DIFFERENCES BETWEEN TRANCE CHANNELING AND MULTIPLE PERSONALITY DISORDER ON STRUCTURED INTERVIEW

Dureen J. Hughes
Los Angeles, California

Trance channeling and multiple personality disorder both seem to be predicated on the basic mental process of dissociation. Dissociation has been defined, very simply, as the opposite of association. Elements of the psyche may be in a dynamic relationship with each other, in which case thoughts, feelings, experiences, etc. are integrated into consciousness and memory (association). Or these same elements of the psyche may be relatively isolated and separate, in which case they are dissociated (Ross, 1989, p. 87). This concept can be traced to Janet (1977). While dissociation in and of itself is a "normal human ability" (Richards, 1990), it is generally accepted that there is a continuum of dissociative phenomena (Bernstein & Putnam, 1986). Bernstein and Putnam have characterized this continuum as ranging "from the minor dissociations of everyday life to major forms of psychopathology such as multiple personality disorder" (1986, p. 728), while Richards (1990) has characterized it as ranging from automatizations of routine behaviors at one end to "co-consciousness" at the other. While Prince defined "co-consciousness" as simply the simultaneous but separate presence of two streams of consciousness (1978), Richards utilizes Beahrs' definition, i.e., "the existence within a single human organism of more than one consciously experiencing psychological entity, each with some sense of its own identity or selfhood, relatively separate and discrete from other similar entities" (1982, p. 182). Phenomena at the far end of the dissociative continuum are the focus of this paper.

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Dissociation in the form of, or accompanied by, co-consciousness is currently found in at least two forms in our own culture: trance channeling and multiple personality disorder. Trance channeling has been defined by Klimo (1987, p. 2) as "the communication of information to or through a physically embodied human being from a source that is said to exist on some other level or dimension of reality than the physical as we know it, and that is not from the normal mind (or self) of the channel." While this activity could be categorized as a type of "possession" following Winkelman's definition, i.e. "a trance state interpreted by the culture as a condition during which the practitioner's own personality is temporarily displaced by the personality of another entity" (1986, p. 194), it should be noted that the trance channels who participated in this research prefer the term "blending" to describe their trance state. The term "blending" connotes harmony and mutual cooperation between the channel and the entity rather than domination of the channel by the entity (Hughes, 1991). Finally, some authors have chosen to include classic "mediumship" within the scope of trance channeling (Hastings, 1991; Klima, 1987). D. Scott Raga has stated that "mediumship is the art of bringing through spirits of the dead specifically to communicate with their relatives. Channeling I define as bringing through some sort of intelligence, the nature undefined, whose purpose is to promote spiritual teachings and philosophical discussions" (quoted in Klima, 1987, pp. 5-6). It is this last definition that most closely describes the activities of the subjects who participated in this research.

MPD and trance channeling may appear very similar to a casual observer in that there are at least two distinct personalities sequentially inhabiting or controlling the same body in each case. Further, it would seem that trance channels fit the OSM-III-R criteria for MPO, i.e.: "the existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)" and "at least two of these personalities or personality states recurrently take full control of the person's behavior" (American Psychiatric Association [APA], 1987, p. 272). Earlier ethnographic and EEG research with trance channels (Hughes, 1991; Hughes & Melville, 1990) raised questions as to whether or not the phenomena of "channeling" could indeed be understood in terms of multiple personality disorder.

Accordingly structured interviews were conducted with ten trance channels using the Dissociative Disorders Interview Schedule (DDIS), developed by Ross and Heber (Ross, 1989, pp. 314-30) to determine the degree of overlap between the complex of symptoms that characterizes MPO, and the phenomenological experience of the trance channels. These results were compared with the DDIS scores of twenty MPD subjects as set forth by Ross, Heber, Norton
and Anderson in their 1989 article comparing patients diagnosed with MPD, schizophrenia, panic disorder, and eating disorder. In his 1989 book on MPD, Ross has further stated that these results (pp. 330-34 in that publication) are typical of MPD as it presents throughout North America.

All subjects also completed the Dissociative Experiences Scale (DES), developed by Bernstein and Putnam (1986), in order to measure the frequency and the number of different types of dissociative experiences among trance channels. Median DES scores and median numbers of items endorsed were compared for the group of trance channels and two groups of subjects whose scores were reported by Bernstein and Putnam (1986). These latter two groups consisted of twenty MPD subjects, and thirty-four normal adults.

