



Applying the Enneagram to the World of Chronic Pain

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Determining Personality Type

All fell clearly into one of each of the following three Enneagram Triads.

- Information Processing Triad (body, heart, mind)
- Horneyan Triad: responses under 'stress'
(K. Horney)
- Harmonics Triad: 'reactive' response in conflict
(Riso & Hudson)



Information Processing Triad (IP)

- ❖ Body: (# 8, 9, 1) tend to process information via the body arena - usually exhibits issues of autonomy, physicality and instinctual aspects Anger issues are often present.
- ❖ Heart: (# 2, 3, 4) feelings/emotions are the central focus for processing information. Image is also important. Emotions & love, compassion and shame - part of the processing of and understanding of the world.
- ❖ Mind: (# 5, 6, 7) - tendency to first understand the world through the mind, through thinking and linking. Security is a focus. Anxiety is often a by-product.



The Hornevia Triad (S)

- ❖ Assertive: (# 3, 7, 8) tendency to move into the “stress” situation - to make their presence known and assert their wills.
- ❖ Compliant: (# 1, 2, 6) attempt to decrease stress by becoming compliant - to external or internal (superego) demands, conditions or to rules.
- ❖ Withdrawn: (# 4, 5, 9) withdraw from the source of stress - either physically removing themselves, or removing their awareness onto other matters, or zoning out.



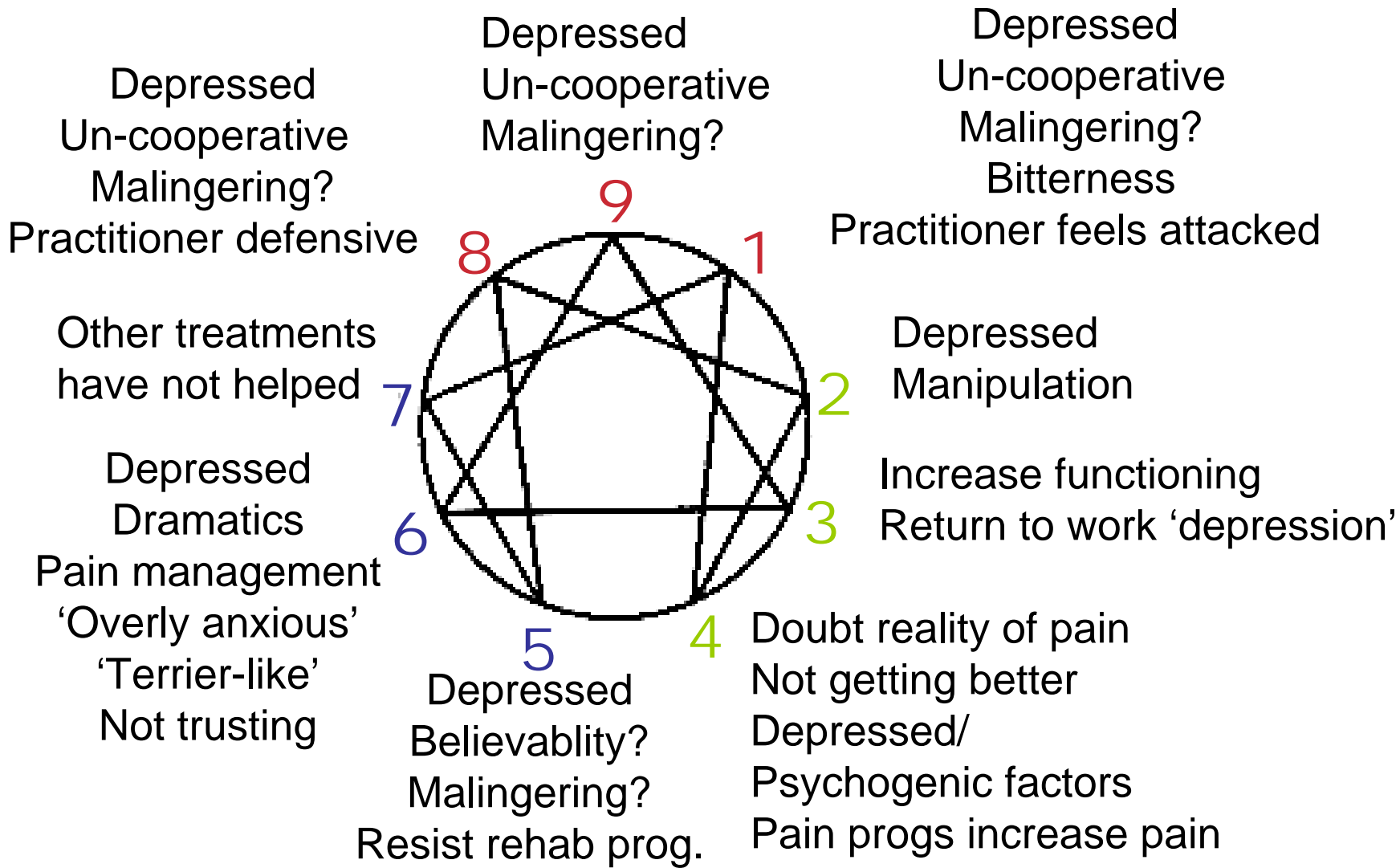
The Harmonics Triad (C)

