APPLYING THE ENNEAGRAM TO THE WORLD OF CHRONIC PAIN

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Abstract

This paper reports on a small part of a broader research project that studied the presentation of personality types with chronic pain in a clinical setting. It reviews the reasons for referral, subjects' presentation, subjects' goals, and practitioners' responses. Significant type-related differences were found in subject presentation and in the practitioner responses to such. Treatment ramifications are briefly addressed.

Introduction

This research arises from my practice as a health psychologist. The hermeneutic methodology is based on a Grounded Theory approach with information gained through the treatment assessment process. Research citings of a consistency of 84% or higher are reported. Confidentiality was strictly maintained.

Pain and Personality

In the first years of experiencing chronic pain most people fight against it in their efforts to return to a pain-free-er life. This is the effort of our personalities to help us "feel better," and to help us attempt to manage within this world of embodiment.

Chronic Pain Statistics

Chronic pain, as defined in Canada, is the experience of "continuous or intermittent pain for at least 6 months."[1] In the USA the period of time is 3 months.[2] Both countries' statistics indicate that the prevalence of chronic pain is high and the cost of chronic pain is high. Eighteen to 29% of Canadian adults experience chronic pain[3] and 25% of our seniors experience chronic pain. Yves Veillette et al.[4] found that of those who are experiencing chronic pain: Nearly 75% reported that it affects their daily activities and has a profound effect on mood, relationships, health, quality of life, and family life. This study also showed a significant increase in the prevalence of anxiety and depression among those who experience chronic pain.

Turk & Melzak,[5] long-term researchers in the area of chronic pain, report that the combined direct and indirect cost of chronic pain in the USA is $125 billion dollars per year, and that the costs of low back pain alone (in the earning ages of 18 to 55 years) is higher than the costs of cancer, cardiovascular disease, brain

stroke, and AIDS combined. These statistics make it clear that chronic pain is prevalent and costly.

Chronic Pain Treatment Approaches

Research on the treatment of chronic pain is increasing. Mostly this research examines medically oriented treatment, psychotherapeutic treatment, or combinations of the two. The majority of these studies focus the treatment goals on decreasing pain and pain experience, and on increasing functioning.

In the arena of research and application of psychotherapeutic treatment approaches with chronic pain, Turk[6] has explored a cognitive-behavioral curiosity-based approach, which he has referred to as the "Inspector Columbo approach." His work has allowed for a loosening of perceptions of people who experience pain, and he has also addressed how people with chronic pain may perceive themselves. This approach has highlighted the possibility of working with chronic pain patients from differing perspectives.

Research Goals

To date, I have found no studies that systematically look at chronic pain in terms of the personality of the person presenting with pain. Thus, this study poses the following questions: How do certain individuals with certain coping patterns and certain worldviews manage their pain? What do they need? How do they view their pain? What problems do they encounter? It seems to me that the answers to these questions would be pivotal in the treatment process. Such answers can help us interact with individual patients more effectively, understand their pain and struggles more specifically, understand their goals more clearly, and delineate effective treatment approaches.

These questions structure the larger research project of which this paper is a part. This paper will review the reasons for referral of someone with chronic pain, the subjects' goals, their pain presentation, and practitioners' responses to these presentations.

Research Parameters

Sample Selection

The following were the criteria for subject selection:

- Adults age 21 years or older.
- Non-terminal and non-malignant pain.
- No clear DSM diagnosis, other than pain chronicity
  -absence of Post Traumatic Stress Disorder diagnosis.
- Minimum of one (1) year with pain.
- Prognosis: Likely to experience pain most of their lives.

- Personality type clearly identified.
- In treatment with myself for two (2) or more sessions.

See Appendix "A," *Table of Sample Particulars,* for more specific information on the types of pain, the age range, and the gender range.

Identification of Personality Types

Enneagram personality identification was undertaken by myself in treatment assessment interviews and ongoing treatment assessments. Treatment assessment interviews consisted of a minimum of two sessions. Each session was one hour to 90 minutes in length. Amongst other assessments I listened for history, object relations interactions, the use of coping strategies, and coping strategy effectiveness. I made use of my clinical experience and training as a health psychologist all the while using the framework of the Enneagram triads. Applied knowledge of the Enneagram triads and how they present, knowledge and identification of coping strategies, and the ability to listen are prerequisites for this method of type identification. Some understanding of the psycho-physiology of body-heart-mind interaction is also helpful.

Subjects were unaware of being typed. Most subjects were familiar with the Enneagram from the material in my waiting room, and many had self-typed through reading this material and using a variety of Enneagram typing tools. If a subject's self-typing and my typing of the subject were not in agreement, the subject was not included in this study. To be included in this study, the Enneagram personality type identification had to be clear via the method used below, and it had to be in agreement with the subject's self-assessment (for those who self-typed and volunteered this information). Subject inclusion meant that personality typing was as clear as was possible. This was undertaken by requiring that each subject fall clearly into each of the following triads:

- Information Processing triad: tendencies around trusting the body, the heart, or the mind space as a chief source of understanding, knowing, and information gathering.
  - Karen Horney's[7] Hornevian triad: tendencies in coping with stressors.
  - Riso and Hudson's[8] Harmonics triad: tendencies of immediate response to conflict.

In constructing the study, subjects' coping strategies were of central interest, and the above triads each delineate three specific categories of ways of copying with or approaching the world. In identifying their coping strategies in terms of the above triads, the Enneagram personality type for each subject became clear through a process of elimination. It was not necessary to delineate the specific placement within each of the triads, identifying each triad was enough to gain a clear identification of the personality type. This method simply and clearly

identified personality type. For details of the above triads and of this method of determining personality types, I refer the reader to Appendix "B."

