Applying the Enneagram to the World of Chronic Pain

Penny J. Whillans

The Canadian Institute for Enneagram Studies

www.canadianenneagram.ca

The IEA Conference, Atlanta, GA., U.S.A.. August 1st, 2008.

Determining Personality Type

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

- Information Processing Triad (body, heart, mind)
- Hornevian 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 Hornevian 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- Withdrawn: (# 4, 5, 9) withdraw from the source of stress - either physically removing themselves, or removing their awareness onto other matters, or zoning out.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.

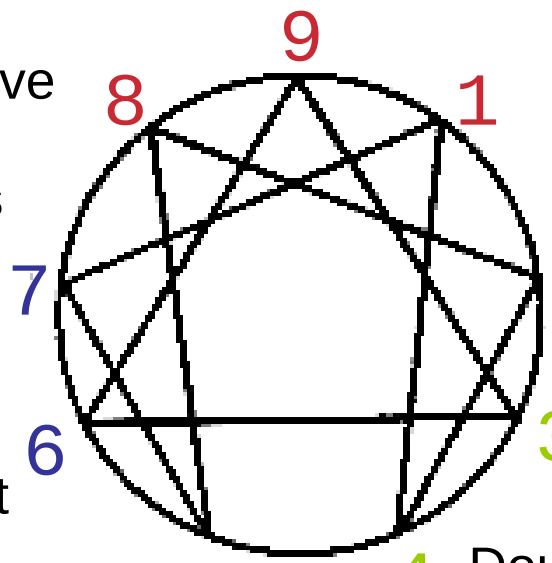
- Reactive: (# 4, 6, 8) an initial emotional reaction and will a tendency to first respond to conflict and life's challenges with a big emotional, instinctual, or fear reaction.

Referrals

Depressed
Un-cooperative
Malingering?
Practitioner defensive

Depressed
Un-cooperative
Malingering?

Depressed
Un-cooperative
Malingering?
Bitterness
Practitioner feels attacked



Other treatments
have not helped

Depressed
Manipulation

Depressed
Dramatics
Pain management
'Overly anxious'
'Terrier-like'
Not trusting

Increase functioning
Return to work 'depression'

Depressed
Believablity?
Malingering?
Resist rehab prog.

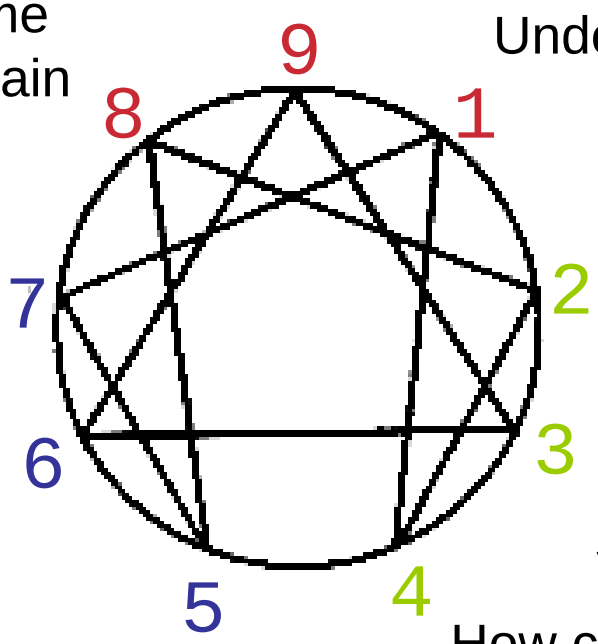
Doubt reality of pain
Not getting better
Depressed/
Psychogenic factors
Pain progs increase pain

Patient Goals

‘feel better’
Decrease
‘brain fog’

Be rid of pain
Believe me
Manage pain

See me
Pain is the problem
Understand diagnosis



What do you have
to offer?

Remain ‘upbeat’
Pain & mood
Less fatigue
Less ‘grumpiness’