Riso & Hudson -

- ❖ Positive Outlook: (#2, 7, 9) in Conflicts an it'll-all-work-out-for-the-better viewpoint: hold onto and look for the positive, (perhaps even sometimes denying the no-so-comfortable reality).
- ❖ Competent: (# 1, 3, 5) tend to move into a conflict and attend to it with their own areas of competency - by pointing to what's 'right,' becoming busy, getting to know more about it.
- ❖ Reactive: (# 4, 6, 8) an initial emotional reaction and will a tendency to first respond to conflict and life's challenges with a big emotional, instinctual, or fear reaction.

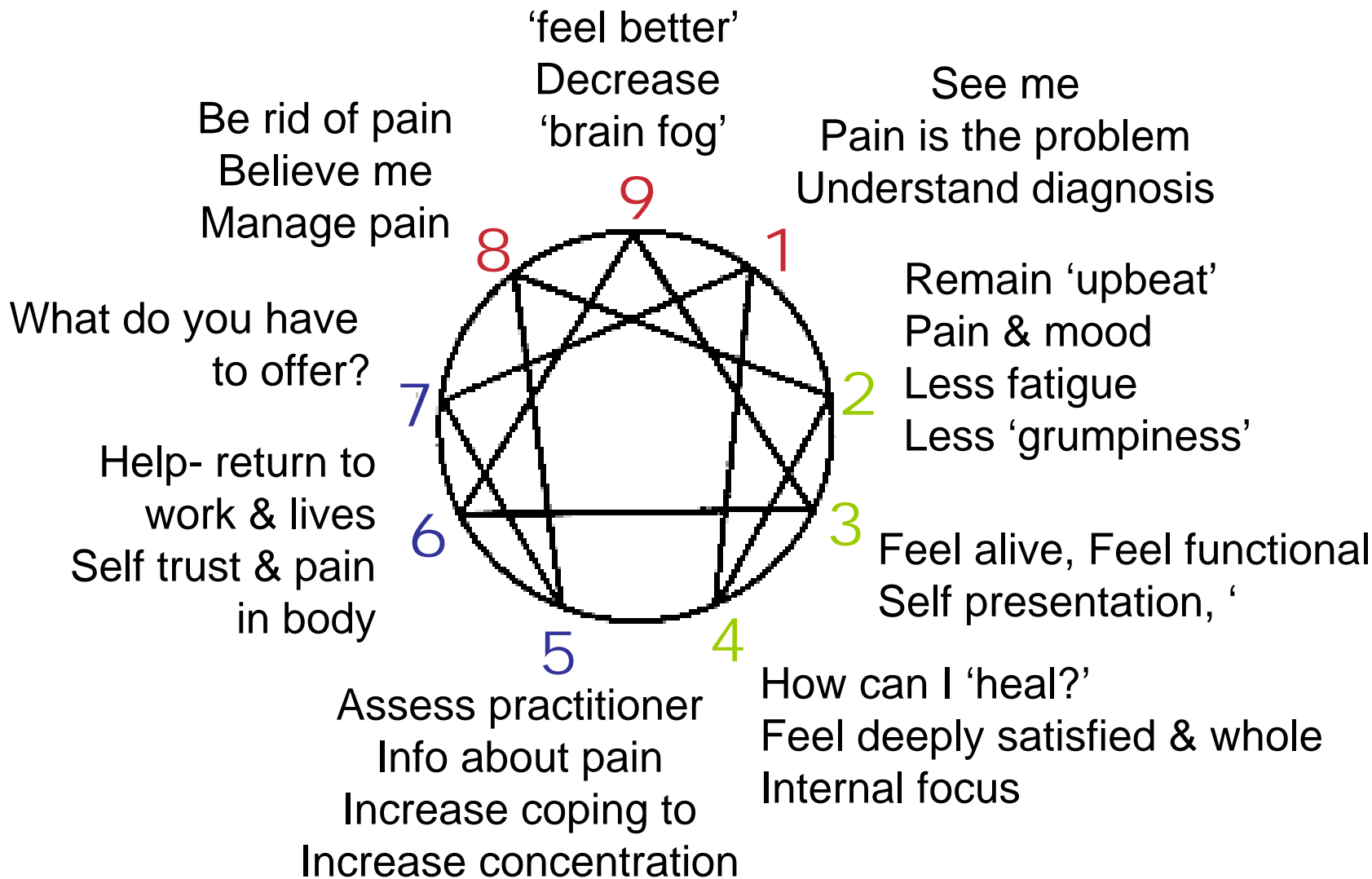


Referrals





Patient Goals





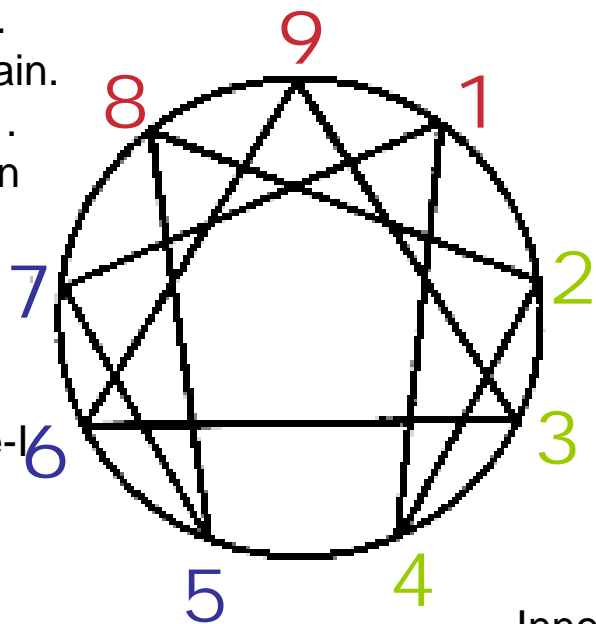
Boundaries

Limited insight. Search out help & push. Push away pain, thoughts, emotions (8)

Readily overwhelmed with pain. Untouchable, inside 'fuzzy' (9)

Sees self as willing & flexible; others do not. Sensitive - in/out & not aware. Inside pressure & threats of suicide. Outside won't help so I have to push others (1)

Demands on external to > pain. Plan, think positive to not feel pain. Pain, not part of 'self definition'. Laughs @ / belittles others' pain (7)



Help others @ cost of < pain
Effort - others appreciate pain
Push and pulls people (2)
Concerns about relationships

Projects-cause of pain & discomfort. Wavers - outside & in. Sees self as highly sensitive-see- emotions stuck in fear & anxiety which < pain (6)

Equates 'being seen' with 'being seen through'. Lashes out & projects. (3)

Pain interferes-inner activity-gets lost. Impressionable. Body not important. Limited understanding of others' behaviours. Maps & shared understandings help.(5)

Inner approach - Willing to change. Very impressionable - in/out
Healthcare enviroverwhelming – cut. Rejects pain as part of me (4)



