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Multiple Personality and Channeling

Rayna L. Rogers, D.O.

Abstract

Psychiatry in the 1980's and 1990's has seen a rapid progression in the understanding of dissociative disorders, especially multiple personality disorder. Another phenomenon which has had a parallel rise in the past decade is trance channeling. Channeling is the process by which an individual enters a trance-like state and surrenders control of the body to a "guide" or "entity" who communicates with the listeners or "sitters" gathered for a "reading." The purpose of this paper is to investigate the relationship between these two phenomena, specifically questioning whether channeling is a variant of multiple personality disorder or if it is pathological.

HISTORY OF MULTIPLE PERSONALITY DISORDER

The first documented case of multiple personality disorder (MPD) was that of Mary Reynolds in 1815 (1). Strange "fits" came over Ms. Reynolds beginning at the age of 18, which, according to the author, were "evidently hysterical." During the attacks Ms. Reynolds might sleep eighteen hours a day and then awaken with large discrepancies in her memory, penmanship and disposition. The patient came to acknowledge two different states of being which alternated in herself, and accounts of her story became a focus of much curiosity and interest after Dr. S.L. Mitchell published it in the *Medical Repository* in 1817 (2).

The next case of multiple personality occurred in Bavaria in 1928 (1). The patient was a man named Sörgel who was "an epileptic, but he had two distinct organizations of consciousness: one criminal and one decent, of which the latter remembered practically nothing outside of its own life, while the criminal personality remembered both lives" (1, p. 283). The questions of Sörgel's epilepsy is obviously an interesting one given the recent hypotheses regarding temporal lobe epilepsy as a possible pathogenetic mechanism in multiple personality disorder. It also represents one of the earlier conceptualizations of this disorder, referred to in early literature as "fits" or "spells" or even possession. This issue will be discussed later in this paper.

In 1906 Morton Prince published his work on Ms. Christine ("Sally") Beauchamp, engendering a great deal of interest in the disorder of multiple personality. Prince remained a major contributor to the fund of knowledge about MPD for years, and went on to report four more cases (2, p. 578). Prince's strategy for treating the disorder failed to produce clear treatment success and future researchers in the field rejected it.

Thigpen and Cleckley, in 1954, reported the case which would bring MPD into the public eye for the first time since *The Strange Case of Dr. Jeckyll and Mr. Hyde*. The

story of Chris Sizemore, first told in 1954 by Thigpen and Cleckley (3) later became the popular book *The Three Faces of Eve* (4). The movie by the same name practically made "split personality" a household term and set the stage for the emergence of the tragically fascinating story of Sybil (5) in 1973. Since that time a very active group of researchers including Allison, Braun, Coons, Kluft and others have worked to increase the rate of recognition of this disorder (6-16).

EVOLUTION OF DEFINITIONS FOR MULTIPLE PERSONALITY DISORDER

The phenomenologic definitions of multiple personality have remained remarkably stable over the years. Taylor and Martin in 1944 described MPD as a condition in which "two or more personalities (exist) each of which is so well developed and integrated as to have a relatively coordinated, rich unified and stable life of its own" (1, p. 282). Eighteen years later Sutcliffe and Jones (17) held that MPD principally involves "significant alterations of personality, loss of self-reference memories and confusions and delusions about a particular identity in time and place." In 1972 Ludwig, Brandsma and Wilbur stated that multiple personality refers to "the presence of one or more alter personalities, each possessing presumably different set of values and behaviors from one another. The appearance of these personalities may be on a "co-conscious" basis or a separate consciousness basis . . . or both" (18).

In 1980, Coons stipulated that periods of amnesia should be present to make the diagnosis of MPD, but this was not included as a criterion in *DSM III*. *DSM III* made a significant advance in the understanding MPD by removing it from the hysteria category and creating the dissociative disorders group.

DSM III-R

After a minor modification, the current diagnostic criteria are as follows:

- a) 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 a thinking about the environment and the self.
- b) At least two of these personalities recurrently take full control of the person's behavior.