METHOD

The Dissociative Disorders Interview Schedule

The DDIS is a 131-item structured interview which differentiates MPD from several other psychiatric disorders, as well as from normals, using DSM-III diagnostic criteria (American Psychiatric Association [APA], 1980). It has an overall interrater reliability of 0.76, a sensitivity of 90%, and a specificity of 100% for the diagnosis of MPD (Ross, et al., 1989). Rather than giving a total overall score, it provides a profile of scores in a number of areas which can then be compared with a typical profile for an MPD patient (Ross, 1989).

The Dissociative Experiences Scale

The DES is a 28-item self-report instrument with a reliability of .84. While the DES is a screening, rather than a diagnostic instrument, it does generally distinguish between subjects who have a dissociative disorder and those who do not (Bernstein & Putnam, 1986; Ross, 1989).

Subjects

The ten trance channels who participated in this study are the same subjects who participated in a study measuring brainwave activity of trance channels while both in and out of trance (Hughes & Melville, 1990). All had been channeling for longer than one year, two had been channeling as long as seven years, and the modal experience was 2½ to 3 years.
None of the subjects had any psychiatric diagnoses currently active. Two subjects had previous diagnoses of anxiety disorder, one subject had a previous diagnosis of depression, and one subject had previous diagnoses of both depression and obsessive compulsive disorder. Seven of the ten had no physical diagnoses currently active. Of the remainder, one 74-year-old subject had cardiac dysrhythmia, one 64-year-old subject had high cholesterol and a bladder problem, and one 35-year-old subject had rheumatoid arthritis, lupus, autoimmune disease and migraine headaches.

Ethical approval (in the form of a Statement of Exemption) for interviewing the subjects had been obtained from Human Subject Protection Committee at the University of California, Los Angeles.

Interview Administration

Nine of the subjects were interviewed by the author. Each interview (DDIS and DES) lasted approximately forty-five minutes. One subject had moved out of the area and so was mailed a modified DDIS, i.e. all major subject headings and "notes" to the interviewer that may have biased the subject against positive responses (due to implications of psychopathology) were removed. Actual interview questions remained unchanged. The unmodified DES was also completed by the subject through the mails.

Data were analyzed using t-tests for continuous data, Fisher's exact test for dichotomous data and comparison of DES medians.

RESULTS

Demographic Characteristics of Subjects

The ten subjects were evenly divided as to sex. They ranged in age from 31 to 74, with a mean age of 47.6 (S.D. =13.17). Four were married, and as a group they had a mean of 0.6 children (S.D. = 1.07). All but one of the subjects had some post-secondary education; four had attained Bachelor's degrees, two had Master's degrees, and two had Ph.Ds. Occupations varied widely, but all were employed and all could be classified as middle- to upper-middle class. Eight had never been jailed; the other two had each spent a few hours in jail for minor infractions.

Clinical Characteristics of Subjects

As shown in Table 1, the trance channels differed from the MPD subjects on all of the DSM-III diagnoses made by the DDIS. While
the differences between the trance channels and the MPD subjects were not significant at the .05 level with regard to DSM-III diagnoses of psychogenic fugue and somatization disorder, it should be noted that this is due to the (relatively) small percentage of MPD subjects positive for these diagnoses, as none of the trance channels were positive for these diagnoses. The average number of somatic symptoms (used in diagnosing somatization disorder) for the MPD subjects in 13.5 (Ross, 1989, p. 331), which compares with an average number of somatic symptoms for the trance channels of 1.8 (p < .0001). The average number of borderline criteria positive for the MPD subjects is 5.3 (Ross, 1989, p. 332) which compares with an average number of borderline criteria positive for the trance channels of 0.3 (p < .0001).

