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PERSONALITY STRUCTURE and the TREATMENT of PHYSICAL ILLNESS and INJURY

"It is much more important to know what sort of patient has a disease than what sort of disease a patient has."

– *William Osler, M.D. (also attributed to others)*

This presentation introduces a model which is based upon an understanding of personality structure and which helps to explain, in a very practical manner, the phenomenological emotional and behavioral responses of adults to various types of injuries and illnesses. The intent of the presentation is to aid practitioners, especially non-mental health practitioners, to be able think about patients in the context of a unifying paradigm of physical and emotional development that has implications for diagnosis and treatment of both medical and psychological disorders – and the complex interaction between physiological and psychological symptomatology as it relates to issues of characterological maturity.

I bring to this discussion a rather unique perspective on this issue in that over the last 18 years, I have evaluated well over 10,000 California Workers Compensation claimants – including personally performing a comprehensive individual clinical interview and reviewing complete files of medical records, mental health treatment, employment records – and at times investigative records. I have evaluated patients from all walks of life who have filed "stress claims" – executives, political employees, civil employees – Police, Fire, EMT, teachers and other school employees, administrators, etc.; blue collar and white collar workers; construction and trades people – and in my satellite Fresno office, many agricultural and field workers. Additionally, many of my referrals have come from the California Department of Corrections – evaluations of correctional employees, including Wardens and other administrators, prison medical and mental health providers, Correctional Officers, and civilian staff (such as cooks and clerical workers). Not only has this provided me with a wealth of information regarding people and personalities, across all boundaries of education, occupation, socio-cultural status and ethnicity – but in having available the medical records of these applicants, I have an

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intimate knowledge of the workings – and failings – of the mental health system within California, both public and private; and the problems in: 1) integrating effective medical treatment with an understanding of the patient's emotional experience during the illness/injury and the impact of that experience upon the efficacy of medical interventions; and, 2) integrating effective medical treatment with any necessary mental health treatment or intervention indicated due to disruptive symptomatology (affective, cognitive and/or behavioral)

To have a comprehensive understanding of a patient, evaluation and consideration must go beyond symptomatology and disease diagnosis; there must be an appreciation of the person's personality structure and level of maturity; i.e., the nature of their use of psychological defenses. The model presented describes levels of "maturity" – in essence, communicating an understanding of characterological development, but largely devoid of technical psychiatric jargon and avoiding relying on any one school of psychological theory. Referring to this model can: 1) help to understand patients' attitudes and reactions during the course of medical treatment; 2) anticipate the interpersonal interactions that occur between the patient and different medical personnel in the face of "stresses" and demands presented by the illness/injury and the treatment process; and, 3) suggest clinical approaches and interventions that can facilitate both the efficacy of medical treatment and the maintenance of emotional stability.

To use this model does not require exploring or discussing the circumstances that may lead persons to become fixated at various stages of development (immaturity/maturity). Such contributory issues may include constitutional factors related to the ability to relate to others (such as congenital neuropsychiatric developmental, cognitive or affective deficiencies); the nature of early parental/caretaker relationships, whether benign or dysfunctional; uncontrollable trauma or loss (due to illness, death, or enforced occupational or other absence of a parental or other important figure); or other disruptive socio-economic factors. In this context, I am using this model only to help explain phenomenologically the behavioral and emotional responses of adults to physical illness and injury, focusing on practical issues related to providing the most effective medical intervention possible, without the treating non-psychiatric physician needing to evaluate the complex root causes of the personality dynamics leading to the level of maturity or immaturity being described.

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A SCHEMATIC OF DEVELOPMENTAL MATURITY

1) Developmental Stage of “Merger” or “Symbiosis”

This Stage describes a person who has never matured psychologically beyond an infantile level, perceiving oneself as a vulnerable entity, lacking in any real autonomy, who must rely on the external environment for care, sustenance, and nurturing. There is at best, if any, a rudimentary internalized sense of “self” or identity, with little or no the capacity to perceive others as having a unique identity.

Traits: Severe immaturity, lack of ability for effective communication regarding emotional or practical issues – beyond very general expressions of discomfort.

The psychological task of this stage of development is to reach the point of an essentially non-verbal belief that, **“If I am uncomfortable, soon enough I will be reasonably satisfied,”** but without yet developing a realistic understanding of the interactions or processes by which satisfaction is achieved.

When there is a (real or perceived) failure of the environment to satisfy basic needs and provide sufficient comfort, this results and a failure of the person to accomplish the developmental task, and there arises and crystallizes intense primal experiences of fear, terror, abandonment and grief – emotional pain that can lead deep clinical depression and/or severely regressive behaviors. The sense of terror and abandonment is not differentiated to the point of being focused upon an individual, as much as related to life itself. A global distrust of living foments, and an overarching sense of hopelessness becomes pervasive, compensated for (effectively or marginally) by social avoidance and dependency.