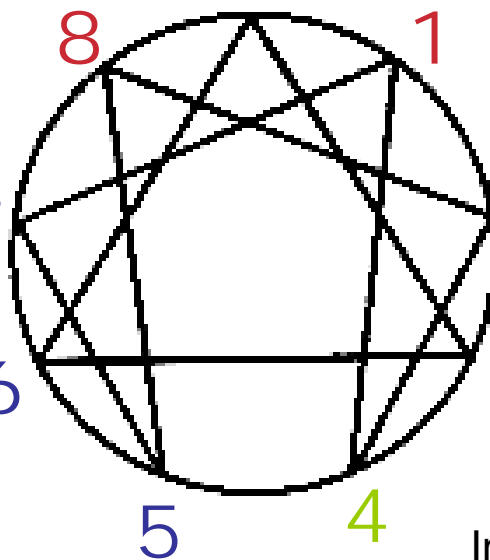
Energy

Force-filled. Large sense of physical power & E irrespective of pain & limitations (8)

Strong physical presence with porous vacancy. Gentle strong E which moves clearly E itself is not 'foggy' (9)

Air of rigid tight effortful containment. Effort & E focused outward E focused on containment of body & 'pain' (1)

Desperate, frantic, scattered, 'removed wooden'. Weary, brittle-like E. Vital E appears tightly mustered to avoid pain experience (7)



Big E behind 'niceness'. Strong centrifugal force around physical presence. High E in self expression. Big & high E can lead practitioners to doubt pain & fatigue levels (2)

Tight vibrating knot of spiraling E. Effort-full E that can switch to strong, gentle, full. Self-report scattered & spinning with pain Velcro-like quality when unaware of needs – look to experts (6)

Intense, cerebral, Big E Contained & fluid source Youthful appearance & abundance of E Impressionable re: E (5)

Outward flow of E with 'hallowness'. Highly vigorous presentation not reflective of E (3)

Intense. Slow inward E - sense of slogging, plodding. 1st changes in treatment deep. All-expansive birthing E (4)



Superego Activity

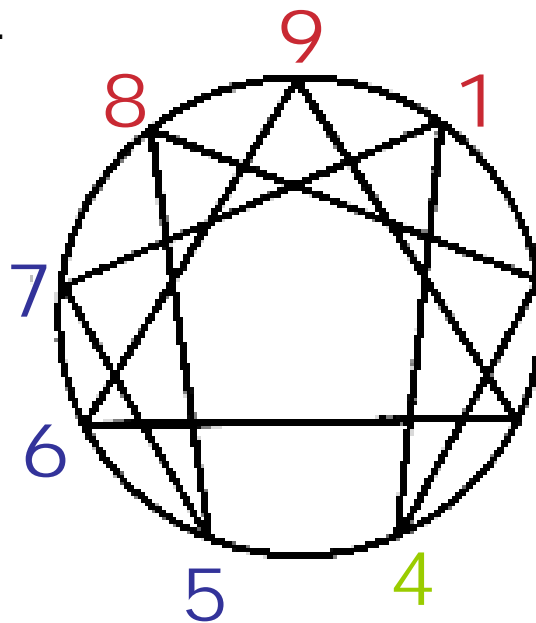
Rejection of pain a violation of strength. Reject emotions Challenges helpers to 'fix'. Insurance difficulties (8)

Distract from emotions around pain. Don't pay attention to pain - keep active.. I'll be better, stay positive. Difficulties expressing. (7)

Must try hard to do what advised - find right source, right practitioner - not get overwhelmed. (6)

Must get the facts & knowledge. Think way through this and inform others (practitioners). Emotions are "wrong thinking" (5)

Pain experience not permitted. Avoid MD - won't help anyway. Pain a rift to inner stability (9)



Got to push others if I'm to get help Got to do it 'right' & with integrity -- & so do the practitioners. No relief from routine & self expectations. Increased pain & decreased sleep. A 'right' action for healing (insurance difficulties) (1)

No one understands me or my pain. It's not possible to be loved with pain. Shame & guilt @ self focus - leads to paralysis (2)

Must not be defeated by pain. Avoid experiencing pain. Focus on 'getting better' (3)

Got to find the right method, I'm not getting it - if I did, the pain would go. Doubt own experience of pain. (4)



The Presentation of Pain & Pain Experience (cont.)