TABLE 1
DIFFERENCES BETWEEN TRANCE CHANNELS AND MPD ON DSM-III DIAGNOSES

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>TRANCE CHANNELS</th>
<th>MPD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N= 10 NUMBER POSITIVE</td>
<td>N=20 NUMBER POSITIVE</td>
</tr>
<tr>
<td>Psychogenic Amnesia</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Psychogenic Fugue</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Depersonalization Disorder</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Multiple Personality Disorder</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Somatization Disorder</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Major Depressive Episode</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>0</td>
<td>12</td>
</tr>
</tbody>
</table>

*Not statistically significant at the .05 level

TABLE 2
DIFFERENCES BETWEEN TRANCE CHANNELS AND MPD ON HISTORICAL ITBMS

<table>
<thead>
<tr>
<th>ITEM</th>
<th>TRANCE CHANNELS</th>
<th>MPD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N= 10 NUMBER POSITIVE</td>
<td>N=20 NUMBER POSITIVE</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>11</td>
<td>.02</td>
</tr>
<tr>
<td>Sleepwalking</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Trance states</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Imaginary playmates</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>15</td>
<td>.001</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>16</td>
<td>.0004</td>
</tr>
</tbody>
</table>

*Not statistically significant
As shown in Table 2, the trance channels differed from the MPD subjects on four of the six historical items known to be associated with MPD.

As shown in Table 3, the trance channels differed from the MPD subjects on sixteen secondary features of MPD. These include objects missing or present where the person lives, handwriting changes, strangers knowing the person, doing or saying things one cannot remember, periods of missing time, "coming to" in an unfamiliar place, amnesia for large parts of childhood after age five, flashbacks, depersonalization, auditory hallucinations, speaking of oneself in the plural tense, and feeling that there is another person inside of one who has a name and takes control of one's body. The trance channels also differed from the MPD subjects with regard to sixteen types of supernatural experiences which included such things as mental telepathy, clairvoyance, telekinesis, clairvoyant dreams, deja vu, feeling possessed, having contact with ghosts, poltergeists, or spirits, knowing something of past lives, and being involved in cult activities. Finally, the two groups differed with regard to eleven Schneiderian first rank symptoms of schizophrenia.

### Table 3
**Differences Between Trance Channels and MPD on Associated Features**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>TRANCE CHANNELS</th>
<th>MPD</th>
<th>(P-VALUE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 10 AVERAGE</td>
<td>N=20 AVERAGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary features of MPD</td>
<td>2.3</td>
<td>8.3</td>
<td>.0001</td>
</tr>
<tr>
<td>Supernatural experiences</td>
<td>9.5</td>
<td>5.5</td>
<td>.001</td>
</tr>
<tr>
<td>Schneiderian symptoms</td>
<td>1.6</td>
<td>6.6</td>
<td>.0001</td>
</tr>
</tbody>
</table>

### Table 4
**Comparison of MPD, Trance Channels and Normals on DES**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>TRANCE CHANNELS</th>
<th>MPD</th>
<th>NORMALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 10</td>
<td>N=20 (P-VALUE)</td>
<td>N=34 (P-VALUE)</td>
<td></td>
</tr>
<tr>
<td>Median DES score</td>
<td>5.66</td>
<td>57.06 (.01)</td>
<td>4.38 (NS*)</td>
</tr>
<tr>
<td>Median number of DES items endorsed</td>
<td>12.5</td>
<td>28 (.01)</td>
<td>11 (NS*)</td>
</tr>
</tbody>
</table>

*p-values denote difference between that group and trance channels.

*Not statistically significant
While Ross, et al. do not provide data with regard to the average number of previous psychiatric diagnoses for the twenty MPD subjects, two large series of MPD patients have yielded averages of 3.6 and 2.74 (Putnam, et al., 1986; Ross, Norton, & Wozney, 1989). The average for the trance channels was 0.5, and when compared to 2.74 (the Ross, et al. large series average), is significant at the .0001 level.

**DES Scores of Subjects**

As shown in Table 4, the trance channels differed from the MPD subjects with regard to both frequency of dissociative experiences (median DES score), and number of different types of dissociative experiences (median number of DES items endorsed). There were no differences between the trance channels and normal subjects with regard to these items.

While Bernstein and Putnam (1986) do not provide data with regard to the average DES score of the twenty MPD subjects, a separate study comparing MPD and complex partial seizures (Ross, Heber, Anderson, et al., 1989) does provide such data for a separate group of twenty MPD subjects. The average DES score for those MPD subjects is 38.3 (S.D. = 20.9) which compares to an average DES score for the trance channels of 6.28 (S.D. = 4.78). This is significant at the .0001 level (t = -21.18). When the average DES score of the trance channels is compared to the average DES score of twenty-eight neurologic controls (5.2) (S.D. = 6.6) as reported in the complex partial seizures study (Ross, Heber, Anderson, et al., 1989) there is no significant difference (t = .71).

