I have described this example in great detail to give the reader a feeling for the process. The following examples of affect, thought and sensation clues will be more brief.





Case 2, AFFECT CLUE (Figure 7):

The previous patient (Case 1), who walked with a cane, was hospitalized at the same time and on the same unit as a 25 year old single white female patient who also had MPD. The two women became friends in the hospital. Both were standing in the dayroom when a manic patient took the first patient's cane and hit her. This behavior was the trigger for this patient to become *enraged*; she took the cane from the manic patient and drew it back to hit her. She then remembered her contract not to hurt herself or anyone else internal or external (Braun, 1984c, 1986). She knew she had to leave the unit or she would hurt someone, but was too upset to ask; she kicked out the door of a locked psychiatric unit and left. She wandered the hospital

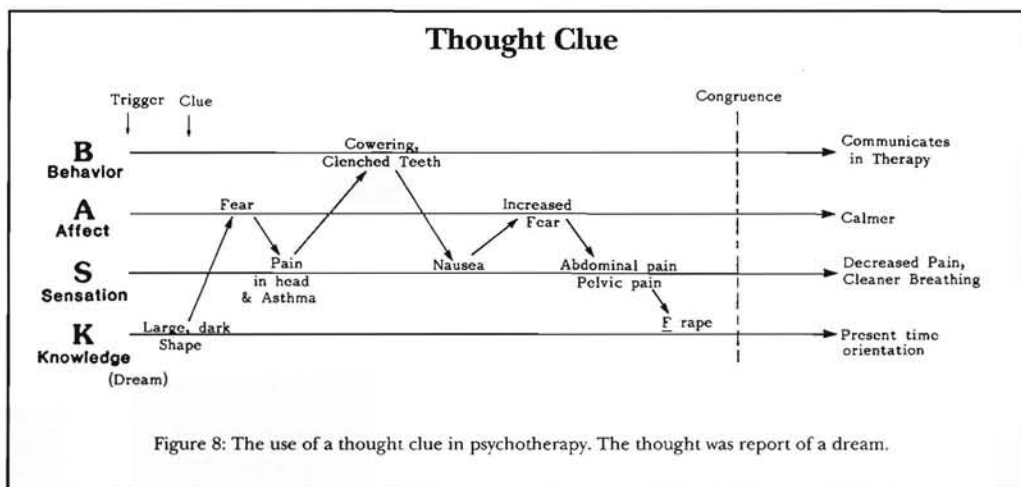
for a while, then returned to the unit and apologized for the damage.

She was still agitated when the incident was processed with the aid of hypnotic relaxation. She commented that she had a headache and a severe pain in the right occipital area. She then was able to retrieve the memory of her mother hitting her in the back of the head with a cane as she attempted to run from her mother. With some additional hypnotic work to stop the pain (somatic memory) she was able to realize the critical difference between the incidents, and differentiate between then and now, allowing congruence of BATS. She became more calm, her muscle tension eased and the pain in her head significantly decreased.

Case 3, THOUGHT CLUE (Figure 8):

The trigger for this young woman was a dream just prior to her discharge from the hospital. The dream image of a *large, dark shape* hovering over her was accompanied by fear and anger (affect), trouble breathing and pelvic pain (sensation), and she was bent over in pain (behavior). This caused her to realize that the dream was a memory of what had actually happened to her, and was causing the symptoms. The recovered memory was of her being orally (clenched teeth) and vaginally (abdominal pain) raped by her father when she was a child. She had better control of her symptoms as an adult, but when a trigger such as the dream returned her to the behavior, affect and sensation of the rape, she lost the control. Under hypnotherapy the memory could be

recovered of her father standing in her doorway before raping her, allowing for congruence of BASK/BATS and resolution of the symptoms.