Diagnostic Considerations: “Inadequate”, Dependent, Avoidant, and Schizoid/Schizotypal personality types

Treatment Implications:

- There is an inability to make use of classical psychotherapeutic intervention.
- These patients may benefit from basic support, provided in a manner appropriate to their level of understanding and sophistication – and their ability to even be

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- receptive to external support without disruptive fear, avoidance, and/or regression
- However, overly “supportive” (i.e., infantilizing or dependency-reinforcing “therapeutic” interventions) will prove counter-productive and will likely increase regressive behaviors, even if decreasing manifest affective symptomatology.
 - These patients may benefit significantly from judicious use of psychotropic medications to address manifest affective (or even quasi-psychotic) symptomatology, particularly if the psychopharmacological intervention is provided early-on, within the context of a supportive relationship – but there can be no expectation that any psychotropic medications will improve the patient’s emotional maturity or baseline level of functioning.
 - Patients in this group are unlikely to be manipulative for secondary gain, but are very likely to be very significantly influenced by environmental circumstances, e.g., family interactions, other relationships, ostensibly supportive individuals or institutions (objectively benign or malignant).

Prognosis after a trauma or injury:

- There is a generally good prognosis for returning to baseline functioning after relatively minor problems – if the person is provided with sufficient appropriate support, in a manner that they are able to accept and appreciate.
- There is a generally poor prognosis for returning to baseline functioning after almost any major physical or emotional trauma.
- The overall prognosis is very dependent upon the severity of the stressor/trauma, and the type of external support system present, that may reinforce recovery, or reinforcement regressive dependency.
- ***Non-mental health medical professionals treating these individuals must be aware that obtaining appropriate psycho-social support from the onset of treatment is essential if there is to be hope for a positive outcome; and that even with appropriate intervention, if the injury/trauma crosses a certain threshold of severity, persons with this personality structure are unlikely to recover, may not be capable of effective autonomous compliance and are likely to move towards chronic invalidism – especially if there are external pressures (family, relationship, or within the social-medical-legal system) that reinforce dependency.***

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2) Developmental Stage of “Malignant Narcissism” or “Paranoid Stance”

This Stage refers to persons who, roughly speaking, are emotionally functioning on the level of a toddler. Normally at this stage of development, the child starts having a sense of being a unique person in the world and having a sense of identity, as opposed to merely experiencing oneself in an amorphous manner, as an entity sensing comfort and discomfort. There is a movement from the more regressive position of expecting that, "If I am uncomfortable; soon enough I will become comfortable...", to the recognition that there are other external entities, be it a person, persons or institution, that have their own identities, and that is/are responsible for providing security and comfort. However, providers of sustenance are not perceived as being other struggling, imperfect human beings. Rather, while the source of sustenance is perceived as a separate entity, it is an entity that is expected to be “magical” and all-powerful (for good and/or evil).

Traits: There is an intense focus on a sense of entitlement; **“I need, I want, I deserve, you owe me...”** – with disappointment leading to rage and destructive acting out

The psychological task of this stage of development is to reach a sense of trust that, **“If I am uncomfortable, and there is something that I want/need, soon enough, my care-taker, in a caring manner, will provide what I need, and I will be comforted.”**

In the healthy situation, the child begins to learn, from the provider of sustenance, how to rationally problem-solve; and the sense of relying and being dependent upon an omnipotent provider is slowly diffused and replaced with a realistic understanding of the limits of self and others, and the ubiquitous nature of frustration. The person learns to be able to tolerate reasonable frustration without immediately believing that someone has been “bad” or “evil”.

If problems occur during this Stage, the emotional response goes beyond a generic sense of abandonment and/or despair, and there is now a deep sense of frustration and fear. There is not only recognition that a significant need has not been met, but also the experience of having been spurned or rejected by an omnipotently powerful caregiver. The person develops a sense of “good” and “bad” that is governed by the level of frustration experienced that in turn is perceived as defined by the satisfaction of the expectations of the omnipotent provider.

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When unresolved frustration occurs, there is an assumption that either the person him or herself has been “bad” – and has caused the omnipotent provider of sustenance to be actively punitive; or that it is the provider of sustenance who is “bad” for unreasonably causing or allowing the frustration to remain unresolved – but still demands acquiescence for needs to be met.

In the dysfunctional or disrupted situation and fixation at this Stage occurs, the person may fully identify with, or even “merge” with the perceived omnipotent power (person or institution); or maintain a dependent and blindly obedient relationship with that power.

In the most malignant circumstances, the person may develop a perception of him or herself as a “bad” person, and then accept and acts out that identity. That is, there may be an acceptance of being “bad” or “evil” with little or no ambivalence or guilt, essentially believing that being evil is simply “who I am”, as a matter of necessity, and fulfilling the implicit or explicit will of the omnipotent provider – without any sense of responsibility for acting in malicious ways.