**DISCUSSION**

The results presented above indicate that trance channels cannot be characterized as suffering from psychogenic amnesia, psychogenic fugue, depersonalization disorder, somatization disorder, depression, borderline personality disorder, or schizophrenia (Tables 1 and 3). They seldom have histories of substance abuse, physical abuse or sexual abuse (Table 2). Despite the fact that three of the ten channels would have met the strict DSM-III criteria for MPD (Table 1), I believe that none of them can be validly diagnosed as multiples based on lack of secondary features of MPD (Table 3) as well as overall profile. MPD has been characterized as "the great imitator in psychiatry" (Ross, 1989, p. 94) because patients are polysymptomatic and often have numerous previous diagnoses as well as long mental health care histories. The subjects of this study did not fit this overall profile, either individually or collectively.
It might be noted that three of the ten subjects responded negatively to the "trance states" question (Table 2), despite the fact all were self-identified as "trance channels." Question #69 asks: "Have you ever had a trance-like episode where you stare off into space, lose awareness of what is going on around you and lose track of time?" (Ross, 1989, p. 322). The three channels who responded negatively to this question objected to various aspects of the wording of the question, as it did not accurately describe their experience.

It is also interesting to note that the trance channels averaged nearly twice the number of supernatural experiences as did the MPD subjects (Table 3) in light of the fact that the presence of these experiences differentiates MPD from other diagnostic groups (Ross, 1989, pp. 108, 332). When the data were examined more closely, it was found that responses to this section of the DDIS were clustered as follows. All of the subjects had experienced mental telepathy, deja vu, contact with spirits, knowing something of past lives, and additional supernatural experiences not specified on the DDIS. Eight of the ten had experienced clairvoyance, and six had experienced clairvoyant dreams. On the other hand, none had experienced telekinesis or been involved in cult activities. Half had experienced contact with ghosts, with three of these having experienced contact with poltergeists. Finally, with regard to the question on possession, one had felt possessed by a demon, one had felt possessed by a dead person, two had felt possessed by some other power or force, and none had felt possessed by a living person. Ross has suggested that ESP experiences are a form of nonclinical dissociation which may occur in otherwise healthy, high-functioning individuals (1989, p. 184). This suggestion is based on the results of an unpublished study in which eleven nontraditional therapists and seventeen psychiatry residents were interviewed with the DDIS and the DES. According to Ross (1989, p. 184) "Neither group exhibited a notable degree of psychopathology.... The item that most clearly differentiated the nontraditional healers from the psychiatry residents was ESP experiences, which were very common in the community-based group. The two groups both had low rates of childhood abuse." It would seem that while supernatural/ESP experiences may indeed differentiate MPD from other diagnostic groups, they are found in a variety of other (non-pathological) contexts, and should not, therefore, be considered inherently symptomatic of mental pathology.

With regard to the DES scores (Table 4), it would seem that while these subjects clearly engage in dissociative behavior at the far end of the dissociative continuum (i.e., "co-consciousness"), as a group they do not experience the types of dissociative phenomena queried about on the DES more often than normals. This suggests that rather dramatic forms of dissociation (co-consciousness) can exist
independently of not only other types of dissociative experiences, but also a high degree of overall dissociation. This may call into question the concept of a single, naturally occurring dissociative continuum, without negating the fact that people who have experienced severe trauma (such as those with MPD) do tend toward a large number of different types of dissociative experiences, and have these experiences with some frequency.

Etiology

It has been widely recognized that MPD is a psychobiological response to overwhelming trauma during early childhood. The form this trauma takes is severe and repeated physical and sexual abuse. A 1986 National Institutes of Mental Health survey found that 97% of all MPD patients reported experiencing significant trauma in childhood (Putnam, et al., 1986). Dissociation seems to be an adaptive strategy utilized by these very small children in order to survive (Ludwig 1983, p. 95). Ross has stated that, very simply, "MPD is a little girl imagining that the abuse is happening to someone else" (1989, p. 72). Thus, per Putnam, "repeated childhood trauma enhances normative dissociative capacities, which in turn provide the basis for the creation and elaboration of alter personality states over time" (1989, p. 45).

Trance channeling, on the other hand, is an activity which its participants believe promotes personal growth and development through the experience of altered states of consciousness. It is very often learned behavior-s-a skill that is routinely taught to adults with no history of physical or sexual abuse. The form that this training takes is meditative in nature, utilizing visualization techniques, and is often done within the context of trance channeling classes (Hughes, 1991).