The fact that all of the subjects included in this study are experiencing chronic pain highlights the coping methods at play and particularly the habitual coping strategies that may be experienced as less and less as "functional." Due to the subjects' ongoing experience of loss and change, and due to the ongoing adjustments that are necessary in light of the challenges they face, these subjects' coping tendencies and ways of understanding the world and themselves are often more readily seen than might be the case with people who are not experiencing the intense and stressful challenges that these people tend to be experiencing.

Limitations of this Research

This study:

- is not an exhaustive study of adjustment processes to living with chronic pain.
- does not address specific diagnoses or the premorbid lifestyle or background.
- does not include the etiology of pain onset which affects how the person experiences their chronic pain and is important within treatment.
- does not address the instinctual variants which likely have a profound bearing on pain presentation and issues inherent in living with pain.
- does not review the healthcare practitioners' personalities.
- is based on subjects that have been referred to myself via:
  - Other healthcare practitioners
  - Lawyers
  - Insurance adjusters
  - Self referral.
- has a subject self-selection bias.
- includes only subjects who have chronic pain of a debilitating nature.
- has a small sample.

All subjects were in treatment with me. Most of these people attend my clinic as a last resort. Because they experience physical pain they are reluctant to see a psychologist, and they usually only do so when all other forms of treatment have failed for them. They have typically been seen by many other practitioners before they visit my offices, and they enter my clinic with skepticism and discouragement.

Findings in Brief

Similarities and Differences

All subjects wished to be rid of their physical pain. All personality types, with the exception of Type #7, were referred to me after having reeived a diagnosis of depression. Given the long-term nature of the pain that these people experience, the consideration of this diagnosis is not surprising. Each person, inclusive of the Type #7, is grieving the loss of a pain-free life and is adjusting to body changes and lifestyle changes. Many people, regardless of their personality type, feel "flattened" by the losses and limitations that accompany chronic pain; even the Type #7s, who, according to diagnostic assessments and self-reports, do not experience depression.

All personality types within the Body/Autonomy or "information processing" triad were referred with a potential diagnosis of malingering and with the label of uncooperativeness. Believability was also a question in the referrals of the Type #5s.

Prominent differences were found between the personality types in their presentation of pain, the reasons for their referrals, the subjective goals, and the practitioners' responses. Please see the Enneagram diagrams in Appendix "B" to "D" as an accompaniment to the descriptions provided below.

Descriptions of Personality Type Presentations

Type #8. The Type #8s in the study were referred because they were thought to be depressed and were seen as uncooperative and possibly malingering. Their referring practitioners felt defensive when interacting with them.

The Type #8s wanted to be believed and stated clearly that they did not think that others, especially their health care practitioners, believed the amount of pain they experienced, because "if they did, then they'd do something about it!" Without exception, their stated goal was to be rid of their pain, and if this could not occur immediately, they were interested in learning pain management.

The Type #8s presented with a steady eye gaze and their bodies moved with power. This combination of gaze and power was often perceived by their practitioners as confrontational. They pushed through their pain and fought it while exhibiting a high degree of non-verbal behavior (e.g., moaning). One Type #8 stated, "You have to push through the pain….What else can you do? … gotta be strong, not weak." They followed their physicians' orders seriously, but without much interest in gaining insight into their condition. Thus, they would often perform activities that would increase the intensity of their pain.

For example, a Type #8 subject might use a neck brace and cane for support while climbing onto the garage roof to mend it. The Type #8s did not see this kind of behavior as inconsistent. They typically saw themselves as following "the

doc's orders," saying things like, "I gotta move don't I?" Such behaviors triggered frustration, confusion, and irritation in their health care practitioners.

The Type #8s searched out help and pushed for it, but without realizing it they also pushed this help away through the way they coped with their pain – by searching out specialists' opinions and undertaking self-destructive activities such as roof repair. They attempted to push away their pain experience, thoughts, and emotions forcefully. Irrespective of their pain location, intensity, or limitations, they possessed a physical power and energy which frequently did not make sense to their practitioners. One Type #8 referred to her energy as a "bear…it is sleeping under the table in its box…it rips out." Another Type #8 said "I can't help myself, I just do things that I know I shouldn't and I regret it later." Their coping scripts rejected pain as a violation of their strength and they challenged helpers to "fix" the pain. All (except one) were experiencing difficulties with their insurance companies. They saw these organizations as not validating their pain, and the Type #8s wanted to "cut them out" and "teach them a lesson" and "[try to] control them like they control me."

Practitioners' Responses. Practitioners' Responses were defensive; they felt attacked and confronted. They observed the energy and behavior of these Type # 8s and so doubted their reports of pain and limitation.

Type #9. With the Type #9s, referrals were made because depression was suspected and uncooperativeness was reported. There were also questions about the possibility of malingering.

The Type #9s entered into treatment saying that they "want to feel better," although they were not clear about what "feeling better" would be like, except that this would hopefully mean the experience of less pain. Each Type #9 voiced the desire to "decrease this brain fog. …… if I could do that, then that would be a lot better."

These Type #9s presented in a pleasant and unassuming manner with no direct information volunteered about their pain. They were readily overwhelmed with their pain, and presented with an untouchable, vague quality if asked to describe their pain or inner experience. Vague verbalizations around their pain were common. When asked to describe his pain, one Type #9 said, "Something is wrong. I'm not the way I used to be. I'm waiting for it all to be over." They demonstrated difficulty describing their pain when they were experiencing it, presenting with an absent quality. At such times they would become "fuzzy," forget, or become "muddled." They had a tendency to withdraw to "instill a stillness," or as another Type#9 expressed it, "I push the pause button." These Type #9s have fallen asleep mid-task or in the middle of a conversation. They could at times lose touch with the physical sensation of pain when the "pain is really bad." All of the Type #9s frequently attempted to avoid the direct awareness of their pain and limitations. Here is an example of what one Type #9, Susan, reported:

"I was [uncomfortable] and antsy…after making love with my boyfriend this morning. I felt more pain. So I said to myself, 'Oh, well it was lovely…but it hurt my back and hip. Oh don't go there, just go to the nice feeling. But I can't have that again! It hurts too much. Oh yeah, well, I'll think about that later. Just remember his arms around me and how good that felt. Remember that connection.'"