At the same time, the person maintains the emotional conviction that those who provide sustenance, although omnipotent, are not benign or caring and are untrustworthy, uncaring, enigmatically unpredictable, and/or terrifyingly malignant – and therefore, to one degree or another, are to be feared – but still are to be obeyed unquestioningly, unless then can be destroyed and replaced by what may be perceived as less malignant omnipotent provider (e.g., escaping a terrifying environment by a gang membership that is perceived as more protective).

To that extent, the sense of being “good” or “evil” becomes distorted and perverted, determined by the relationship to the person perceived to have omnipotent power; and there is no further exploration or examination of the morality, justice, fairness or logic of those demands, beyond the most simplistic and self-centered (narcissistic) rationalizations. While in certain social settings, the person may adopt a (manipulative) demeanor of wanting to “appear” to be “doing the right thing”, there is actually no compunction about surreptitiously breaking rules as may serve his or her purpose – in the service of meeting needs and/or appeasing the perceived omnipotent provider.

There is essentially a totalitarian view of all aspects of interpersonal relationships – family, socially, occupationally and with medical providers.

Diagnostic Considerations: Paranoid, Sociopathic, “Malignant Narcissistic” or highly narcissistic personality types

Treatment Implications:

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- Persons functioning at this level are unlikely to form a working therapeutic relationship in any capacity or milieu other than to serve his/her own immediate needs – i.e., with perceived alliance with an omnipotent power; or an alliance with a person or institution that conveys and reinforces a sense of omnipotence. Manipulative, overtly dysfunctional or severely dangerous/destructive relationships occur in all aspects of life – including relationships to medical and mental health professionals. In fact, medical and mental health professionals (and even medications) may initially be invested with omnipotent, unrealistic expectations – inevitably leading to frustration, disappointment, and regressive and/or destructive acting out.
- These persons may initially appear cooperative and/or charming, but soon enough, subtle or overt demandingness and manipulativeness will emerge; followed by overt or covert intense rage and/or other destructive acting out when expectations of omnipotence prove unfounded.
- These persons are unable to make use of classical psychotherapeutic intervention;
- At times, these persons can make use of a very carefully constructed psychotherapeutic intervention taking into account the severity of the characterological pathology, i.e., theoretically, a very careful psychotherapeutic approach appropriate to dealing with severe narcissistic pathology, using techniques identified by such writers as Kohut and Kernberg, can be useful – if the person maintains the motivation to stay in therapy.
- Use of psychotropic medications can be helpful, but considering that these persons generally have poor internal affective and behavioral controls, the use of psychotropic medications have notable pitfalls including risks of over-stimulation, disinhibition of affect or impulses and significant proclivity towards substance abuse. Effectiveness of psychotropic medications is often transient – as the initial relief of symptoms may again trigger omnipotent expectations that are inevitably disappointed, at which point the medication is rejected – either directly, through misuse, or unconsciously (such as via somaticized development of side-effects).

Prognosis after a trauma or injury:

- The outcome of any treatment intervention, medical or mental health, is very dependent upon what the patient believes is in their best interest at the moment:

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- At times that may mean a successful return to baseline; at times an indefinite period of claimed disability (often manipulative, or fueled by substance abuse); at times prolonged periods of disability, followed by “magical cures” – as the “best interest” of the person may change over time.
- These persons are very reactive to any medical-legal process present – that itself is imbued with an illusion of omnipotence that certainly is inevitably disrupted, since the medical-legal system is, in reality, *anything but* omnipotently caring and providing.
- Realistic goals and expectations can help the practitioner to tolerate and manage these patients – an awareness that the “best possible” result may be a matter of incomplete resolution of medical issues with a focus on “harm reduction.” **The practitioner must fastidiously avoid reinforcing an illusion of omnipotence and promise of a perfect “cure” – that, if not possible, will lead to a potentially interminable vicious cycle of treatment interventions and failures.**

3) Developmental Stage of “Shared Omnipotence”

*This brings us to what I believe is the central developmental stage of our culture, that I call the Stage of “Shared Omnipotence.” Developmentally, in general terms, a child starts dealing with this stage during the later toddler years, and then again works through these issues, on a different level that is deeper and more intense, all though “adolescence” (that for these purposes, in this culture, can be seen to range from the pre-teens into the mid-or-late-20’s). During this stage, there is a movement beyond just expressing the sense that “I am uncomfortable”, or a need to be provided for by an omnipotent protector – to appreciating that in dealing with the challenges of life, there are various interpersonal interactions involving two (or more) imperfect human beings. In addressing needs, the focus becomes, “**I want you to give me that.”** There is awareness that “in order to have my needs met, I cannot rely upon the universe as a whole, or on a God-like omnipotent power who will “magically” relieve me of any problems or distress – rather, I must also rely upon other fallible human beings to work with me.”*

However, most significantly, the wish for a sense of all-encompassing security and omnipotence has not yet been accepted as unrealistic, and there is an expectation that with a “perfectly” loving/caring relationship, albeit involving imperfect individuals, from that relationship, a mutually omnipotent protective power will arise. The other individual is not expected to be omnipotently protective, and the person himself or herself does

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not expect to become omnipotent – but there is the constant wish and expectation that the relationship formed will confer upon both parties a mutual omnipotence, and simply put, “We will live happily ever after.”