Case 4. SENSATION CLUE (SOMATIC MEMORY) (Figure 9):

This 23-year-old single white female felt anxiety (affect) and a burning sensation on her right forearm. She then actually burned her left forearm with a cigarette. This caused a reduction in her anxiety, and significantly inhibited her communication in psychotherapy (behavior). When she attempted to talk this potentiated and increased the sensation of burning in her right arm, which resulted in actual blister formation in previously burned areas on her right forearm. The chaining of facts (knowledge) yielded the memory recovered in hypnotherapy, of an abusive mother burning her with cigarettes and warning her *not to tell*. Her work in psychotherapy was perceived as *telling* and triggered her burning of herself, done by a maternal introject or

Sensation Clue (Somatic Memory)

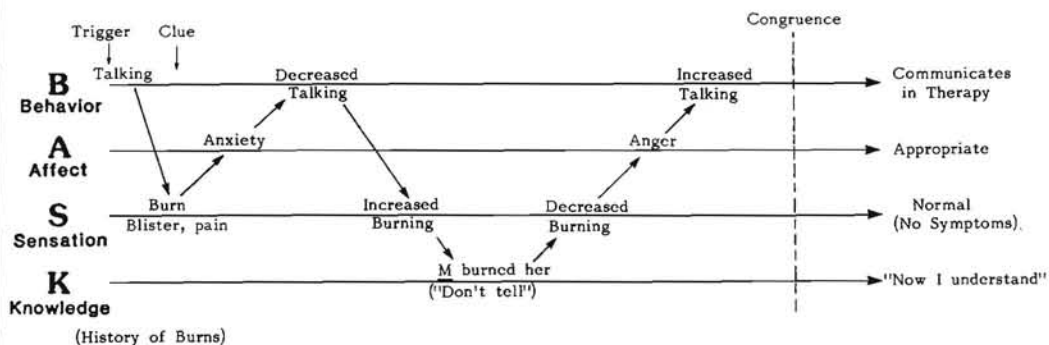


Figure 9: The use of a separation clue, a somatic memory, in psychotherapy. Clue observed by the therapist: Burn blister on left arm as well as blister on right arm without thermal injury.

alter. Psychotherapeutic work with the hypnotically recovered memory changed her thinking, decreased and finally ended the symptoms and thus increased the patient's ability to communicate with the therapist. The blisters absorbed quite rapidly after the revelation in therapy.

Case 5. SENSATION CLUE (PSYCHOPHYSIOLOGIC [PSYCHOSOMATIC] ILLNESS) (Figure 10):

In this patient, a 30-year-old single white female, the trigger for this episode was finding that her new roommate in the hospital was a black woman. Her symptoms of stuffy nose and nausea (sensation), avoidance (behavior), anxiety and fear (affect) were made understandable by chaining with a factual memory (knowledge) of an event in her childhood. She was five years old when her father had been put in jail for speeding and

driving without a license; she had to accompany him to the police holding area where the black inmates taunted her and reached for her through the bars. Her fear was overwhelming, and the fear was linked with the smell of the jail which caused her to become nauseated in conjunction with the fear. When BASK elements were made congruent by therapy, and thought brought current reality to bear, her anxiety was decreased, the symptoms ended, and she related well to the new roommate.

Sensation Clue (Psychosomatic Illness)

