University of Kentucky

From the SelectedWorks of James M. Donovan

August, 1996

Multiple Personality, Hypnosis, and Possession Trance

James M Donovan

Available at: http://works.bepress.com/james_donovan/20/
Multiple Personality, Hypnosis, and Possession Trance

Summary

Multiple personality disorder [MPD] and possession trance [PT] are examined from the perspectives of presenting morphology and demographic epidemiology. The goal is to ascertain whether at these levels MPD and PT are disparate phenomena, or warrant treatment as two instances of a single type. The data favor the second alternative, and from this we infer that both MPD and PT are culturally manipulated instances of a unitary psychobiological ability. But by virtue of this manipulation, differences do exist between the final forms, especially on the dimension of whether they are experienced as states of health or illness.

Contents

Introduction
1. Multiple personality disorder
2. Possession trance
3. Comparing MPD and PT
4. Deutsche Zusammenfassung
5. Literature

Introduction

Multiple personality disorder [MPD], and possession trance [PT] have long been of interest to psychiatrists, psychologists, and anthropologists, not to mention the general public. Tradition has it that these experiences are largely heterogeneous.

Effort to distinguish the two relies upon the very real observation that MPD is generally considered an illness, while PT, perhaps beginning as an illness, most frequently ends as a healthful state. This need not always be the case, of course. Even multiple personality can be a healthful and workable solution to certain environments and problems, as BEAVERS (1982) goes to some lengths to argue. In any specific case we must be careful to distinguish between multiplicity per se and multiplicity gone awry. On the other hand, possessing spirits have been known to deliberately harm, even to kill their hosts (e.g. GEERTZ 1973: 115, HURTON 1990: 222), so it would be misleading to characterize PT as intrinsically a healthful or benign experience. But as a rule, multiple personality must be admitted to be a disorder in our culture, while such a sweeping conclusion cannot be asserted about possession trance.

This divergence cannot be wholly attributed to a simple difference of post facto interpretation. While it is safe to say that the case of MARY REYNOLDS which is for us prototypically MPD, would have been interpreted as an instance of PT had she been Brazilian, such complete translatability between the two is ill-advised. One cannot assume, in other words, that all possessed persons are really afflicted with MPD.

ROGLER and HOLLINSHEAD (1961: 17) write that spiritism functions therapeutically by providing "an outlet for mental illnesses". This harkens to the common assertion that shamans are those who have healed themselves of mental aberration, or at least learned to control it, and manage even to stay on the right side of the genius/madness line. While PT manipulates altered awarenesses for healthful gain, MPD signals not a manipulation, but loss of ability to manipulate these awarenesses. PT may be stigmatized because of its socioeconomic associations, but
MPD is medicalized because of its detrimental impact upon individual ability to function effectively (and one hopes not, as some have pointed out, because the simple fact of multiplicity contravenes the theology of a single God making man in his own image, and thereby with a unitary consciousness).

This difference leads to dissimilar ideal outcomes. Whereas MPD strives most commonly for regained control over the executive subsystems, and incidentally thereby effect personality integration, PT seeks an accommodation between them. Here, life effort will become integrated even where consciousness does not.

Despite these categorical disjunctions, the similarities between MPD and PT, and these with hypnosis, are several, not the least of these being the historical (cf. KENNY 1986: 84f). As RICHEPORT recounts, “the question posed in the last century was how one might explain involuntary behavior”, those types of responses about which we say that “I didn’t know what I was doing,” or “Something must have come over me”. Consideration of this problem leads to three possible solutions:

the person had several personalities functioning independently of each other; the person was possessed by spirits who took over at times; or the person had behavior outside awareness and so was doing something unconsciously. [RICHEPORT 1991: 168]

Because MPD, PT, and hypnosis respectively were originally competing explanations for a single set of facts, they inevitably share many overt features. Rather than emphasizing the differences of the presenting patterns, we want to know whether beneath lies a more substantive relationship. If it seems inconsistent to accept the nonequivalence of the end products while yet searching for a common source I might here invoke a chemical analogy: That diamonds and coal are nonequivalents does not alter the fact that they are composed of exactly the same stuff.

For reasons of brevity, we can make only one comparison, that between MPD and PT. Table 1 does, however, reflect values for all three phenomena for interested readers.