Clinical manifestations which help to establish the presence of distinct personality states are described in detail by Braun (19). Changes occur in the physical, behavioral, psychological and psychophysiological aspects of the individual. This may include voice changes, variance in posture, clothing, handedness, language, memory, mood, sexual identity and orientation, pain threshold, EEG pattern, Galvanic skin response and TAT, Rorschach and MMPI results.

VARIOUS CONCEPTUALIZATIONS OF MULTIPLE PERSONALITY

For the first one hundred and fifty years or so, conceptualization of MPD centered around Janet's idea that multiple personality was a special case of hyste-

ria (20). A prominent group of writers including White (21), Hollander (22), Kernberg (23), Ludwig (18), and Rigall (24) talked about the motive of escape in the creation of new personalities, but may have missed the mark concerning what the patient was escaping from. For example, Rigall wrote that "by dramatizing himself into some other personality, [he] for a time gets rid of the burden of his neurosis" (24, p. 847). In a variation of the hysteria hypothesis, Reed (25) quotes Kraepelin, as cited by Schneider, as describing "the hysterical personality" as "displaying emotional responses, a delight in novelty, vivid imagination, striving to be in the limelight and a tendency to cheat" (26). Schneider himself refers to such individuals as "attention-seeking psychopaths." Schneider goes on to say that "the most striking way of dealing with this passion for attention is pathological lying, for this individual needs to be endowed with certain powers of fantasy and invention . . ." (27). Reed applies this explanation to dismiss channeling behavior.

Regarding the hysteria explanation, Greaves states that most authors who have systematically reviewed the literature are convinced that "it has been both a mistake and a disservice to classify multiple personality as a special case of hysteria" (2, p. 583). According to Greaves, this view is at best an "oversimplification." It has been shown that the various personality states or "alters" may "utterly fail to show neurotic organization" (2, p. 586). In fact, personality states in MPD may fall into virtually any category of psychiatric description, and this is "neither diagnostic nor typical of hysterical organization" (2, p. 586).

Some theorists have purported that because splitting is used as the primary defense and symptoms include impulsivity, disturbance of identity, rage, mood swings, unstable interpersonal relationships and self-destructiveness that MPD is really a form of borderline personality disorder. Indeed Buck (28) has described a case of MPD which met the criteria for BPD in *DSM III*, and both Fast (29) and Searles (30) have described multiple identity formation in borderline states (31). Splitting, however, is a generic process and, as noted by Lichtenberg and Slap (32), is not "confined to any specific category." What remains unclear is why people with multiple personality exhibit discrete, named personality states whereas patients with a borderline disorder do not. Also, the presence of a borderline personality does not preclude the diagnosis of multiple personality disorder if the patient meets the criteria for the diagnosis. In fact, Horevitz and Braun (12) have found that between 20% and 70% of MPD patients meet the criteria for borderline personality disorder. This is not surprising in light of the common origin for both disorders in childhood trauma, usually in the form of sexual and/or physical abuse. Some theorists even consider that there may be a continuum including borderline personality disorder and dissociative disorders, though this is not a settled question (33).

Another source of diagnostic confusion in the arena of MPD is temporal lobe epilepsy (TLE). As mentioned previously, the patient called Sörgel was believed to suffer from epilepsy, though it is difficult to ascertain what if any effect it had on Sörgel's multiplicity. An "Interictal Behavior Syndrom" of TLE has been described by Waxman and Geschwind³⁴ which includes "alterations in sexual behavior, religiosity and a tendency toward extensive, and in some cases compulsive writing and drawing."

In addition to behavioral and personality changes in between seizures, the person with partial complex or psychomotor epilepsy may manifest amnesic periods and sometimes very complex automatisms for which the person has no recollection. These patients may also experience an aura prior to the seizure which may include *deja-vu*, *jamais-vu*, depersonalization, derealization, paranoia, changes in mood and organized hallucinations (35). Persinger has described similar personality characteristics in clinically non-epileptic individuals who show mild epileptic-like temporal lobe dysfunction on the EEG. He called these personality traits "temporal lobe signs" and found that they correlated positively with hypnotic susceptibility and the tendency to have experiences that were interpreted as paranormal (36). The issue of hypnotic susceptibility is particularly interesting in light of the known high hypnotizability of people with dissociative disorders such as MPD. Bliss, for example, found that 28 patients with MPD had a mean score of 10.1 on the Stanford Hypnotic Susceptibility Scale, Form C. This was significantly higher than normal controls or patients with phobias (37).

