‘Multiple Personality Disorder - Demons and Angels or Archetypal aspects of the inner self’

Dr Haraldur Erlendsson

Introduction

The validity of Multiple Personality Disorder (MPD) as a category of illness has been questioned by many. Some feel it is only caused by hypnotic induction and not seen in real life. It is well known in the literature; one of the famous stories that describe it is ‘The Strange Case of Dr. Jekyll and Mr. Hyde’ by Robert Louis Stevenson that has been made famous by the Hollywood film industry. It is a 19th century thriller about a man who unlocks his evil alter ego and pays a terrible price for it.

MPD is often confused with schizophrenia, even to this day. The name schizophrenia comes from the idea of split personality. In the International Classification of Diseases (ICD-10) MPD is described as a condition where two or more distinct personalities take full control of the behaviour and when there is some inability to recall events occurring in the different states. The exclusion criteria include states that are induced by substances such as alcohol and other organic causes, though some feel that these should rather be seen as a spectrum of the illness. In DSM-IV, the USA classification, the definition is similar but the illness has been given another name: Dissociative Identity Disorder (DID).

Epidemiology

Lifetime prevalence of Dissociative Disorders is about 11% and the prevalence of MPD has been estimated to be about 6%. The illness is seven times more frequent in women than men. Only about 0.1% of the population will present to the psychiatric services at any point in time with MPD. The notion of the illness is neglected by the majority of clinicians who rarely make the diagnosis especially in the United Kingdom. When looked for on acute psychiatric wards as many as 6% of patients fulfil the criteria for MPD. At least 40% of those that are given the diagnosis of MPD have previously been given the diagnosis of Schizophrenia. Any one with the diagnosis of Schizophrenia that does not have blunted affect, a thought disorder and the empty deterioration of schizophrenia should be considered having MPD. The average number of first rank Schneiderian symptoms is 4.5, which is about the same as in Schizophrenia.

Aetiology

The main causes of MPD are abuse and neglect in childhood. It is, however, acknowledged that it can be induced in adulthood and that has and may still be used in undercover operations by military intelligence. Of course, it can be factitious and maintained by secondary gain.

The Osiris Complex

One of the models that have been created to explain the symptoms in MPD is the Osiris Complex. It is based on the observation that traumas in childhood are more likely to cause it than if they occur later in life.

The legend of Osiris is of the legendary king of Egypt who was killed by his envious brother Set and cut into pieces that were spread around the kingdom. Later Isis his wife gathered the pieces together and brought him back to life.

One of the skills humans learn early in life is to play with many roles. This skill continues into adult life. We learn to switch between many roles in a single day, being a father, brother, professional etc. Some states like sexual activity have perhaps more separation from the rest. Sexual abuse seems to have a very profound causative effect; this may be because of its trans like nature. Our dreams are like a theatre where different aspects of being can be experimentally expressed. However for most of us there is a continuity of memory between our many daily roles and the switching is voluntary. The harmony between different states is disturbed in personality disorders, especially Emotionally Unstable Personality Disorder (impulsive/borderline).

The integration of our different states seems to be accomplished before or around puberty. It is this integration process that is delayed in MPD. Parts of the self take on the abuse and other parts distance themselves from it as if it was happening to someone else. One of the survival mechanisms of children ensures that they become attached to the carers so even when their own parents abuse them they still love them. Then they grow up with both love and hate for the same person; that becomes very difficult to integrate and can lead to ongoing splitting within the mind. The defence mechanisms in MPD are different from the normal repression of traumatic material that is sometimes called horizontal splitting. In MPD we see dissociation of the person or vertical splitting.

Features of Different Personalities

Many of the writers on MPD are uncomfortable with the notion of many personalities in one body. The number of personalities or ‘alters’ varies from 2 to above 100, with the mean about 15. The clinical presentation of these different personalities can be very complex. The different ‘states’ can claim to have their own name, their behaviour may be different and their mood states can be different. They may have markedly different mannerisms and facial expressions. They may also dress differently and talk with a different accent. Some have different sexual identity and orientation.