1. **Multiple Personality Disorder**

We are interested in two types of information about this fascinating condition: First, what are the identifying and characteristic features of the disorder (its morphology); and second, persons who suffer this disorder are likely to share what other features (its epidemiology)? Armed with the particulars of MPD, we will see if information on similar variables exist for possession trance.

KLUFT (1985a: 3) defines MPD as “a severe dissociative disorder involving a disturbance of both memory and identity”. “What is essential to MPD,” he says, “is no more than the presence, within an individual, of more than one structured entity with a sense of its own existence” (1985a: 4).

Strictly speaking, however, while “Amnesia is a strongly associated feature, [it is] not an essential criterion in DSM-III” (KLUFT 1985a: 3), or in DSM-III-R. But given the consensus that “Amnesia must be present to diagnose multiple personality” (BRASSFIELD 1983: 146), it will be accorded such status in DSM-IV (CARDENA 1992). We should read this news with CRABTREE’s (1985: 251) bifurcation of amnesia in mind:

“With event amnesia, the individual lacks knowledge of an experience; with identity amnesia, he lacks connection with the subject who had the experience.” MPD can be defined by the presence of identity amnesia. Although event amnesia is “generally a part of multiple personality, [it, unlike identity amnesia,] is not one of its essential characteristics” (CRABTREE 1985: 251).

With such minimal defining criteria, we are not surprised that MPD is notoriously difficult to diagnose, in part due to its overlap of symptoms with other psychiatric conditions. CASTILLO (1991) relates research showing MPD patients to have more schizophrenic symptoms than did...
schizophrenic patients. Such overlap leads some mental health workers to believe that MPD is better diagnosed as something else, and to doubt whether it exists at all as a unique psychiatric entity. Against this background, workers have attempted to achieve reliable MPD diagnoses by secondary indicators.

They are interested to enumerate the observable signifiers of the underlying mental conditions. Many checklists have been constructed toward this end. For instance, TALIERCIO (1991: 81f) attributes to a team led by FRANK PUTNAM the following list of factors intended to serve as "possible indices":

(a) amnesia; (b) periods of extremely regressed, violent, or apparently psychotic behavior alternating with periods of excellent relatedness and high levels of social functioning; (c) auditory hallucinations; (d) depressive symptoms; and (e) somatic complaints.

Alternatively, KLUFf (1985a: 6) suggests twelve signs. It is unclear how many of these items must be present to warrant a diagnosis of MPD.

Each of these lists' attempts to routinize diagnosis of MPD is less than ideal. The first relies on highly subjective determinations of which behaviors of not merely "regressed", but "extremely" so. If SZASZ (1961) has warned us about the complications involved in the labeling of behavior as psychotic, we can only imagine how these issues are compounded if we take as a diagnostic criterion behaviors which are only "apparently psychotic." KLUFf's list similarly depends overly much on the actions (effective treatment, correct diagnoses) or reactions (deciding one's behavior has changed) of others to shed light on the psychological condition of the patient.

Diagnosis could be made more reliable if there were some physiological indicator of multiple personalities. KLUFf (1985a: 7) concludes that "As of this point, no physiological or psychological test result is a definitive diagnostic clue for MPD." Nonetheless, according to BRAUN (1983a: 85) "Electrophysiological differences have been reported by several authors," including EEG differences between personalities. As a general rule, these "EEG differences occur predominately in alpha rhythm" (COONS 1988: 48).

LUDWIG et al. (1972) studied visual evoked responses (VERs), described by COONS (1988: 49) as "a complex electrical measurement of the brain's response to light stimulation." A more thorough study on this dimension by FRANK PUTNAM (1982) has shown that on several measures, including the VER, there exist more differences between personalities within a multiple than between "personalities" in a control group of simulators" (BRAUN 1983b: 131). Results of "the patients' alternate personalities varied not only on amplitude, a measure of attention, but also on 'latency'; latency measures something more 'hardwired',... and the variability points to the possibility of alternate circuitry for alternate personalities" (HERBERT 1982). These results are "cautiously interpreted ... as indicating a neurophysiological difference between multiple personality patients and controls that cannot be faked" (BRAUN 1983b: 125).