In spite of some similar features, temporal lobe epilepsy can usually be distinguished from MPD on the basis of brief duration of seizures, aura phenomenon, EEG findings and hypnotic or amytal interviews (36, p. 577). This is not to imply, however, that the person cannot exhibit both seizures and symptoms of MPD. A possible connection is hypothesized by Charcot and Marie (38) who wrote that "a person who becomes amnesic for any reason, even from an epileptic attack, and comes to in a new place and among strangers may well need and develop a new personality with which to meet social and economic demands."

Iatrogenesis is another popular conceptualization of MPD which must be discussed. Skeptics of the existence of MPD have asserted that the symptoms exhibited by patients with MPD are created via hypnosis or by shaping of the patient through encouragement to enact multiple personality-type behaviors (39). Canadian psychologist Graham Reed implies that MPD is an amusing curiosity enacted by "hysterical patients" in order to please their doctors and retain their interest (28). Although worsening of MPD by iatrogenic error has been reported, there is, according to Kluft, "no evidence that clinical MPD can be produced *de novo* by iatrogenic manipulations" (40). Kluft goes on to say that "phenomena analogous to and bearing dramatic but superficial resemblance to clinical MPD can be elicited experimentally or in a clinical situation if one tries to do so or makes technical errors." Gruenewald concurs: "Although injudicious use of hypnosis may have a variety of untoward effects, causation *de novo* of MPD does not seem to be one of them" (41). A number of experiments using hypnosis have attempted to produce MPD or related states. The case that came closest was Leavitt's patient "Dick" (42). However, Dick had no history of amnesia and the artificially produced personalities Dick displayed did not dissociate spontaneously when not under hypnosis (43). Of note, sometimes true multiples are discovered initially through incidental hypnosis, and Allison has reported a number of these cases (44). At present the most widely accepted etiology of multiple personality is childhood trauma. This trauma usually takes the form of physical abuse or incest, but may also include accidents, war horrors, exposure to

death or ritualized torture (as is alleged to occur in the case of satanic cults). Extreme ambivalence is a unifying feature of these traumas, and it is supposed that a child might use dissociation as a "way out" of the bind that she (or he) finds herself in. The condition of multiple personality has its onset in childhood, usually by the age of 8 years. Morgan and Hilgard have stated that this is the age of maximum hypnotizability (45). Hypnotizability is a feature ubiquitous among those with dissociative disorders and persists into adulthood. It is estimated that 98% of patients with MPD experienced child abuse or neglect, and 75% to 90% of known MPD patients are women (36, p. 571,573). The most likely explanation for the observation that there is a strong predominance of females with MPD is that far more girls are abused than boys (46,47). However, Bliss (8) has found a number of male multiples in the criminal justice system, which suggests that males with MPD may present in different ways, often with an antisocial style of behavior, and may consequently be underestimated in prevalence.

CHANNELING

Historical Origins

Channeling is a relatively new term, but the process it denotes is an ancient one. There is almost no mention of trance channeling or mediumship in the scientific literature, although lay literature on this subject is abundant. Other words which describe the people who do this include psychic, medium, shaman, healer, oracle, prophet, witch-doctor, fortune teller, guru, mystic, master, priest, seer, savant, soothsayer, teacher, light-worker, adept and visionary. Belief in channeling phenomena has its roots in prehistoric and primitive cultures. Psychologist Jon Klimo of the Rosebridge Institute in Berkeley, California writes that "[channeling] appears to be an essential element in the origins of virtually all of the great spiritual paths. It is not just a curiosity of current interest based on a resurgence of inner voices, visions and trance seances and automatic handwriting. Rather, the phenomenon is an important aspect of human consciousness, a crucial experience for human beings in all cultures and times, even though we do not yet understand its origins and mechanisms" (48). Those behaving in ways characteristic of mental illness have traditionally been associated with the divine, especially if they received special visions or messages. Some historical figures often considered to have been the channels of their day are Moses, the Oracle of Delphi and Jesus Christ.