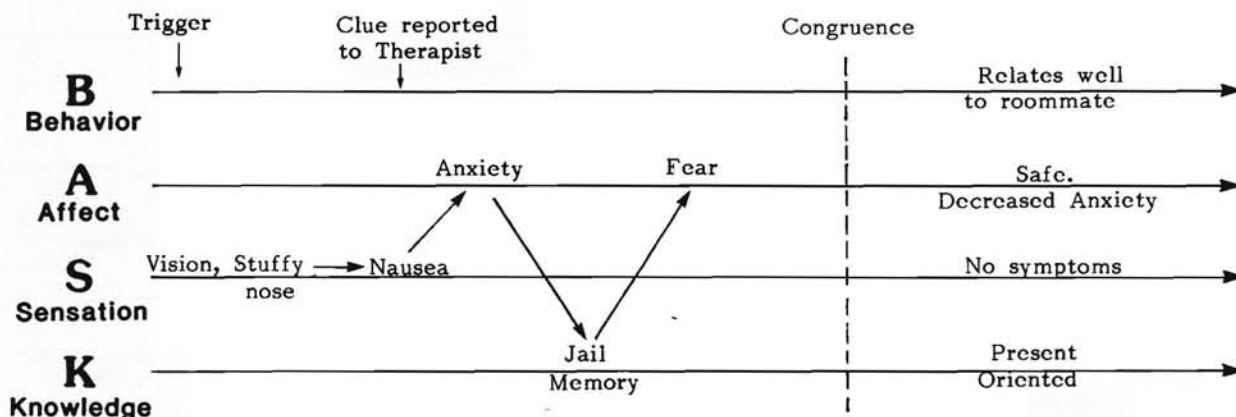


Figure 10: The use of a sensation clue, a psychosomatic illness, in psychotherapy. Clue reported to therapist: stuffy nose and nausea.

DISCUSSION AND SUMMARY

After falling into disuse and nearly into disrepute for decades, today the concept of dissociation is increasingly seen as a powerful tool to both describe and explain a broad range of mental phenomena that are observed in many psychiatric disorders. In cognitive psychology, dissociation is seen as holding important clues to the structure and function of the cognitive unconscious (Kihlstrom, 1987). Today's renewed interest in dissociation may be attributed in some measure to its explanatory power in psychiatry as well as its compatibility with contemporary research in cognitive psychology. Waning interest in behaviorist psychology also opened the way for reconsideration of the dissociation, first proposed by Pierre Janet in 1889 (Janet, 1889), to explain automatisms and other psychopathology that we might today describe as *dissociative*. Also contributing to rekindling of interest in dissociation as a concept in mental disease is the declining force of Freud's dismissal of dissociation in favor of *repression* and the acknowledgement that incest and child abuse really do occur.

The therapist's understanding of dissociation may be enhanced by a two-dimensional model of behavior-affect-sensation-knowledge (BASK) functioning along a time continuum (Figure 1). If dissociation is defined as the separation of an idea or thought process from the ongoing flow of consciousness, then the BASK model of elements of consciousness may be used to illustrate that dissociation can occur on any or all BASK axes.

The BASK model (Braun, 1988) is shown to complement the previously developed neuropsychophysiologic, state-depend-

ent learning model (Braun, 1984a) and the 3-P model (Braun & Sachs, 1985a) of multiple personality disorder (MPD), which postulated that predisposing, precipitating and perpetuating factors are the necessary and sufficient causes of MPD. The relationship between MPD and severe child abuse is made apparent by the three theoretical presentations.

The major assumption of the 3-P model is that dissociation is used defensively by the patient as a fragmentation/compartmentalization process. Personality fragmentation is a heavy price to pay for the escape from pain and conflict; however, it may be what allows for survival at the time. Therefore, the major goal of psychotherapy should be reassociation of fragmented thought processes and their eventual full integration allowing for congruence of BASK/BATS on the space/time continuum.

The goal of psychotherapy is to obtain congruence across all the BASK/BATS dimensions in space/time, thus yielding a decrease of dissociated thought processes, a decreased need for the defense of dissociation, and more control over interactions with the environment. The two-dimensional, passive BASK model is changed into a three-dimensional, dynamic behavior-affect-thought-sensation (BATS) model to relate BASK to the therapeutic process. The outcomes of congruence of two, three, and four of the dimensions are shown, and the BASK model is used to diagram the process of psychotherapy in achieving congruence at all levels on the space/time continuum.

It appears that the BASK/BATS Model is a useful tool in the conceptualization of dissociative disorders and their treatment, as well as in psychotherapy in general.

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