To summarize this section, those clinicians who are inclined to allow for the existence of MPD at all would be predisposed to suspect its presence should the following be present: (1) involuntary switching between personalities (or personality fragments); (2) identity amnesia at least, where not event amnesia; (3) distortions in time perception; and (4) EEG and VER differences between personalities.

Despite the difficulty articulating sufficient and necessary diagnostic criteria, some people are in fact diagnosed with MPD. What do these people have otherwise in common? Immediately, it must be noted that by all reports females predominate as MPD patients, sometimes by a ratio of five to one (TALIERCIO 1991: 84), although the reported figures range from a high of 14:1, to a low of 2:1 (PUTNAM 1985: 81). Additionally, more than 90 percent of MPD patients have been reported to have been abused as children (cf. GOODWIN 1985: 2).
So clearly is this relationship perceived to hold, that Wilbur (1985: 26) can claim that "Without abuse, we would have few cases" of MPD.²

Table 1

<table>
<thead>
<tr>
<th></th>
<th>MPD</th>
<th>Hypnosis</th>
<th>Possession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Amnesia</td>
<td>Yes</td>
<td>If suggested</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>BRASSFIELD 1983</td>
<td>HILGARD 1986</td>
<td>BOURGUIGNON 1991</td>
</tr>
<tr>
<td>Time distort</td>
<td>Yes</td>
<td>Yes</td>
<td>(Yes)</td>
</tr>
<tr>
<td></td>
<td>KLUIT 1985a</td>
<td>BEAIRS 1982</td>
<td>DAVIDSON 1976</td>
</tr>
<tr>
<td>Diff EEG between states</td>
<td>Yes</td>
<td>Yes</td>
<td>YES</td>
</tr>
<tr>
<td>Right lateral?</td>
<td>No</td>
<td>Yes</td>
<td>(Yes)</td>
</tr>
<tr>
<td></td>
<td>FLOR-HENRY ET AL. 1990</td>
<td>MACLEOD-MORGAN 1982</td>
<td>LEX 1979</td>
</tr>
<tr>
<td>Epidemiol.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predom. sex</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Physically abused</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>GOODWIN 1985</td>
<td>NASH ET AL. 1984</td>
<td>BILU 1985</td>
</tr>
<tr>
<td>Stress &amp; anxiety</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>BRAUN &amp; SACHS 1985</td>
<td>FRANKEL 1974</td>
<td>RAVENSCROPT 1965</td>
</tr>
<tr>
<td>Age of 1st appearance</td>
<td>.5-12 years</td>
<td>5-14 years</td>
<td>adolescence</td>
</tr>
<tr>
<td></td>
<td>BRAUN &amp; SACHS 1985</td>
<td>PUTNAM 1985</td>
<td>BOURGUIGNON 1991</td>
</tr>
<tr>
<td>Biological substrate</td>
<td>Yes</td>
<td>Yes</td>
<td>(Yes)</td>
</tr>
<tr>
<td></td>
<td>KLUIT 1985b</td>
<td>MORGAN 1973</td>
<td>LEX 1976</td>
</tr>
<tr>
<td>Family history</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>BRAUN 1985</td>
<td>MORGAN 1973</td>
<td>GOLDENTHAL 1985</td>
</tr>
<tr>
<td>Age-related decline</td>
<td>&gt; 60 years</td>
<td>37-40 years</td>
<td>&gt; 45 years</td>
</tr>
<tr>
<td>Culture bound</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>MARTINEZ-TABOAS 1991a</td>
<td>ORNE 1959</td>
<td></td>
</tr>
</tbody>
</table>

0= Derived from literature on meditation/mysticism
Wilbur’s (1985: 30f) explanation for how these influences lead to MPD is instructive: Abuses create in the child a state of an unacceptable and threatening feeling: for example, rage. The child learns that the feeling is unacceptable, and that it must not only be unexpressed, but it must not even be consciously “felt”. The feeling or affect is repressed and remains in the unconscious, outside of awareness. When the repression of feeling is accompanied by conflicts (both in relation to that particular feeling, and with regard to related other feelings that are also repressed), the combined presence of the overwhelming affects and the serious conflicts (both of which have been repressed) may result in the emergence of an alternate personality as a vehicle for the symptomatic expression of these affects and associated conflicts.