Help- return to
work & lives
Self trust & pain
in body

Feel alive, Feel functional
Self presentation, ‘

Assess practitioner
Info about pain
Increase coping to
Increase concentration

How can I ‘heal?’
Feel deeply satisfied & whole
Internal focus

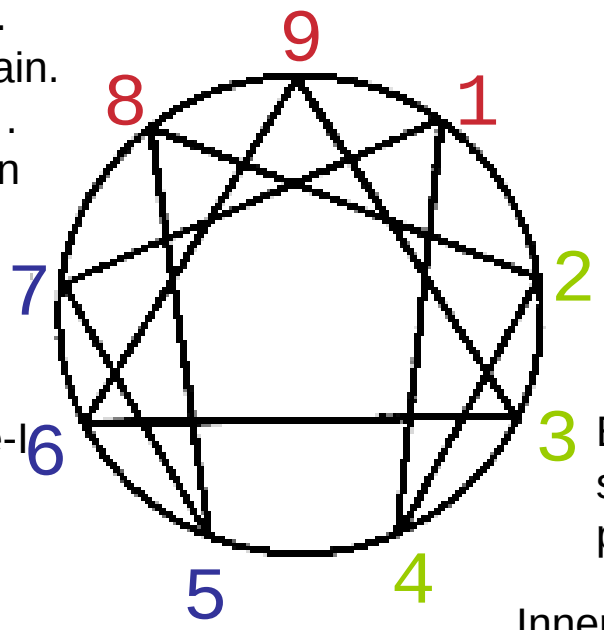
Boundaries

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-I 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 envir overwhelming – cut. Rejects pain as part of me (4)

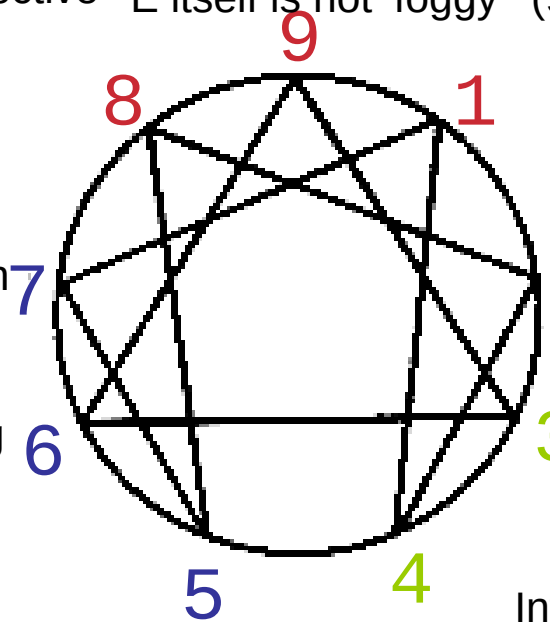
Energy

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)

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

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

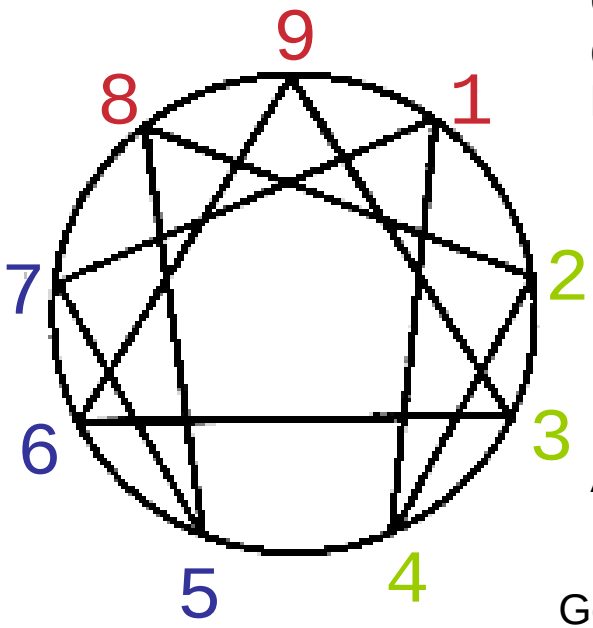
Intense. Slow inward E - sense of slogging, plodding. 1st changes in treatment deep. All-expansive birthing E (4)

Superego Activity

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

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)



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

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

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

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

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

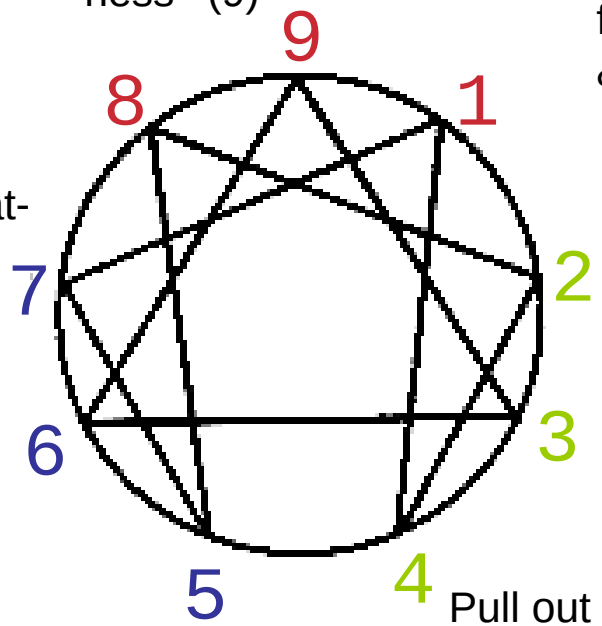
Practitioner's Responses To Patient

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-cooperative-ness' (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)

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

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

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