All had medical diagnoses that were vague, irrespective of pain etiology.

I experienced the Type #9s as having a strong physical presence with a porous vacancy; gentle strong energy that moved clearly. This energy itself was not "foggy," although their experience of themselves was foggy and they expressed difficulty thinking clearly and remembering. The Type #9s tended to avoid their medical practitioners and understate their pain, doing the latter because they felt "foggy" in their minds. Pain appeared to be causing a rift in their inner sense of stability and the fogginess was experienced as a loss of who they used to be. All subjects had been prescribed medications and would follow medical advice without enthusiasm. Most also attempted their own way of "getting better" by returning to familiar activities and following alternative treatments without their practitioners' knowledge.

Practitioners' Responses. The practitioners all voiced a strong desire to help the Type #9s, but they expressed confusion about how to do this. Often, high doses of medications had been offered and accepted without clear beneficial effects. Practitioners were confused about this lack of benefit and about their patients' seeming lack of enthusiasm in following advice or in clearly reporting pain triggers and experiences. They saw this behavior as "uncooperative."

Type #1. The Type #1s were also referred because of depression and uncooperativeness and potential malingering. Practitioners noted displays of bitterness, and each practitioner reported feeling attacked.

The Type #1s wanted to be understood. They reported that they felt misunderstood, saying that their practitioners "think I am the problem, when it's this pain that is the problem ... not me!" They also reported diagnoses that didn't make sense to them and their desire to understand these diagnoses. They wanted the practitioners to fix the problem, and they were clear and strong in stating that the problem was pain, not them.

All the Type #1s in this study expressed difficulty accepting their diagnoses. They talked a great deal about their pain and the limitations it caused. They tabulated their pain and physical symptoms in detail in an attempt to have their pain taken seriously, and in the hope that their physicians would see the pain as the problem. There was a high degree of complaining and frustration voiced about their health care practitioners. Each in their own way stated that, "there is no reason that I should have pain. If no scar tissue is evident and there is pain then it must be that they [the practitioners] just haven't found the damage yet," or "it

must be that people are assuming that I'm psychologically loose, and that I am making all this pain up."

These Type #1s were also concerned about "doing it right." They held a belief that if they were provided with the "right" diagnosis, the "right help," they made the "right effort," and the practitioner listened and read the reports in the "right way," they would not have to feel the pain; they would not have pain. All Type # 1 subjects in this study saw themselves as willing and flexible, while health care practitioners and friends did not see the Type #1s in this way. The Type #1s saw themselves as sensitive to their external and internal environments, but I observed that they appeared quite unaware of both.

The Type #1s verbalized a high degree of "inside pressure" and voiced threats of suicide. A belief was expressed that "'outsiders' wouldn't help" so they felt forced to pressure people to help them. Energy-wise they exuded an air of rigid, tight, effortful containment. Their effort and energy was focused outward and on the containment of their body and of their pain. As mentioned earlier, they operated with a strong "I've got to do it right and with integrity" standard and they held this standard for themselves and for their practitioners as well. Many of the Type #1s carried tape recorders to their appointments to ensure that they spoke "right," were heard, and to ensure that the practitioners would be held accountable. They provided themselves with no relief from their pre-pain routines and daily expectations despite increasing pain intensity. This increased pain usually lead to decreased sleep, setting up a cycle of increased pain. All of the Type #1s experienced insurance difficulties in their attempts to find "right" and the "honest" action for their healing.

Practitioners' Responses. These Type #1s have often refused pain medications they have been offered. All of the Type #1 subjects had been prescribed with antidepressant medication. Practitioners became frustrated with what was seen as resistance and with what they saw as unreasonable and high demands placed upon them. All the practitioners in this study reported feeling pressured by the Type #1s and were angry and somewhat frightened by the Type #1s' behaviors and demeanor. The practitioners responded with a tendency to lecture and become stern. In addition, they brought witnesses to their meetings and assessments.

Type #2. The practitioners referring the Type #2s were vague in their referrals, stating that they wanted to help these people with their pain, but also vaguely recognizing that they felt somewhat manipulated.

The Type #2s in this study recognized the link between their experience of pain and their moods. And they focused on their moods, their fatigue, and their relationships.

The Type #2s were cheery and bright in their initial presentation, and they each focused on attending to the welfare of the practitioner at the beginning of each

contact. Presents of flowers and baked goods were frequent. They were poor historians and pain was often reported in anatomically unlikely locations, e.g., sharp shooting pain traveling in cartilage. They presented with limited body awareness and seemed lost to themselves. They demonstrated altered gaits and postures, and they often used physical aids such as canes, braces, and bandages. They functioned with greater consistency and reported greater satisfaction when they were provided with a structured program that was overseen by their practitioners.

They showed a tendency to help themselves feel better by focusing on aiding others, even though it might increase their own pain; they then wondered why it was that others couldn't seem to understand the pain they experienced. They attempted to "get them [others] to appreciate my pain" and limitations. Their experience of pain caused them concern for their relationships. Their chief focus was on relationship and on the importance of not pushing people away due to their pain. Yet they tended to demonstrate a push-pull in relationships. One Type #2 reported, "others think that I'm exaggerating. Other still expect me to do things that I can't do! You'd think they'd get it by now, after I've told them so many times that I just can't do these things." And yet, the Type #2s would continue to do things they told others they couldn't do.

Behind their "nice" behavior and their desire to maintain relationships despite the interference of pain, was a big energy; an energy that I experienced as a strong centrifugal force around their physical presence. They seemed to put a lot of energy into their self-expression. This energetic expression and the push-pull nature of their relationships could lead their practitioners to doubt the reality of the Type #2s' pain. These Type #2s operated on the premise that "no one understands me or my pain," and made statements like, "it's not possible to be loved with this pain." They experienced shame and guilt because of their self-focus, and they felt paralyzed by confusion, acting "nice" all the time, which did not allow for their experience of pain to be clearly expressed, delineated, or heard.