While this process describes the escape from strong negative emotions, a similar process avoids pain and other physical trauma (Siegel, Hunt & Dondershine 1988).

An abused child thus adopts short term strategies to handle her environment, but which entail long term costs. Once this defensive strategy is chosen, it is unusual for it not to become habitual:

Their use of these mechanisms is not defensive, but structural. They resort to splitting not only to avoid anxiety under special stress, but to function daily throughout life. They tend to split objects and affects because they never learned how to integrate. [Lasky 1978: 363f]

As a result, the mean number of personalities for an MPD patient is 13.3, with a median of 9 and mode of 3 (Taliercio 1991: 99).

Of course, not all children who are abused develop MPD. Much of this differential outcome has to do with the type of abuse, which we are told must be “frequent, unpredictable, and inconsistent” if it is to generate MPD (Braun & Sachs 1985: 47). Abuse may ultimately prove to be a special instance of a more general precipitating stimulus, since it is possible for MPD to occur without known childhood physical or sexual abuses (cf. Braun & Sachs 1985: 54).

There is some evidence to suggest that there are windows of developmental vulnerability during which these stimuli are more likely to effect MPD outcomes. Braun and Sachs (1985: 77) hold that

“in the vast majority of recorded cases, the first splitting off of an alternate personality appears to occur ... from age six months to approximately 12 years,”

although they note (1985: 79) that first diagnosis of MPD does not usually occur until around age 28.5 years. At the other end of the life cycle, we find a “low incidence of MPD” in the over-60 age group (Taliercio 1991: 131).

Early windows arise most likely from the confluence of the child’s general impressionability and from the state of relative immaturity of the ego’s mechanisms of defense. Thus, stimuli which may evoke a habitual dissociative reaction may fail to do so if the subject has other defenses from which to choose. Since these alternative mechanisms are usually in place by adolescence, we would expect, and empirically it seems to be the case, that the cycle culminating in MPD is never initiated at later stages of the life cycle.

One of the postulated keys to explain the differential outcomes of similar family environments may be to identify those children who display dissociative potential, such as day-dreaming or focused attention while watching TV or reading a book. Possession of such ability, which is “proposed to have biological determinants” helps explain the transgenerational occurrence of MPD (Kluff 1985b: 43). For instance, in one sample of eighteen MPD patients,

“Some evidence of dissociative phenomena was reported and/or observed in the family histories of all... cases” (Krahn 1985: 147).

Kenny (1981: 355) has called MPD a “Protestant disease,” and elsewhere argues that MPD is “a culturally specific metaphor, not a universally distributed mental disorder” (Kenny 1986: 3; cf. Castillo 1991). The question of the cross-cultural incidence of MPD should interest us very much. If, as is to be suggested here, MPD and PT are cultural moldings of a generic un-
derlying ability, then we would expect there to be an inverse relationship between the co-inci-
dence of the two. Where one is common, we would expect the latter to be uncommon.

A recent survey was conducted to ascertain the worldwide prevalence of MPD (COONS ET
AL. 1991). We disagree with its conclusion that "MPD is definitely not a culture-bound pheno-
menon and that it probably has a worldwide distribution" (1991: 124). It is not enough that
"MPD can emerge in a social and cultural setting quite different from that of the continental
United States" (MARTÍNEZ-TABOAS 1991b). Uncovering a single case hardly enables us to con-
clude, for instance, that 'MPD occurs in Columbia' the way we mean it when we make the
same claim about the United States.

Overall, the survey encourages our expectation that MPD and PT are mutually exclusive in-
terpretations. Where MPD is common (USA, Canada, Holland are all rated as having "case re-
ports too numerous to count"), we know PT to be an unusual happening. Contrarily, where we
know ethnographically that PT is very common, the survey is able to uncover few MPD cases.
Brazil provides only 2 cases. According to MARTÍNEZ-TABOAS (1989), no MPD cases were re-
ported for any Latin American country until his own report, and that was from the United
States-dominated Puerto Rico. In India, where spirit possession can be quite common, CASTILLO
(1991: 163) claims that only five cases of MPD were documented as of his writing.