There are also many physical attributes that can change such as dominant handedness, visual acuity and even sensitivity to allergens and degree of endocrine disturbance including hypothyroidism and diabetes.

One of the many unusual aspects of MPD is the frequency of headaches (79%) and extra sensory perception (ESP). These include telepathy, telekinesis, clairvoyance, seeing ghosts, poltergeist contacts and out of body experiences. These are the main non-specific clinical features of MPD.

Making the diagnosis

As MPD is a great imitator of most other mental illnesses, it can be tricky to make the diagnosis. It is important to acknowledge that on average MPD patients fulfil the criteria for seven Axis I disorders and three Axis II disorders. Most of them suffer from Recurrent Depression (98%), PTSD (85%), Anxiety (79%), Substance Abuse (65%) and

many from Schizophrenia (40%), Somatoform and Somatisation Disorders (41%) and Eating Disorder (38%). They also fulfil on average about four different categories of Personality Disorder. This complex presentation is an important part of the presentation, especially in the more severe cases. The normal clear boundaries of categories seen in other disorders disappear. The only other category that shows similar features is Borderline Personality Disorder especially when severe. Some feel that it is in fact just a lower grade of the same illness. Perhaps it would be better to talk about a spectrum of psychological trauma-related illnesses, from Acute Stress Reaction through to PTSD, Borderline Personality and MPD. One can also talk about a spectrum of dissociative symptoms from amnesia, fugue to partial and full-blown MPD. The picture depends very much on the severity, and chronicity of the trauma, as well as the age at the time of the trauma. The key of the matter is that ICD-10 and DSM-IV are mainly descriptive categories, but for MPD it is more helpful to see it in the context of the cause because of the complexity of the psychopathology.

Most patients with MPD are aware to a degree of the switches in behaviour. They sometimes meet people they don't recognize but who state they know them. They find items at home that they can't remember putting there. They may have considerable blank periods from their childhood, but also sometimes flashbacks from these same periods. They may notice changing in handwriting and have periods where they feel unreal. Sometimes they feel as if another person was there and they talk of we/us rather than in the first person. They frequently hear voices talking in their head, as is often found in Borderline Personality Disorder. Sometimes they also remember another person taking over their body.

Many clinicians will not make the diagnosis until they have talked to at least a few of the alters directly while the patient is in a hypnotic state, or during a Sodium Amytal induced trance.

To aid the clinical interview in making the diagnosis many questionnaires and structured interviews have been developed. The easiest screening questionnaire is the Dissociative Experience Scale (DES) that takes about 10 minutes to complete and 5 minutes to score. It is the best self-report instrument for measuring dissociation. One of the best-structured interviews is the Dissociative Disorders Interview Schedule - DSM-IV Version (DDIS). DDIS takes about 45 minutes to administer.

Personalities or Possession?

When alter personalities are asked about whom they believe they are, they say they are: children (86%), helping spirits (84%), demons (29%), another living person (28%), dead relatives (21%) and a person with opposite sex (63%). The two largest case series that have looked into this are by F W Putnam (1986) who described 100 cases and C A Ross (1989) who described 236 cases. Even though the majority of alters claim not to belong to the individual the prevailing opinion is that these are in fact parts of the individual.

DSM-IV defines Possession Trance as a single or episodic alteration in the state of consciousness characterized by the replacement of customary sense of personal identity by a new identity. This is *attributed* to the influence of a spirit, power, deity, or other person. Later in the definition DID (MPD) is excluded. However this is difficult - the definition is based on a belief attributing the state to a spirit etc. and this is very common in MPD.

If the different personalities claim to have a history very different from the main personality, should we take them at face value? After asking a series of questions like: Is anyone there? Who are you? Since when have you been there? Where were you

before? What effect have you been having on the main person? Why have you not moved on? When the answer clearly states the belief that they are an entity coming from outside the person, should we take the answers at face value? Should we use the answers given to differentiate between Possession and Multiple Personality Disorder? Maybe the diagnosis of MPD should include the notion of Possession Trance. The problem here is that not many clinicians are comfortable with the notion of afterlife and entities from different worlds of existence.