Practitioners' Responses. Initially the practitioners expressed desires to help the Type #2s find ways to decrease their pain, but when the Type #2s reported that their pain occurred in increasingly higher intensities and in unlikely locations, and when the 2s didn't appear to be setting boundaries to attend to themselves, the practitioners began to doubt reported pain experiences. They began to see the expression of pain as dramatics, and they felt manipulated and became irritated. They then tended to be firm about time boundaries in their meetings with the Type #2s.

Type #3. Type #3s and their practitioners typically focused on the goal of increased functioning. The Type #3s experienced a drive to return to work and they experienced difficulty returning to work in a satisfying manner.

Practitioners assumed that this was due to depression.

The Type #3s felt less alive and less functional and this was of concern to them. Their focus was on their self-presentation. For example, they would make statements like, "I don't want others to look at me and think I'm a gimp and am useless," and "I don't want to feel useless, and I do when I have this much pain."

The Type #3s were often viewed as the practitioners' dream patients because they voiced their strong desire to "get better" by increasing functioning and returning to work, they appeared to take advice, and did not readily complain or attempt to analyze their pain or their practitioners. They initially fit well into the traditional rehabilitation programs. One Type #3 subject said, "I want to move through this like Rick Hanson of Christopher Reeves."

Type #3s presented with a strong sense of self and were able to clearly verbalize their pain locations. They were not able to clearly delineate pain triggers. The Type #3s tended to be emotionally affected by their pain and to distract themselves from their emotions by increasing their activity levels. They attempted to avoid being deeply affected by their pain, by the responses of others, and their emotions. One Type #3 said, "I'm remaining encased and separate here. And I can laugh at you, or scoff, from within."

The Type #3s equated "being seen with being seen through," and thus, they tended to avoid being seen as being in pain Their energy was not reflective of their highly vigorous presentation. The superego messages concerning their pain were ones of "not being defeated by the pain," and so avoiding pain was important. The focus was placed on "getting better," without a clear understanding of what "better" might be, except that it was associated with the satisfaction of functioning.

Practitioners' Responses. The practitioners of these Type #3s were comfortable in their referrals, expressing that all was going as expected in the rehabilitation or adjustment process, and that the patients were keen and taking advice. The practitioners were often missing symptoms.

Type #4. The Type #4s were referred because they were "not getting better." Each Type #4 had expressed doubts about the reality of their pain, and now their practitioners were beginning to doubt it too. It was assumed that "psychogenic factors" must be involved in the pain etiology and maintenance, and that these Type #4s must be depressed. All of them had undertaken two or more pain programs, and while they may have reported feeling "better" within the programs, they all reported that the programs resulted in increased pain.

The pressing question for these Type #4s was "how can I heal?" "Healing" was defined as feeling deeply satisfied and whole, "even if I have to have pain." Their goals were internally focused, and not necessarily focused on their pain. As one Type #4 said, I want "help coping with this pain, to get rid of this pain if possible, and if not possible, to not be this way, so I can feel satisfied and live a life."

The Type # 4s demonstrated a tendency to be cautious and self-critical around their pain, protectively guarding their reports of pain and their limitations. They reported that they could "feel good" even when a high level of pain intensity and pain experience was present. They expressed awareness that "there must be something I am doing wrong when I have pain and don't feel good." They questioned if they were imagining their pain, and they wondered if they were "just not getting something." In doubting their pain their practitioners were encouraged to doubt it too. The Type #4s tended to focus on altering their emotions in an attempt to alter their pain experience, even although the pain intensity tended to remain unaltered. They experienced difficulty reporting to their practitioners what was true and accurate for them about their pain "because so much is true." They also reported experiencing difficulty reporting their pain experience because "people don't want to hear this, and I don't want to tell them because, well, it doesn't feel good. I don't want to feel!"

The Type #4s employed an internal approach and expressed a willingness to change, believing that if they changed, their pain would also change. They rejected their pain as being a part of them. Each had busy daily schedules that included appointments with several practitioners from different healing backgrounds. They were impressionable and found the world of health care overwhelming. When overwhelmed by appointments, or physical touching (e.g., medical examinations, body work) they "cut it off" and withdrew into their homes. I experienced the energy of these Type #4s as intense, slow and inward in nature, with a sense of slogging, plodding. Treatment changes occurred slowly and tended to be deep. When changes occurred an all-expansive energy was present within the Types #4s.

Practitioners' Responses. Most of the practitioners working with these Type #4s had undertaken a variety of methods in attending to the needs of these subjects. They were able to see the sincerity of these Type #4s. Medications were often the first solution that was tried, and when the pain persisted and heightened with treatment, they, along with the Type #4s, became frustrated. As these subjects began to overtly doubt the reality of their pain, the practitioners began to do so as well, and referrals to mental health were made. The practitioners verbalized the likelihood of psychosomatic symptoms. They became confused and frustrated with what appeared to be "all or nothing" behavior around attendance at appointments.

Type #5. The Type #5s were also seen as depressed and possibly "malingering." There was some question about "believability" regarding their pain. The practitioners had difficulty equating the high degree of reported pain with these Type #5s' style of wanting more information, their less obvious nature of their emotional presentation, and their difficulty with reporting body symptoms clearly or by location. The Type #5s were resistant to attending the prescribed rehabilitation programs. Having researched them, they reported that they

"don't make sense," or they found that their practitioners were not able to clearly and concisely answer their questions about these programmes. The referral sources found this irritating and frustrating. Most of the Type #5s scoffed at the practitioners' reasons for referral. One Type #5 said, "the doctors don't know what they are doing. We're all being experimented upon anyway. They don't know much about the body yet, and they are using me to find out."