MARTÍNEZ-TABOAS (1991a: 129) counsels that "we should doubt the notion that MPD is an
atemporal and universal phenomenon." According to him,

MPD will maximally unfold: (a) in individualistic societies (such as Canada and the United States);
(b) in countries where the self is autonomous and separate; (c) in cultures where child abuse and
neglect are rampant; and (d) in those places where dissociative capabilities are primarily used to de-
fend the individual self. In those other cultures where the self is collective and interpersonal in na-
ture, where children are respected, and where dissociative states are split off into semiotic systems
of gods, ghosts, or ancestors - then we should not be surprised if MPD is rare or even non-existent.

Summarizing, the modal MPD patient is (1) a female (2) who was sexually, physically, or
emotionally abused or traumatized, (3) as a child between the ages of six months to twelve
years. She is suspected to possess (4) a biological substrate for dissociation ability, as well as
(5) a family history replete with dissociation if not MPD itself. She is most likely both (6)
under sixty and (7) either American or currently living in a Western European derived or influ-
ence society.

2. Possession Trance

ERIKA BOURGUIGNON (1991) surveyed much of the world's literature on the subject, and from
her we find the following information of interest:


   Indeed, evocative of the incidence of MPD, she states that "children are hardly ever seen to ex-
perience possession trance and that the phenomenon is relatively rare in older people" (1991:
39; cf. MISEHEL & MISEHEL 1958; CRAPANZANO 1973: 94; RAVENSCROFT 1965: 174; VARMA

2. "Possession trance is followed by amnesia in most cases" (1991: 24).

3. "The very fact that an individual's first possession trance is usually spontaneous and
   involuntary suggests the personal psychological roots of this behavior" (1991: 39).
Although later possessions are usually restricted to ritual contexts, MISCHEL & MISCHEL (1958: 252) report that among the cult elite “possession may take place at any time and in almost any setting” (cf. SARGANT 1973: 163; RAVENSCROFT 1965: 178; BOURGUIGNON 1989).

Many issues are not reviewed by BOURGUIGNON and hence we must turn our attention to other sources. DUREEN HUGHES (1990: 5) reports that there is “a distinctive and unusual EEG profile characteristic of the trance channeling state.” Specifically,

“the trance channeling state ... is characterized by large, statistically significant increases in amount and percentage of beta, alpha and theta brainwave activity” (HUGHES & MELVILLE 1990: 184).

HUGHES (1990) also found for her sample that while 75% of MPDs “reported a history of physical abuse,” only 10% of trance channelers did. Likewise, these groups rated 80% and 10% respectively for reports of sexual abuse (1990: 6). Contrarily, BILU’S (1985) “analysis of 63 cases of dybbuk possession tends to confirm an association between possession and prior sexual trauma” (GOODWIN, HILL & ATTIAS 1990: 99).

ADAM CRABTREE (1985) describes the case of Anna Ecklund, a young girl who, in the early 1900s, was the object of a dramatic exorcism. The father of the possessed girl “admitted that he had repeatedly tried to force his own daughter to commit incest with him” (1985: 99). It may be noted that at the time of this admission, the deceased father was one of the spirits possessing the girl.

More generally, the circumstances “in temporal proximity to the occurrence of first possession is the death or estrangement of a prominent family member, or an important change in the peasant’s social status or personal responsibility” (RAVENSCROFT 1965: 180).

Stress and trauma, then, are relevant to the onset of PT, even if it is not typically of a sexual nature. In any event, an influential role of physical or emotional trauma and sexual abuse cannot at this time differentiate between MPD patients and PT participants.

Few other experimental results pertain directly to PT, most literature directing its attention toward meditation and mystical states of consciousness. It is unclear, both theoretically and experimentally, how mysticism and possession are to be related. BARBARA LEX’S (1976; 1979) discussion of ritual trance seems to mediate between the two. Although the ethnographic description of the experiences she is attempting to explain are akin to PT (eg., she finds LEWIS’s discussion from Ecstatic Religion [1989] pertinent), she has, according to MARUSICH (1991: 54), “assumed that what occurs during trance is parallel to that which occurs during meditation.”