Ross, who has written the most comprehensive textbook on MPD (1997), has occasionally used spirit release methods like many others in this field. However, he prefers to the treat alters the that claim to be external like any other parts of the personality. He helps them to deal with any relevant traumatic material and aims for full integration with the rest of the person.

My view is that possession and multiple personalities are not necessarily mutually exclusive but rather frequently co-occur.

Attempts to release entities may fail if the traumas that brought them in are unresolved. It may be important to differentiate between possession trance and spirit attachment. The latter means that the person that emerges in hypnosis has never taken full control of the body outside hypnosis. It may certainly have had a negative effect on the person. In some cases spirit release methods may be method of choice.

Generally I feel that symptoms should be dealt with within the conceptual boundaries that they present themselves. So, if within hypnosis the personality speaking gives a history of a different life, a clear time when it entered the body in question and what is holding it back, then one should help it to 'find its way to the light'. This notion of entering the light can also be seen as a metaphor for integration with the spiritual self. As this is a field where it is difficult to be certain, it may be helpful to see these ideas as models and that having a number of models at the same time may make the therapist more flexible in his approach.

Why make the diagnosis?

The importance of making the diagnosis of MPD is that therapeutic work can be very successful. Among comparably severe psychiatric diagnoses, MPD may be the condition that carries the best prognosis if proper treatment is undertaken and completed. Richard Kluft has provided most of the literature on treatment outcome based on observation of his own caseload. He saw 171 cases privately over a period of a decade. Stable integration was achieved in 67.5% of cases and it took on average 21.6 months to reach this. Most of the others improved even though they did not reach stable integration. Only 24.2% were in treatment longer than 30 months. His client group was all seen privately and they may have been in the milder range of illness. Most of the clients that reach integration remain stable after treatment or have short episodes of instability triggered by major live events.

Ross has followed up his series of over 100 patients and has calculated that the cost to the health service following treatment is markedly reduced and that treatment is likely to be cost effective. This is because a proportion of the cases of MPD are very expensive to the Health Service. They are frequent attendees of GP surgeries, A&E, community mental health services and psychiatric inpatient units.

Treatment Guidelines of ISSD

The International Society for the Study of Dissociation has prepared and published on its website detailed treatment guidelines for Dissociative Identity Disorder

(MPD). Their recommendations are quite extensive. They suggest three one-hour dynamic psychotherapy sessions per week with, if possible, support between sessions. They also recommend treatment for at least 2 years and for some up to 7 years. This means 200-1000 hours of therapy time, which has major cost implications.

An Alternative Treatment Approach for MPD within the NHS

A psychiatrist working within the NHS has no possibility of managing a case of MPD within the ISSD guidelines because of time constraints. Then again, there are beliefs systems within the NHS that do not sit comfortably with the notion of spirit attachment and spirit release therapy. To reduce therapists' time the author has therefore brought together techniques from various sources that clients can learn to do themselves. The emphasis is on self-help training with ongoing support from the psychiatrist.

Being with the Inner Mind

The first step in treating MPD should always involve educating the individual about models of the mind, aetiological models of MPD and about the many different methods used to treat it.

The first method I use I take from Rossi's book 'The Twenty Minutes Break'. Brief periods throughout the day are used to observe the content of the mind, perhaps for a minute or two every hour or two. For these few minutes, attention is paid with loving respect to every thought that comes into the mind, whether it is pleasant or unpleasant. Observing without judgment is the key thing as this helps the individual to sit more comfortably with the content of this mind. This is done without attachment, to prevent the thought from engaging the mind, especially if there is a heavy load of negative emotion. This induces a sense of good will towards all aspects of the mind. It is done with the belief that in fact every part of the mind is trying to do the best it can. When 'bad thoughts' come up, it is the burdened part of the mind asking for help rather than trying to make the conscious mind suffer. Every time one adds something good to a thought it will return to the depths of the mind somewhat different and the next time it arises, it will feel slightly better. If this approach is maintained throughout the day, then after a year most thoughts have been given time, attention, fascination and respect, and that hopefully will help them to be more receptive to processing.