On initial contact the Type #5s' priority was to assess me and my knowledge as it applied to them. They wanted to know that the practitioner "knows what they are talking about." Once this was established to their satisfaction, the Type #5s wanted to hear logically presented information about pain and long term pain. They wanted to learn about "coping" and to learn how to increase their ability to concentrate without the pain interfering. One Type #5 said that her pain "incessantly" makes "demands on me and makes it impossible to concentrate. I can't work or draw connections like I used to."

The Type #5s did not demonstrate very much emotion and presented with a "stunned open-eyed" expression when they did not follow my logic. They tended toward a caustic judgment of their practitioners. They viewed their bodies as poorly functioning machines with a problem: the problem was pain. They reported their pain factually and when asked to describe the qualities and characteristics of their pain they became easily frustrated. They appeared befuddled by sensations and body responses. They would use physical aids only after factually reviewing possible benefits and would, in most cases, reject the aids as "unnecessary" or "impractical" after a trial period of use.

The Type #5s were able to theorize about their pain and when directly asked, they were open and willing to share their theories about it. For the Type #5s pain interfered with their internal activity and this was a significant concern for them. When pain interfered in this way they experienced themselves as "lost" and impressionable. Their body was not as important as the aliveness and functioning of their thinking. They expressed concern about their ability to "remain able to use my mind." They demonstrated a limited understanding of the behaviors of others. And they very much appreciated, wanted, and benefited from maps and diagrams that helped them understand their body, their pain, and the link between physical pain and cognitive functioning. They were able to understand and apply their understandings of pain as related to such theories as the neuromatrix theories, the gate-control theories and energy use theories.

I experienced these Type #5s as being a contained and fluid source of intense cerebral energy. They all had a youthful appearance and were affected by others' energetic presentations. Emotions were believed to be "wrong thinking" and they felt driven to get the facts and think their way through pain. They wanted to understand their pain first and if they deemed it beneficial, they would share their understandings with their practitioners; although this rarely occurred. They viewed their practitioners as "technicians who can't help me understand."

Practitioners' Responses. The practitioners working with the Type #5s reported that they did not see the patient presentation and pain with clarity. They frequently felt threatened by the many questions of the Type #5s and thought that their credibility as health care practitioners was being questioned. They wondered aloud about the credibility of these Type #5s' reported pain. Practitioners sometimes viewed the Type #5s' need for information and understanding as resistance to advice and pain program participation.

Type #6. The Type #6s were referred by practitioners who saw them as "dramatic" and anxious about their pain. One practitioner represented the concerns of other practitioners with this group when he remarked about one Type #6 that she "is like a terrier holding onto [her desire of] getting better, getting fixed, and having no pain." He remarked that her pain was increasing as was her anxiety. It was assumed that these Type #6s were anxiously depressed and that they required cognitive-behavioral treatment (CBT) and "pain management."

These practitioners were frustrated and concerned, because the Type #6s no longer trusted the medical system as they once had.

The Type #6s in this study wanted help. Without exception, they wanted help to return to work and to their pre-pain lives. These goals changed during treatment to wanting to trust themselves, their pain and their bodies. One Type #6 entered into treatment saying "I need help, someone has to help me. It's all too much. People don't believe how difficult it is for me. I want to get on with my life. … I want to get back to doing things." After a few months this goal changed to wanting to "be calm, to be centred and to be in aligned grounding."

The Type # 6s presented as spinning within their thinking and all were attempting to avoid their pain, their fears of pain, and what pain meant to them. They verbalized a sense of extreme pressure and demonstrated an intense outwardly focused vigilance. They were determined to get better and were impatient for progress. They were experiencing sleep problems and difficulties with decision-making. They had been trying to think to "solve" the impact of their pain and to distance themselves from the pain. All used pillows, blankets, or special chairs and postures; all shifted their bodies frequently and verbalized discomfort when holding a position for "too long." Movement appeared difficult and painful for them. Their focus spun around the topics of "why is this pain here?," on their pain, and on their suffering with it. They were clogged with rationalization about their pain, and were readily distracted by their pain and discomfort. Many of these Type #6s described their pain as though there were many pains in many locations.

These Type #6s frequently tended to project the cause of their pain and discomfort onto others and saw themselves as highly sensitive. I saw them as insensitive to their environments, tending to be stuck in their fears and anxiety, which increased their pain intensity. I experienced these Type #6s as tight

vibrating knots of spiraling energy; effort-filled energy that could also switch into strength and gentleness.

The Type #6s self-reported that they felt scattered and experienced themselves as spinning in pain. They seemed unaware of their needs and looked to outside sources (e.g., the practitioners) to guide them and delineate their needs. All reported that their practitioners "didn't get it … that I have this pain … they have no idea how bad it is." They were driven by strong messages of "trying harder" to get good advice, follow this advice, find the source of pain, and to not get overwhelmed. This "trying harder" tended to exacerbate their pain intensity and experience. A counterphobic Type # 6 talked about the importance of "not letting the pain beat me," and of "kicking myself in the ass so I don't feel [the overwhelm and the pain]."

Practitioners' Responses. The practitioners of the Type #6s were frustrated with the changing treatment approaches of these Type #6s and also with their changing presentations. They resisted the "terrier-like" approach of these Type #6s and reacted to the lack of trust the #6s exhibited. They tended to see these Type #6s' anxieties as having little to do with their own interactions with these subjects. These anxieties were perceived as directly related to the patien and not due to the pain, the limitations, and grief. That is, these Type #6s were seen as overly anxious, and that their anxiety caused or exacerbated their pain.

Type #7. The Type #7s in this study were referred because other treatments hadn't worked. Suggestions of CBT were made. The Type #7s were the one type that was not viewed as depressed: nor did they self-identify as depressed. These Type #7s entered my clinic with the approach of wanting to know what I could do for them; they had researched me prior to our first meeting.