If we are allowed to broaden our net so that PT includes mystical states of consciousness generally, we could fill in several holes in our table. We learn that “alteration of time and space perception” is typical (DAVIDSON 1976: 348). In the same article we also read that there is a sound basis for the hypothesis “that links the right hemisphere to mystic experience” (1976: 372). LEX’S (1976; 1979) formulation offers that

“the right hemisphere is believed to be the dominant locus of activity during the religious experience concomitant with ritual trance. Ritual trance, then, must promote right hemisphere dominance, and it does so through ergotropic excitation” (MARUSICH 1991: 53).

The crux of her scheme is that ritual trance is at base a biological experience concerned with the “manipulation of neurophysiological structures in the human body” (LEX 1976: 110).

If trancing is a biological feat, then we can expect the ability to be normally distributed, so that some individuals are gifted in this area, while some who fall on the opposite tail of the bell curve will display little talent.

With such unequal distribution of a biological ability, we are not surprised that mediumship tends to “run in families” (cf. GOLDENTHAL 1985: 58). While we know that inheritance is a common medium of transmission for this role, there has been no study to my knowledge which
seeks to quantify the interaction between degree of subject’s relatedness to a practicing medium and the likelihood that subject will also be a practicing medium.

Finally, relative to the relationship between possession and early abuse, CASTILLO (1991: 322) quotes J.M. MASSON’s opinion that

"all ascetics suffered massive traumas in their childhood in one of three ways: they were sexually abused, or they were the object of covert or overt aggression, or they lost those closest to them early in their lives."

This statement is particularly eye-catching because it was written in 1976, long before such post facto attributions of abuse achieved the fashion they enjoy today.

3. Comparing Multiple Personality and Possession Trance

An impressive similarity surrounds the emergence of both PT and MPD within the individual. As Table 1 reveals, every variable for which there are specific data concerning PT matches the value for MPD. Even the supplementary evidence from mystical experiences reveal only one major discrepancy, the same we find between hypnosis and MPD: hemispheric lateralization. Given the grossness of the left/right hemisphere dichotomy, it is unclear how much weight should be given this single distinction.

A nontrivial argument can be made to relate PT and MPD. We can approach this same problem from the other side as well: What are the explicit objections to this conclusion? We can best tackle this problem by considering point by point CARDENA’s (1989) objections. We should note, that Dr CARDENA was writing for other purposes, and toward one with which we agree – that MPD and PT should not be clinically conflated. But his expert summary of the issues provides a convenient point of departure for our discussion.

1. The distinctions of some native psychologies between what they regard as a pathological multiple personality disorder and religious possession.

This objection attacks the inverse relationship discussed above between MPD and PT by holding that they are independent diagnoses. While PT cultures do have alternative interpretations of ostensibly “possessed” behavior, these alternatives are almost always more along the psychotic, schizophrenic lines than anything identifiable as “MPD.” Thus, LINDHOLM (1990: 159) can state that

in every culture where shamanism occurs, the people themselves clearly distinguish between the authentic shaman’s mental state and the truly insane ... This distinction is made even though the actions of both may be similar, and in spite of the fact that “insanity” ... is the sign of the shamanic gift in an initiate.

It is a long way from simple insanity to indigenous pathological MPD. If in fact these cultures had indigenous categories approximating MPD, it would seem likely that a conventional, Western MPD diagnosis would be more readily accepted and applied frequently than was revealed in the COONS et al. (1991) survey.

2. The clear evidence for early traumatic etiology in MPD but not among possession initiates.

This issue has already been discussed in depth. The relationship between early trauma and later possession activity, while not so clear as that documented for MPD patients, is still far from being as uncertain as CARDENA would here depict it.
3. The distinction between a voluntarily induced, controlled and contextually appropriate possession and the usual experience of uncontrolled and involuntary manifestations reported by people afflicted with MPD (cf. NOLL 1983: 450).

It is true that inherent within the concept of MPD is that switching between alters is not fully controllable by the primary personality. Both Hughes (1990) and Rogers (1991) observed this involuntary switching. But this fact does not support the conclusion Cardena wishes. The error here is highlighted by Antze (1992: 322):

It is a mistake to assume that there is a widely useful distinction between spontaneous (and hence pathological) trance on the one hand, and trance which is "authorized as a normal part of a collective cultural or religious practice" on the other. To the extent that any form of trance is recognized as such by members of a culture and therefore given meaning, it is culturally "authorized," even if only as a form of illness.