This means that patients present with differences in:

- ❖ Pain reporting
- ❖ Treatment goals
- ❖ Treatment adherence



Brief Findings

Consistency with presentation & type:

- ❖ Referrals affected by
 - Information processing,
 - assertive style,
 - reactives

- ❖ Referrals not related to patient goals

- ❖ Patient Goals strongly relate to patient 'boundaries'



Brief Findings (cont.)

Patient Goals *relate to* boundaries *influenced within the interaction with:*

- ❖ Long Term Pain
- ❖ Themselves/ internal dynamics
- ❖ Healthcare practitioners & system
- ❖ Friends, family, work
- ❖ Insurance &/or legal organizations



Practitioner's Referrals

- ❖ We refer in response to Patients'
 - Information Processing

- ❖ Ways of:
 - Asserting,
 - Withdrawing,
 - Reacting.



Practitioner's Referrals (cont.)

❖ Biases:

- Personality schema
- Training
- Histories



Practitioner's Referrals (cont.)

- ❖ Practitioners refer according to their own responses and reactions

- ❖ Not –
 - recognizing the patients' goals
 - considering the personality priorities



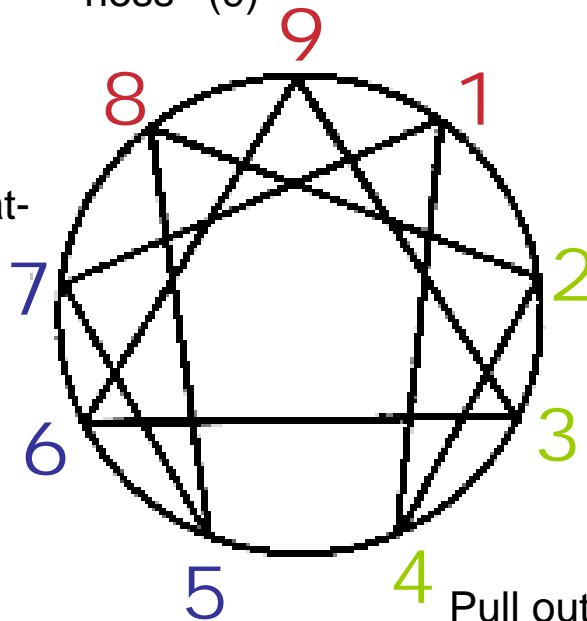
Practitioner's Responses To Patient

Defensive; feels attacked. Affronted. Looks at behaviour, energy & doubts patient (8)

Desire to help - confused as to how. Medications often over-prescribed. React to 'un-cooperativeness' (9)

Medications - frustration on refusal. Feels pressure, & becomes defensive. Angry & frightened. Witnesses, lectures & becomes stern (1)

Likes positive approach. Pain underestimated. Confused. Frustrated with analyzing of treatment & patient. Send to 'cognitive behaviour'. Frequent diagnosis of bipolar. (7)



At first, wants to help, then doubt patient experience. Sees dramatics. Feels manipulated & is irritated-cuts patients off at first session (2)

Frustration with changing treatment. Frustration with changing patient. Resist 'terrier-like' approach. React to lack of trust. See anxiety as related to patient. (6)

Credibility attacked-so questions patient credibility. Patient picture not clear. Threatened with patient questions. (5)

Feels comfortable. Everything progressing as 'should/ expected.' Often misses symptoms. (3)

Pull out all efforts. Medications at first. Sees sincerity. When pain persists & patient's self-express, begins to doubt reality of patient. Frustrated - tried everything - is it 'psychosomatic?' (4)



If Practitioners are to help

- ❖ We need to step back - out of our own personality dynamics
- ❖ Be aware of our biases in training & experience
- ❖ Place 'our goals' to one side
- ❖ Be curious about the goals and reports of the patients
- ❖ Address these &
- ❖ help the patient provide the information we need.



What does this mean in Treatment?

The Personalities -

- ❖ Present with pain & pain experiences differently
- ❖ Present with different goals around their pain
- ❖ Require different treatment



Thank You