These Type #7s were initially viewed by their referral sources as dream patients. The practitioners feel good and hopeful around them and they enjoyed, their high upbeat energy, their quick thinking, and their determination to be their best. There was a forced quality about these Type #7s. They held their bodies in a contained manner, with flat facial expressions, despite their smiles. Emotions were not reported even in relation to their pain. There was a frantic quality as they planned and focused on "thinking positive" about their pain.

Even when a Type #7 was doubled over vomiting with high intensity pain, the effort to remain positive, to even tell a joke, was present. The Type #7s projected their discomfort and demonstrated a low tolerance for uncomfortable topics, inclusive of talking about their pain. When asked to describe his experience around his pain, one Type #7 responded with avoidance and projection, saying, "It's not me that feels [pain], it's my son. He's just not emotionally mature enough to face the world. What do you think his problem is?"

The Type #7s answered direct and pointed queries about their pain briefly and generally. Visible pain behaviors were absent. They were able to use the gate-control methods of pain, and they made conscious use of adrenaline and endorphin "rushes" to override their pain experiences. Understatement of pain and pain experience was the chief way of coping in order to maintain a familiar sense of self. Each one of these Type #7s rejected pain as part of their self-definition. Several laughed upon the delivery of severe prognoses. One Type #7 shouted "that's not me!" and then laughed at the woes of others who were experiencing pain. This coping style made challenging for the practitioners to learn about the Type #7s' pain.

I experienced these Type #7s as having a desperate, scattered, removed, and wooden quality about them when they were asked to share their pain experiences. They were weary, and I experienced a brittle energy in them. Their vital energy seemed to be tightly mustered to avoid awareness of their pain experience, to distract from emotions and to keep themselves active at almost all cost, even the cost of increased pain.

Practitioners' Responses. All the practitioners liked and encouraged the "positive approach" of the Type #7s. They tended to underestimate the Type #7's pain and pain sequelae. Many appeared to be having a lot of counter-transference feelings with these subjects. The practitioners became confused, side-tracked, and then frustrated that no significant change was occurring. At this point they tended to refer the Type #7s for CBT, not knowing what else to do to help. These Type #7s were frequently practitioner-diagnosed or questioned about the possibility of with bipolar disorder.

Summary and Comments

Patterns emerged in the charting of the referrals, the subjects' goals, and the presentation of pain and pain experience.

Referrals

There is a strong consistency between personality type and the practitioners' reasons for referral. The Body/Autonomy triad subjects were referred with questions of "malingering;" this was true for the Type # 5s as well. All those within this body-based triad were referred with comments of being "uncooperative," and the practitioners of the Type # 8s and Type #1s reported feeling defensive with these subjects.

Type # 7s were the single personality type that had no referral diagnosis of depression. This in itself is interesting, given that grieving for the loss of a pain-free lifestyle and the adjustment process is often diagnosed as depression by the referring practitioners. This speaks to both the coping style of the Type #7s and to how this style is received by the practitioners.

Subjects' Goals

There is a strong similarity in the consistency of self-reported treatment goals within each type. Significantly, without exception, the stated treatment goals of the subjects differed from the reasons for referrals. The Type #3s' stated goals were the closest match with the referral goals.

Pain Presentation and Pain Experience

This study shows evidence of a clear and consistent type-presentation with pain. It is worth repeating here that pain presentation was reported within each type at a percentage of 84% consistency or higher. That is, the cited material in this study is reported only when 84% or higher of all those within the type have demonstrated it or reported it.

To Summarize

This study indicates a high consistency within personality types regarding pain presentation. This study also shows a difference between the goals of each personality type with pain, and a consistent difference between the practitioners' reasons for referral. Also of significance in this study is that pain presentation for each personality type does not necessarily relate to the location of pain or pain intensity, instead it seems that it could relate to personality and to the individual prioritization of coping mechanisms of the personality.

What Does this Mean for Treatment?

The sample size for this research is specialized and small and further studies are needed for analysis. If further study indicates that personality types in the generalized population present with distinct and consistent differences in pain reporting, treatment goals, and treatment adherence then we need to look closely at our treatment approaches with people with chronic pain, such that we can more accurately meet their needs. We may also need to question our goals and biases as practitioners.

If *practitioners are to help* we need to step back out of our own personality dynamics and be aware of our biases in training and in experience. We need to be curious about the goals and reports of the patients, address these, and also guide the patients in their reporting of the information we need. Practitioner training on working with personality dynamics and chronic pain will be necessary and beneficial.

Recommendations for Further Research

Further study on practitioner referral patterns would place light on the interactions between the practitioners and the subjects. From the information gleaned in this study it appears that the referrals are based largely on the practitioners' responses to the subjects' manner of processing information about pain, to their ways of asserting their needs, and to the type of withdrawal that is

used. It also appears that the practitioners may be highly influenced by their own personality, their treatment biases, and professional training, and that they do not tend to take the subjects' priorities, personality dynamics, and ways of presenting into consideration when they make referrals. More study is needed in this area.

More in-depth research on the practitioners' personalities and referral patterns will yield interesting information, as would study on their views of chronic pain and approaches to treatment. Of utmost importance will be the research on the presentation of pain as it relates to instinctual variants and the stacking of these. And, as mentioned earlier, further research is needed on the differing treatment needs for personality types who experience chronic pain.