Both Rossi and Jung talk about the importance of the numinosum in therapeutic work. The experience of fascination, mystery and the tremendous were summarized in the word numinosum by Rudolph Otto (1932/1950) to describe states of arousal that are characteristic of all original spiritual experience. For Carl Jung the experience of the numinosum became the essential driving force in human motivation and the process of individuation. Rossi in his new book 'The Psychobiology of Gene Expression' suggests that consciousness is attracted to anything new and interesting. Consciousness becomes fascinated and that turns on gene expression and neurogenesis, which leads to the building of a better brain. The use of fascination and admiration leads to a more transmutable state of thoughts and beliefs. This state can, through the automatic processes in the mind, lead to change.

Using the Symptom

The second method I use is from Rossi's book The Symptom Path. Rossi postulates that the feeling of every thought is the energy needed to engage the mind and

bring about the high arousal, where processing can take place all by itself. All that is needed is to go with the flow. He has developed a few simple techniques to support this process. One of them is the 'hand polarity technique' where he inspires the Inner Mind to link one of the hands to the problem. He then inspires the mind to review all thoughts and experiences linked with the problem and at the same time allowing these to gather as a feeling and a sensation in that hand. He then uses the other hand as a crucible where the mind can gather together anything that might help and everything that is the very opposite. Then he suggests that the two hands could explore together a common meeting ground so that this process can become mutually advantageous to these two different domains of the mind.

Another of Rossi's symptom methods is to allow a feeling of a problem to settle anywhere in the body and then ask the mind to explore it as a sensation, and then as an image. Everything that comes up is acknowledged as stepping-stones in a process that if allowed to continue will lead to new insights and shift in the problem.

I ask the client to set aside ten to twenty minutes on a daily basis to allow this to happen. I try to empower them for this work by telling them that Inner Mind has all it needs except the support from Conscious Mind. When the inner and outer meet and there is 'fascination' then healing takes place.

Finding a Place of Healing

The third set of exercises I teach is more in a visual format. I ask the patient to do this as part of his daily longer session. I take the idea for this work from Jung's 'Active Imagination'. Sensitive but focused consciousness on inner dialogue with the novel and numinous figures of our dreams and fantasies is a way of engaging and facilitating healing and individuation. As a preparation of this work I discuss Jung's ideas about various functions of the mind and how they can appear in fantasies and dreams such as the Shadow and the Wise Old Man, for instance.

For me the work with the Shadow is the beginning of the processing of the traumatic material. It is about preparing the Shadow to engage in positive therapeutic work. Initially most people experience the Shadow as a threat - bringing up the pain or covering it in darkness and numbness. This part of the Inner Mind has often become bitter from the Conscious Mind having rejected its efforts to break through and carry out the tasks that await. Learning to see the Shadow as your best friend, who carries the burden and looks to you for help in transforming your burden is the first step.

This work is facilitated by allowing a ‘safe place’ to emerge in the mind. This can be anything such as a garden, a cave, a field or a mountain. The Inner Mind is given an opportunity to create it all by itself, without any interference from the Conscious Mind. Patience and admiration with clear intent empowers the mind to do the job. Once the safe or sacred place emerges, the ‘feeling’ of the place is invited to appear as a person or an animal. That person becomes the first guardian of the work.

Often right at the start many people only see emptiness in the mind and feel upset since ‘nothing’ is happening. I tell them that the ‘nothing’ is what is happening and that it is the first face of the Shadow. Its face is usually that of faceless emptiness and once recognised and acknowledged, it opens the door to the other brighter aspects of the Inner Mind. Through persisting, other specific memories or problems come up, as if they knew that healing is about to take place and they want to be the first ones to be attended to. They are invited to come up, acknowledging them and then asking them to allow the Conscious Mind to explore more deeply with the promise that they will be called upon when the place of healing has been found. In some way they are like the Guardians of the Threshold in mystery tales.