Ultimately, not all contextually appropriate possessions are voluntary (cf. the adventures of Archipiado [Waber 1991]), and, at the very least, since transitions between personalities can often be easily accomplished while hypnotized, it is hard to characterize MPD as rigidly involuntary (we need not raise the immense philosophical difficulties in clarifying just what is "voluntary" and what is not). While one can contrast voluntary with involuntary trances, and agree that the latter deserves clinical attention, these categories are not coterminous with PT and MPD.

4. The phenomenological distinctions between most MPD manifestations and some possession phenomena, particularly transcendent possession.

Cardena's focus upon phenomenology is particularly curious because DSM-III-R, using the same criterion, chose not to elevate possession to its own psychiatric disorder.

The belief that one is possessed by another person, spirit, or entity may occur as a symptom of Multiple Personality Disorder. In such cases the complaint of being "possessed" is actually the experience of the alternate personality's influence on the person's behavior and mood. [American Psychiatric Association 1987: 271f]

It would be difficult to maintain that distinct psychobiological fundaments are working in MPD and possession trance, given the case histories. For instance, one of the first MPD cases, Mary Reynolds, involved an alter who claimed to have been "first born in 1475 and had transmigrated into new bodies periodically since" (Kenny 1986: 51). Ernest Hilgard (1986: 37) reports from the literature one case where a woman's alter

"claimed to have been a childhood friend ... who had died and then had become a part of [the patient]." This case, he concludes, "is partly that of 'possession' and partly that of double-personality with a better integrated part beneath a disturbed surface personality."

We might suspect that the only reason these cases became ones of MPD and not PT pertains to the interpretation of significant others (e.g. the attending physician) and the patient's own expectations, and not wholly to the condition itself. In other words, these same cases might have had different interpretations (cf. Sargant 1973: 56) had they occurred in India or Brazil instead of in the United States. This is the conclusion reached by Castillo's (1991) detailed comparison of South Asian spirit possession and MPD in North America. As was stated in the Introduction, however, this immediate conversion will probably not hold for every instance.

Ultimately, convergent phenomenology is one of the strongest reasons to suspect MPD and PT to be related, and not, as Cardena argues, grounds to differentiate between the two.

It has been possible to counter every objection Cardena raises to an identification of an underlying similarity between MPD and PT. We may legitimately conclude, then, that PT and
MPD are, at the level of morphology and epidemiology, largely one and the same, and from this we may infer a single psychobiological basis for both, as probably expressed in the mechanisms of dissociation and focused attention. In this, our review ratifies LUDWIG'S (1983: 95) conclusion that

Given an individual's capacity for dissociation, these molding influences [of individual psychological needs and conflicts, social forces and cultural factors] will determine whether the outward manifestations will be that of hypnosis, mediumistic trance, arctic hysteria, fugue or multiple personality.

This is not to say, however, that MPD and PT are perfectly equivalent or interchangeable at other levels. There seems good reason to treat MPD but not PT, although distinguishing between the two can be difficult. Because both are end products of cultural manipulations, differences can be observed at that of individual impact without contradicting the finding of a genetic relationship.

Notes

1. When DSM-IV goes into effect, Multiple Personality Disorder became Dissociative Identity Disorder [DID]. This change has not been uncontroversial (cf. ISSMP&D 1993). It is unclear whether this category has undergone a simple relabeling, or a more substantive restructuring. In order to avoid confusion if the latter should prove to be the case, the article reflects the older language of the literature upon which it was based.

2. Coming from the other direction, COONS (1985:161) is willing to argue that "the occurrence of multiple personality disorder should be considered presumptive evidence of child abuse until proven otherwise." Given the hysteria that this child abuse can elicit, a "guilty until proven innocent" attitude seems ill-advised. It is also unclear how the current debate about practitioner-guided false memories may impact on the correlation between MPD and suddenly recalled abuses and the new false memory syndrome.