Appendix "A:" Table of Sample Particulars: * = Soft Tissue Injuries
+ = Motor Vehicle

Personality Type #	Sample Size (63): Women(39)/ Men (24)	Age Range in Years	Years with Pain	Diagnoses	Reason for Referral	Client Goals
8	4/ 2	40 - 57	1 - 19	Traumatic injuries, post surgical pain, STI*	Question of malingering. "Unco-operative." Energetic sensitivity. Sensitivity to medications.	"Tried everything else."
9	4 / 2	24 - 58	5 - 7	STI* Post accident, immune deficiency	"Depression." 'resistant to instructions' queries re: honesty	Queries re medications "something wrong" want it 'fixed'
1	5/ 2	30 - 59	4 - 8	STI* bladder reconstruction	Projections & difficulties of practitioners. "depression"	Want –answers - to be heard - to be understood - to increase functioning & decrease pain.
2	4 / 1	23 - 49	2 - 11	Fibromyalgia. STI*	'depression'	Want to - increase their joy in giving to others. - decrease in pain desired too

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Personality Type #	Sample Size (63): Women(39)/ Men (24)	Age Range in Years	Years with Pain	Diagnoses	Reason for Referral	Client Goals
4	4 / 2	29 - 48	3 – 9	"STI * with psychogenic factors." Nerve impingement.	'depression' 'not getting better, there must be psychological reason.'	Want to feel satisfied. Want to be rid of pain but if this is not possible, then they want to live with pain in a fulfilling way.
5	3 / 3	40 - 68	2 - 11	"Post trauma STI*." "Immune deficiency." Nonprogressive connective tissue disorder.	'depression' Believability?	Want to 'handle' pain and emotions. Want to regain cognitive clarity and ability to concentrate.
6	8/ 2	28 - 75	1 - 7	Fibromyalgia. STI*. Kidney dysfunction. diagnosis unclear	'depression,' anxiety, pain management sensitivity to environment	Want 'help.' Ie at first this is to be rid of pain, this changes to anxiety management, attending to sleep deprivation, increasing functioning and 'alignment." Want to decrease 'mind spin'
Counter-phobic 6 7	3 / 2 2 / 3	32 - 58 32 - 53	2.5 - 10	STI* Nerve impingment	'depression' no change in pain and limitations	Feel "stuck" with no movement toward decrease in pain. Want to return to work and decrease cognitive confusion.
			4 - 47	Fibromyalgia post OR, Skin disord. Disc degen, arthritis	Further tr options	What can therapist provide?

Applying the Enneagram to the World of Chronic Pain.

Appendix "B:" ***Determining the Personality Type:***

All the people included in this research study fell clearly into a specific aspect within each of the following three Enneagram Triads. For example; a person would be categorized as a # 8 personality type if the way s/he demonstrated how s/he processed information was through the body; if the way s/he responded when experiencing a stressor tended to be within the 'assertive' aspect of the Hornevian Triad; and if within the Harmonics Triad the person tended to demonstrate a 'reactive' response in conflict. Only the Personality Type #8 tends to process information through the Body / Autonomy triad, asserts under stress and is reactive in conflict. A similar process is true for all the other types. Thus, simply by being able to place an individual clearly within each of these three triads I was able to determine the personality type.

The Information Processing Triad (IP):

This is the triad that looks at how we tend to first process information through the prism of body identification, or heart space identification, or mind space identification.

IP Triads:

Body: (# 8, 9, 1) When one tends to process information via the body arena one usually exhibits issues of autonomy, physicality and instinctual aspects (whether rejected or over shadowing). Anger issues are often present.

Heart: (# 2, 3, 4) Feelings/emotions are the central focus for these people in processing information. Image is also important. In the "heart" centre - love, compassion and shame as well as emotions present as part of the processing of and understanding of the world.

Mind: (# 5, 6, 7) The individuals in the 'mind' triad have a tendency to first understand their world through the mind, and through the process of thinking and linking. Security is a focus. Anxiety and fear are often by-products.

The Hornevian Triad (S):

This is a triad developed by Karen Horney[17]. Her division emphasizes how an individual 'automatically' tends to cope with long term stress.

S Triads:

Assertive: (# 3, 7, 8) These people have a tendency to move into the stressful situation to make their presence known and assert their wills.

Compliant: (# 1, 2, 6) These folks attempt to decrease stress by becoming compliant; compliant to external demands and conditions or to internal ones (superego) or to rules.

Withdrawn: (# 4, 5, 9) These people attempt to withdraw from the source of stress. They do this by either physically removing themselves, or by removing their awareness onto other matters, or zoning out.

The Harmonics Triad (C):

This triad was recognized and developed by Riso and Hudson[28]. It refers to how people tend to respond/react to conflict.

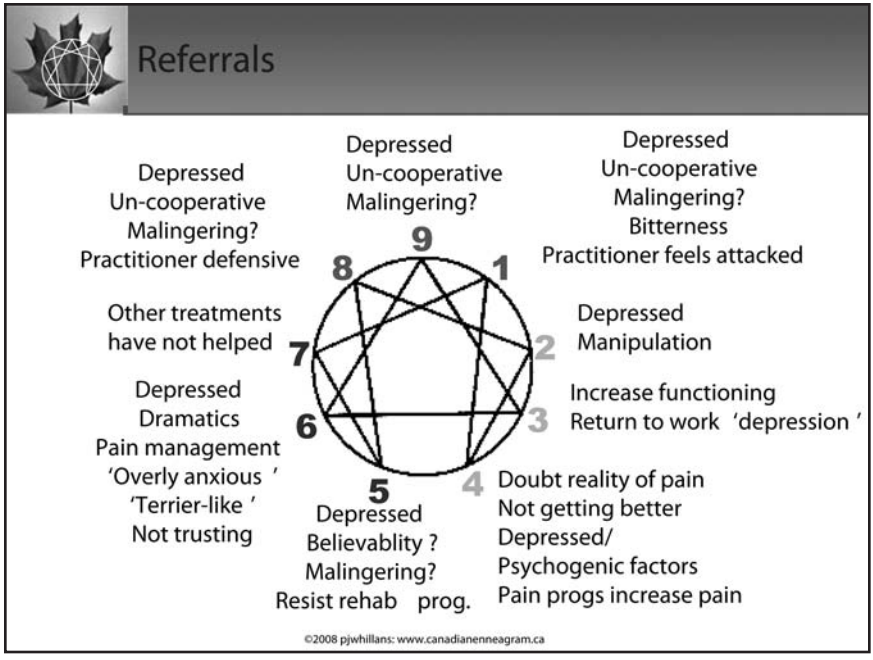
C Triads:

Positive Outlook: (#2, 7, 9) These folks tend to view 'life' and the conflicts that occur in their lives first from the it'll-all-work-out-for-the better viewpoint. Their attitude is one of feeling, holding onto and looking for the positive, (perhaps even sometimes denying the no-so-comfortable reality).