For an excellent, in-depth examination of channeling and detailed discussion of the hypothetical mechanisms which may account for this process, the reader is referred to Klimo's book *Channeling: Investigations on Receiving Information from Paranormal Sources* (48). The theoretical issue involved in such an investigation are too cumbersome and complex to be done justice in this brief article. It is important, however, that channeling be described phenomenologically for purposes of comparison with MFD.

Phenomenology of Channeling

In the 1980's the standard channeled "reading" consisted of a channel, an audience (which may be large or small, paid or free) and some mechanism for recording the information, usually a tape recorder. The channel sets the stage for the session by providing a quiet and comfortable room, often slightly darkened. He or she assumes a comfortable position in a chair or lying down, although they may get up and move about later in the reading (49). Once relaxed, the channel usually begins by closing both eyes, breathing deeply and rhythmically, focusing the mind on a point of imaginary light. The channel will then imagine herself/himself to be encased in a protective light bubble before departing to some imaginary idyll, thus surrendering the body for use by the "guide" or "entity."

It is noteworthy that some channels are completely unaware of (and therefore amnesic for) what transpires during the session. Others, however, achieve a state of conscious "sharing" of the body and can hear and remember at least some of what went on. Most channels state that as soon as the reading is over they can recall much of what was said, but the memory fades rapidly, similar to the forgetting of a dream after awakening.

Sanaya Roman and Duane Packer have written a "How to" book for channeling which instructs the reader step by step in the techniques and the philosophy of channeling (50). There are other instructional books for channelers, but Roman and Packer's is the most widely read and delineates the "standard operating procedure" for modern American channels.

DISSOCIATION AND CHANNELING

Some features of trance channeling deserve special attention due to their similarity to certain psychiatric phenomena. It can hardly escape notice that the trance induction advocated by Roman and Packer is remarkably similar to hypnosis (48, p. 221). Some channels even require a "facilitator" or "director" to put them into a trance, analogous to the usual psychiatric hypnotic induction: "While John David set up the tape recorder, Steve leaned back in his chair and tried to relax. After some five minutes it was obvious he was having trouble, and John David, thinking perhaps that it might help him, asked Steve to look into his eyes and told him to relax. Steve closed his eyes again, breathed easily for a moment or two, and then began to speak in a voice which was of the same tenor of his normal voice, but strikingly more intense. The first thing he said in a state of trance was "you haven't permitted me to be in touch with you for a while . . . I have come to you to explain the systematization of the universe . . . I am called Sepotempuat" (487, p. 188).

Hypnotic susceptibility is a feature common both to MPD and trance channeling, and the underlying mechanism is presumed to be "mental dissociation" (487, p. 243). Dissociative phenomena which may occur in both MPD and in channeling are automatic writing, glossolalia, accent changes, auditory internal hallucinations and behavioral automatisms such as singing, dancing or creating art. Other dissociative

disorders beside MPD may include these features, in particular psychogenic fugue. Many channels and people with MPD also report having paranormal experiences such as out-of-body experiences, *deja-vu*, *jamais-vu*, precognition, depersonalization and derealization episodes at a rate well above the norm (510).

A. Sharon Heber et al (52) studied 12 "alternative healers" (who often use a form of channeling) with the Dissociative Experiences Scale (53) and the Dissociative Disorders Interview Schedule (51), comparing them to 19 psychiatric residents and 102 known MPD patients. The groups were compared in terms of schneiderian symptoms, secondary features of MPD and number of ESP or paranormal experiences. The residents rarely endorsed any of the positive items, whereas channels endorsed an average of 2.4 Schneiderian symptoms, 3.0 secondary features of MPD and 7.8 ESP experiences. In comparison, MPD patients reported more first-rank symptoms and more secondary MPD features, but fewer ESP experiences than the healers.

Childhood abuse or trauma is another possible commonality to both channeling and dissociative disorders such as MPD. In her doctoral dissertation, psychologist Margo Chandley (54) found that "many channels appear to have background of neglect or abuse." Chandley goes on to point out, however, that "one out of every four people in this country have been abused or neglected" (48, p. 131), and therefore the number of channels reporting abuse may not be far from the expected incidence for the population in general, especially given that most channels are women.