Function

MPD also differs from trance channeling with regard to the function of dissociation. For multiples, dissociation is a defense mechanism, a way of blocking out of conscious awareness horrific emotional and physical pain. It is also their primary coping mechanism-when things go wrong, they compulsively dissociate (Putnam, 1989, p. 141).

For trance channels dissociation is a method of achieving altered states of consciousness in a quest to attain a sense of spiritual connectedness to something larger than oneself. Further, there are a number of trance activities or exercises that the entities (disem-
bodied personalities) "do" with their channels while they are in trance. These activities add to a sense of not only having a spiritual life, but also expanding or improving it (Hughes, 1991).

**Control**

There are also differences with regard to control over the "switching process." Multiples compulsively dissociate, with switching between alter personalities being triggered by any number of environmental and internal stimuli (Putnam, 1989, p. 117; Ross, 1989, p. 103). In contrast, trance channels exercise complete control over the "switching process." They consciously decide when, where, and if they will go into trance. There are specific, somewhat stylized, culturally appropriate contexts for the activity, and the "entities" do not come through unless and until they are invited (Hughes, 1991).

**Pathology**

Finally there is the matter of pathology. MPD is, above all, a dissociative disorder. Ross has compared MPD patients with circumpolar shamans and has found that whereas "the shamans were healthy and used their dissociation in a culturally integrated way, the MPD patient tends to be dysfunctional and socially isolated" (1989, p. 13). Peters and Price-Williams have suggested that the cultural embedding of an altered state of consciousness may be an important means of discriminating pathological states from shamanism (1980, p. 406). Bourguignon has pointed out that "the great difference between MPD patients and the characteristic Haitian cult initiate (or for that matter, a possession trancer in any of our 251 sample societies and many others as well) is that these (the multiple personality) dissociations are purely idiosyncratic; the behavior is not learned by following a cultural model" (1976, p. 38). Trance channeling is a form of dissociation that is not idiosyncratic but is instead highly culturally contextualized through trance channeling classes, specific meditative techniques, etc. Trance channels also use dissociation in a culturally integrative way, in that they are utilizing their psychobiological capacity for dissociation for the purpose of actualizing, at a personal level, culturally relevant themes such as personal growth, increased responsibility for their own lives, self-trust, and empowerment of the individual (Hughes, 1991). While the absence or presence of cultural contextualization may be an indicator of sorts as to whether or not a specific type of co-consciousness can be categorized as "pathological," I believe it would be specious to suggest that it is cultural contextualization that accounts for the lack of psychopathology evidenced among the trance channels who participated in this...
study. Rather, I would suggest that it is the experience of trauma, to which dissociation is a reaction, which leads to the psychopathological aspects of MPD, rather than the process of dissociation per se. Further, I would suggest that it is the lack of repetitive trauma-induced dissociation in early childhood which accounts for the lack of psychopathology evidenced among the trance channels who participated in this study despite the fact that they clearly evidence co-consciousness. In sum, extreme dissociative phenomena, i.e. co-consciousness, cannot be assumed to be inherently pathological or automatically accompanied by psychopathology, nor can one form (e.g., trance channeling) be equated with another (e.g., MPD) even when they are found within the same society.

CONCLUSIONS

These DDIS and DES data indicate that trance channels differ in highly significant ways from subjects with multiple personality disorder. Trance channels cannot be presumed to be multiples despite the fact that both groups exhibit co-consciousness (extreme dissociative behavior). Trance channels do not exhibit a high degree of psychopathology (DDIS results), nor do they experience a high frequency or large number of different types of dissociative experiences (DES results), but they do experience trance states and extrasensory and supernatural experiences. While both trance channeling and MPD are predicated on dissociation at the level of mental process, they differ with regard to etiology, function, control and pathology. For multiples dissociation with co-consciousness is idiosyncratic and compulsive, while for trance channels the dissociative experience with accompanying co-consciousness is culturally contextualized and under the conscious control of the practitioner. It is suggested that the independent variable with regard to psychopathological aspects of dissociation is whether or not the dissociative activity is trauma-induced, rather than where the activity might lie on a dissociative continuum.

REFERENCES


Requests for reprints to: Dureen J. Hughes, Department of Anthropology, UCLA, 405 Hilgard Avenue, Los Angeles, CA 90024-1553.