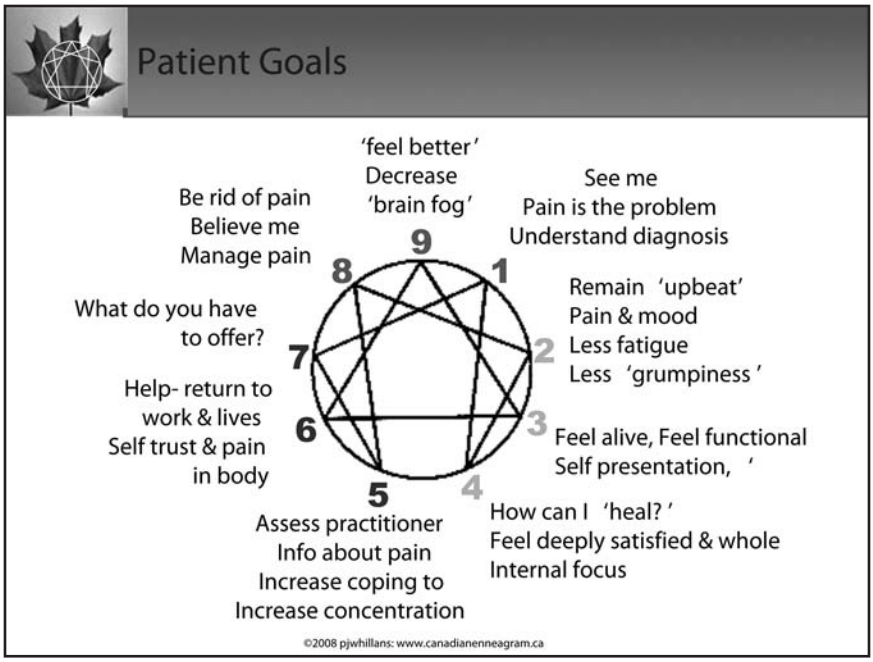
Competent: (# 1, 3, 5) These are the folks that tend to move into a conflict and attend to it with their own areas of competency, by pointing to and working for what's 'right,' by becoming busy, by getting to know more about it.

Reactive: (# 4, 6, 8) These people have an initial emotional reaction and will tend to first respond to conflict and life's challenges with a large emotional, instinctual, or fear reaction.

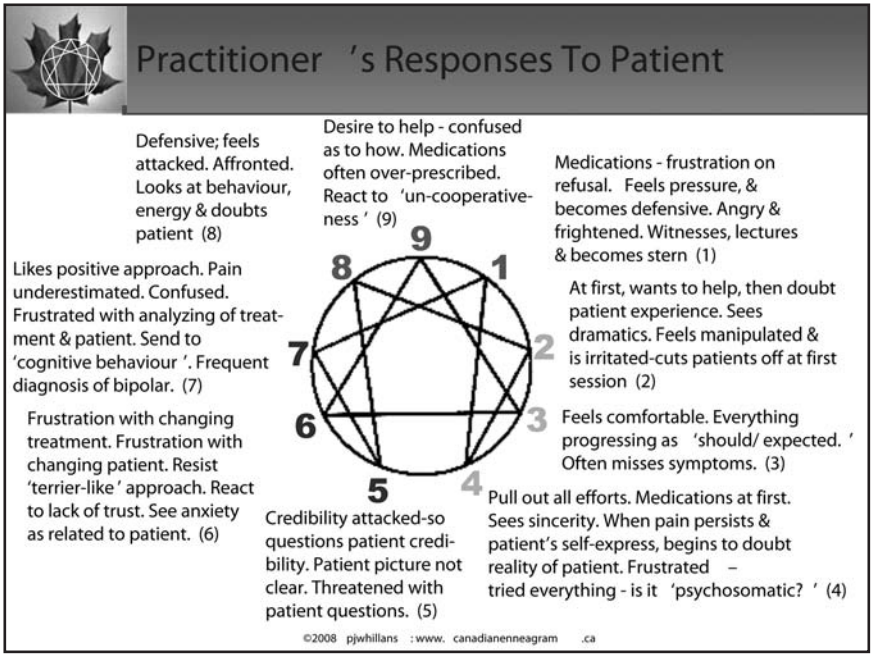
Appendix "C:" ***Cited Reasons for Referrals for Each Type***



Appendix "D:" ***The Subjects' Stated Goals by Type***



Appendix "E:" ***Practitioners' Responses to Patients by Type***



Endnotes

[1]Chronic Pain Definition, Canada: *Statistics Canada,* February 2008

[2] USA definition of Chronic Pain

[3]Statistics Canada, February 2008.
Also, University of Western Ontario, studies reported in Stat. Canada

[4]Yves Veillette et al in *The Canadian Journal of Anesthesia* 52:600-606 (205)

[5]Turk & Melzack, *Handbook of Pain Assessment* 2nd edition, NY Guilford Press, 2001

[6]Turk, D, Rudy, T. (1986) *Toward a Comprehensive Assessment of Chronic Pain Patients: A Multiaxial Approach.* Pittsburg Center of Pain Evaluation and Treatment, University of Pittsburg School of Medicine.

[7]Horney, K. (1945) *Our Inner Conflicts* W.W. Norton, NY

[8]Riso, D & Hudson, R. (1999) *The Wisdom of the Enneagram: The Complete Guide to Psychological and Spiritual Growth for the Nine Personality Types.* Bantam Books, Toronto.

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