One of the problems of this work is that it can become like a written script and then it becomes empty and shallow. Expecting change and receiving it with fascination keeps the process constantly renewed. As the patient starts to reap rewards from his efforts it becomes even easier to stay in admiration of this automatic process. Ending every session with thanks further empowers the Inner Mind.

In the visual mode of work I first direct the attention of the patient to the source of light, like the sun in the sky and linking that with breathing. This is used to allow light to enter the body and the mind when breathing in and releasing weight and darkness when breathing out.

The next task is to allow a compassionate figure to emerge that is strong enough to meet and balance the pain of the Shadow. For those who have had little positive experience with anyone in their lives this can be very difficult. Most often it appears as a benevolent dead relative or a religious figure. Once that aspect has emerged the processing of traumatic material can start.

The processing work has its dangers, just like the engagement phase of the Shadow. If the negative feelings become too powerful and there is not enough gentle loving power to meet them, then it leads to further pain and no healing. Clear boundaries need to be set. The Shadow and its material must be distant enough to be easily manageable and the material must be small enough to be ‘a piece of cake’. That is to say both easy and small. If this work is not easy and fascinating then it is not healing. It takes time to master this aspect. Multiple small steps are more helpful then a few faulty leaps.

In the safe place, all the alters are allowed to emerge one after the other and are given time for dialogue. The issues they bring are dealt with one after another. A feeling of togetherness is cultivated, with imagery of holding hands and sharing feelings and memories. The most important part of this is gentle warm persistence. If there is resistance then the persistence is not being gentle enough.

I find that the mistakes the patients make while learning this process are the keys for success. Mastering them leads to further fascination and engagement with the Inner Mind. It usually takes about six half hour sessions to master the basics of this approach. The most important aspect of the ongoing sessions is to help the patient to motivate himself to do the work. Sometimes it is helpful to have the partner or friends keep a regular check on the person to remind them and encourage them to maintain regular work.

I now want to briefly describe one case of MPD that I have treated with these methods.

A case of Multiple Personality Disorder

Rod was a 47-year-old salesman when he was referred to me by his GP. He had been divorced from his wife for four years. He had two children in their teens that lived with their mother. Rod was in a new relationship and his partner had given him an ultimatum: 'Either you deal with your problems or I will leave'.

Rod's problems were complex. He suffered from sudden changes in mood and it was these that were creating havoc in his relationship with his new partner. With what seemed to be minor triggers, this very gentle and caring man became abusive, especially to those whom he normally really cared about and appreciated. Rod had only a faint recollection of these incidents, which happened many times a week. He also had severe social anxiety and the lingering feeling that everyone was out to get him. He felt most of the time that he did not really have any memories, nor that he knew whom he really was. He often felt unreal and distant and felt he could not see things clearly. At times he heard faint voices talking among themselves. He had severe obsessive traits and often spent his nights making cue cards to help him to remember whom he was and how he should respond to people, especially at work.

Rod's childhood had been very difficult. He was brought up in considerable poverty. Both his parents had alcohol problems and there were repeated fights in the family homes throughout his childhood. His father suffered from sudden changes in mood where he became violent with Rod and his two brothers. Rod's father had little recollection of these episodes. Rod's older brother was also violent towards him. Rod was bullied at school due to his poor clothing and lack of washing and this lead him to have a very low opinion of him self.

Rod had been in contact with the psychiatric services once before his referral to me and this was during a difficult period in his relationship with his ex-wife. He was thought to suffer from cyclothymia and he was treated with a mood stabilizer, which had very limited effect. He said that he hardly had had a normal day in his life. However, since meeting his new partner things had started to change slowly for the better.