4. Deutsche Zusammenfassung

Multiple Persönlichkeit, Hypnose und Besessenheitstrance

Ungeachtet all dessen, was über „Multiple Personality Disorder“, die Spaltung in mehrere Persönlichkeiten, (MPD) und „Possession Trance“, einen Zustand der Besessenheit, (PT) geschrieben wurde, bleibt das genaue Verhältnis zwischen beiden unbestimmt. Einerseits vertreten einige eine strikte Trennung, in dem sie richtigerweise betonen, daß MPD üblicherweise eine Krankheit ist, während PT ein gesundes Erlebnis ist. Auf der anderen Seite kann dem entsprochen werden, daß bei den gegebenen zahlreichen oberflächlichen Ähnlichkeiten, die zwei nicht mehr als kulturelle Ausführungen desselben Prozesses sind.


Der Unterschied zwischen PT und MPD in den Folgen ist, daß während ersteres eine Manipulation von veränderten Zuständen darstellt, verlangt letzteres einen kompletten Verlust dieser Zustände. Obwohl diese Unterscheidung eine unterschiedliche klinische Behandlung der beiden beinhaltet, rechtfertigt es nicht, auf ungleiche genetische Grundlagen zu schließen.

Auf der Suche nach relevanten Variablen, die MPD und PT zugeordnet werden können, untersucht dieser Aufsatz die Literatur, um die vorliegende Morphologie und die demographische Epidemiologie von jedem dieser Phänomene zu skizzieren. Im Fall der Morphologie sind die untersuchten Dimensionen:

- Freiwilligkeit, Gedächtnisverlust (Amnesie), die Verzerrung von Zeit („time distortion“), Elektroenzephalogramm-Unterschieden zwischen Zuständen, und hemisphärische „lateralization“. MPD und PT stimmen in jeder dieser Variablen überein, mit Ausnahme der hemisphärischen „lateralization“. Während Nachforschungen ergeben haben, daß MPD die linke Hemisphäre betrifft, ist die rechte der Ort der Besessenheit von einem Geist.

- Epidemiologische Variablen sind unter anderem: dominierendes Geschlecht, Mißbrauch in der Vergangenheit, Alter des Ausbruchs, biologische Substrate, Familiengeschichte, altersbedingter Verfall und interkul-
Multiple personality, hypnosis, and possession trance

5. Literature

American Psychiatric Association

Antze, P.

Beahrs, J.O.

Bilu, Y.

Bliss, E.L.

Bourguignon, E.

Brassfield, P.A.

Braun, B.G.

Braun, B.G. & R.G. Sachs

Cardeña, E.
Castillo, R.J.

Coons, P.M.

Coons, P.M.; Bowma, E.S.; Kluft, R.P. & V. Milstein

Crabtree, A.

Crapanzano, V.

Davidson, J.M.


Frankel, F.H.

Frischholz, E.J.

Geertz, Clifford

Goldenthal, M.H.

Goodwin, J.

Goodwin, J.; Hill, S. & R. Attias

Herbert, W.

Hilgard, E.R.

Hughes, D.J.

Hughes, D.J. & N.T. Melville
Hurston, Zora Neale

ISSMP&D (International Society for the Study of Multiple Personality & Dissociation)

Kenny, M.G.

Kluft, R.P.
1985a Making the Diagnosis of Multiple Personality Disorder (MPD). Directions in Psychiatry 5, Lesson 23.

Lasky, R.

Lewis, I.M.

Lex, B.W.

Lindholm, C.

Ludwig, A.M.

1972 The Objective Study of a Multiple Personality: Or, Are Four Heads Better than One? In: Archives of General Psychiatry 26: 298-310.

Martinez-Taboas, A.

Marusich, A.S.

Mischel, W. & Mischel, F.

Morgan, A.H.

Morgan, A.H. & E.R. Hilgard

Nash, M.R.; Lynn, S.J.; & D.L. Givens

Noll, R.
Orne, M.T.

Peters, L.G. & D. Price-Williams

Putnam, F.W.

Ravenscroft, K.

Richeport, M.M.

Rogers, R.L.

Rogler, L.H. & A.B. Hollinshead

Salisbury, R.

Sargant, W.

Shor, R.E.; Orne, M.T & D.N. O'Connell

Spiegel, D.; T. Hunt & H.E. Dondershine

Szasz, T.

Taliercio, J.V.

Taylor, E.

Varma, L.P.; Srivastava, D.K. & R.N. Sahay

Wafer, J.

Wilbur, C.B.