Discriminating Features

There are some notable differences which may help to separate the pathological condition of multiple personality disorder from the non-pathological individual who happens to practice channeling. It is important to be able to do this for several reasons. First, it is clearly desirable to correctly diagnose MPD where it exists so that the patient can obtain proper treatment. Second, it may be equally important to avoid "pathologizing" a normal individual by giving her/him a label which has enormous social and economic consequences. Third, although these people would be unlikely to seek treatment, it would be important to understand the psychodynamic underpinnings in those people who 'perform' channeling as an act calculated consciously or unconsciously to bring attention and "egoenhancement" (27) to an otherwise ordinary or uninteresting person, to say nothing of financial gain.

Three concepts which may be useful in the differential are:

1) *Degree of Voluntariness*. It is unclear to what extent this can be a discriminator, but for the most part channeling is a voluntary, self-induced event whereas the switching of MPD is usually involuntary and may even take place without the host personality's awareness. However, multiples can usually learn to switch themselves voluntarily using self-hypnosis, and on the other hand, this author is aware of at least one channel who first met his "guide" in the form of an unbidden audiovisual hallucination while driving his car.

2) *Names, Numbers and Ages*. These items, especially when considered together,

are powerful discriminators. Regarding numbers of 'alters' or 'entities', people with MPD rarely have fewer than three alters, the average number being just over 13 (14,15). Channels, on the other hand, usually have only one source or guide (487, p. 237). Again, this is an oversimplification. Allison has reported a significant number of multiples with only two personalities (55), and the generally accepted theory of channeling does not limit the number of entities to one. In the author's experience, most channels have one primary guide whom they most often employ, but are also able to call forth numerous others if requested or even spontaneously. More useful are the stated ages of the alters or entities. At least 75% of multiple personality patients will have at least one child personality, but virtually no channels report having a child source. Names can also be helpful in the differential. For channeled entities, names are generally of a biblical, historic or wholly fictional in character. In MPD patients the names of the alter personalities may be somewhat more ordinary, but interestingly are often symbolic or coded (36, p. 572). An alter's name may describe the function that that personality serves in the system, such as the Protector, Used One, Whore, Anger, Little One, Hope or Faith. Some alters have no name at all. Clearly there is a large area of overlap in the range of names, but names which are "classic" may lend a degree of confidence to the determination of which process is at work in an individual.

3) *Language, Accent and Grammar.* Grammar and syntax changes are the rule for both channeling and MPD, and often reflect the developmental stage of the personality or fragment. Changes in accent are also common, and the degree of authenticity varies. Linguistic analysis has been used to "debunk" claims of channeling non-native English speaking entities whose accents turned out to be bogus (56). Similarly it is not difficult to determine whether an entity or alter speaking in an entirely foreign language is genuine or not if even a modest level of sophistication is used. Kluff reports a case of a woman with MPD who had one personality that could speak her family's native language even though the patient had no conscious knowledge of the language (57). To date no verified reports of a person channeling in a language foreign to him or her have appeared, though there are numerous cases of glossolalia (speech-like but nonsemantic sounds) occurring in the context of trance channeling (28).

SUMMARY

In conclusion it should be clear that trance channels are likely to be similar to people with multiple personality disorder in many ways, especially if the channeler enters full trance and is not a fraud. Channeling behavior could in some cases be the first manifestation of an otherwise latent dissociative disorder, and this paper has explored some of the potentially discriminating features which might clarify an otherwise confusing picture. Naturally it would not be valid to use diagnostic criteria such as those contained in the *DSM III-R* when analyzing a non-patient population. However, useful features for differentiation include consideration of the degree of voluntariness, names, numbers and ages of alters or entities, language usage and

history of childhood trauma. Compelling reasons to understand the differences between the two groups include diagnostic mandate for proper treatment of psychiatrically ill patients and the desire to avoid applying pejorative psychiatric labels which carry unpleasant consequences to people who are otherwise normal but have chosen to engage in a creative social activity which is currently very much in vogue.

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