Therapeutic Sessions

I saw Rod initially for a one-hour assessment and then for 12 half-hour sessions over 18 months. Right from the start he was very keen and initially felt elated, as now his symptoms made sense. For a while one of his difficult personalities, whom he called 'The Beast' started to act out more, which led to his partner joining him for his sessions with me. This acting out seemed to be happening when Rod was neglecting his inner work and also when he was taking on more stuff than he could easily manage. Regular support and discussion with the partner solved that problem. In his work, mainly two aspects of his inner mind emerged. One was the Beast who presented his anger. The other was a very relaxed and easy-going presence. Later other aspects emerged, such as the Dwarf Guardian of his place of healing and a very spiritual being whom he saw as a Great Giant.

Progress

Rod started to have normal days where he felt himself to be without sudden changes in his mood. Slowly his social anxiety improved and he felt more at ease at

work. He developed a warm relationship with the alters and slowly started to notice that people seemed nice and were no longer a threat. When his unreality feeling improved he stopped using his cue cards. At times he felt he did not need the exercises any more but that was usually followed by a period of worsening. His ability to process his traumatic material took a forward leap when a 'Holy Being' emerged in his work. That person seemed to be able to transform the pain with awesome compassion and light. Then Rod started to feel that all the alters were together at times. His skills at the workplace rapidly improved and he was given increasing responsibilities. After about eighteen months of therapeutic work the fluctuations between different states disappeared. I followed him up a year later and found that he had then remained stable.

Reflection

Rod's illness was in the milder spectrum of MPD and he had many favourable prognostic factors. He is very intelligent and he was very keen to work with his problems. Even though he had suffered for many years, he had been able to hold down a stable job and have a relationship during these years. He had never been admitted to hospital. During therapy he was in a very supportive relationship that enabled him to continue with the work. However just as with more dynamic approaches with MPD, the process took a relatively long time.

The advantage that I saw with these self-help techniques in this case, besides the much-reduced therapist input, was that Rod felt that he himself owned the progress he made.

Final remarks

Multiple Personality Disorder is in many ways a very unusual presentation of mental illness. Because of its strangeness, many therapists even reject the whole idea of it. Over the last thirty years there has been a growing interest in this disorder and now we know much more about its causes, symptoms and treatability. There is still considerable controversy as to whether the alter personalities should be seen as attached entities as most of them claim to be. Spirit Release Techniques have been used successfully as a part of the treatment in published cases. The International Society for the Study of Dissociation has prepared guidelines for the treatment of the disorder that is primarily along dynamic lines. Until now it has been assumed that only intense and longstanding input from therapists can lead to integration. This author suggests a more self-help approach with daily attention and fascination with the inner world, presenting one case of Multiple Personality Disorder that reached stable integration in eighteen months with only thirteen sessions with the therapist.

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Diagnosis

DSM-IV (appendix) diagnostic criteria for dissociation trance disorder

A. Either (1) or (2):
(1) Trance i.e., temporary marked alteration in the state of consciousness or loss of customary sense of personal identity without replacement by an alternate identity, associated with at least one of the following: narrowing of awareness of immediate surroundings or unusually narrow and selective focusing on environmental stimuli
Stereotyped behaviours or movements that are experienced as being beyond one's control
(2) Possession trance, i.e., a single or episodic alteration in the state of consciousness characterized by the replacement of customary sense of personal identity by a new identity. This is attributed to the influence of a spirit, power, deity, or other person, as evidenced by one, (or more) of the following: Stereotyped and culturally determined behaviours or movements that are experienced as being controlled by the possessing agent
Full or partial amnesia for the event
B. The trance or possession trance state is not accepted as a normal part of a collective cultural or religious practice.
C. The trance or possession trance state causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The trance or possession trance state does not occur exclusively during the course of a psychotic disorder (including mood disorder with psychotic features and brief psychotic disorder) or dissociative identity disorder and is not due to the direct physiological effects of a substance or a general medical condition.

Note. The diagnostic criteria for DSM-IV dissociative trance disorder appear in Appendix B: "Criteria Sets and Axes Provided for Further Study."