Traits: The basic position of this stage becomes, **“I want you to give me what I need, and I will care for you, AND WE WILL LIVE HAPPILY EVER AFTER. But if that expectation is disrupted, I will be devastated – because you, as a person, have disappointed me, and not only have you hurt me, but you have destroyed my sense of there being security in the world! I will be totally enraged at you. And I expect that you will feel the same emotions, and the same feelings towards me.”** There is also often an expectation that the relationship formed should convey “shared omnipotence” to the extent that, “As long as I maintain a commitment to the relationship, the relationship will survive any disruptive or dysfunctional behaviors I may commit... Any transgressions of my own will be absorbed, neutralized and forgiven by the inherent omnipotence we create... I will be shown unconditional love and caring...”

The focus of these persons is on relationships, rather than on specific needs. In fact, frustration of needs can be tolerated – and significant amounts of pain and guilt can be tolerated – *if* the illusion of a continuing relationship affording “shared omnipotence” is maintained. These persons tend to act out dependently and manipulatively within relationships in desperate attempts to maintain their treasured illusion of shared omnipotence – or out of unmitigated terror, fear and rage, if that illusion has been fatally disrupted.

When relationships do not provide what is desired, feelings of personal devastation, anger and rage inevitably arise that are far out of proportion to the actual disappointment, and are accompanied by feelings of, fear and dread – as well as guilt mixed with rage. There is no sense that one can survive, or be “whole” outside of a relationship that conveys “shared omnipotence”.

The psychological task of this stage of development is to recognize that life is imperfect; that “living happily ever after” only occurs in fairy tales; and that in a caring, loving relationship, imperfections of self and others, and (objectively non-abusive) frustrations and disappointments, can be tolerated and resolved.

In the healthy situation, negative reactions to frustration are comforted and resolved, and the ability develops to tolerate frustration within relationships without either party being perceived as having been abusive, abusive in retaliation, or abandoning the other party; and without either person “falling apart” emotionally (i.e., losing a sense of self, personal wholeness and personal integrity).

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However, if the person perceives (accurately or inaccurately) that an acknowledgment of imperfection or disappointment, (that is internally perceived as frightening and angering), is also causing a similar fear and anger in the other party, no healthy resolution can occur, fixation at this stage occurs, and “rescuing” the relationship involves implementation of a variety of defenses (i.e., distortions of the reality of the situation) to try to restore the illusory “shared omnipotence”. Some of those defenses can be relatively benign, even if not optimally mature (i.e., the “neurotic” defenses); but at the more pathological end of the spectrum, the defenses can be highly disruptive or dangerous (i.e., “borderline” defenses of splitting, dissociation, projection, inappropriate acting out of anger, or turning to substance abuse, illicit sex, or other dysfunctional and ultimately self-defeating ways of relieving frustration). Further, if even those defenses fail to restore the sense of “Shared Omnipotence” – and ultimately, dysfunctional defenses usually do fail – the person is prone to periods of serious depression (that may take the form of classical clinical depression or a somaticized loss of physical health and integrity).

Various options are available to a person who is fixated at this stage to try to ameliorate the painful and terrifying position of perceiving him or herself as a “hopeless, helpless, incomplete person”, and to “rescue” the relationship conveying Shared Omnipotence include: 1) unrealistically deny or rationalize away that a disruptive event has occurred (i.e., “I didn’t really need that anyway; I’m OK, you’re OK...” – the most extreme form of which would be analogous to the position of an anorexic “I can’t possibly be frustrated, deprived or hungry – already have more than I need”; 2) attributing the cause of the disruptive situation to a different source (technically, “projection” or “splitting”), so that the illusion of an ongoing relationship of Shared Omnipotence can be maintained, while some third party is blamed for the difficulties; 3) use of chemical means (licit or illicit) to restore an illusion of comfort and omnipotence; or, 4) in essence “surrender”, and regress to a more immature level of functioning.

Some persons become so adept at using the less-dangerous, more rationalistic (if not actually realistic) and “reasonably” socially appropriate defenses, that they can maintain themselves within a “cycle” of “good functioning” and “minor” acting out, without ever actually resolving the developmental issues, but without decompensating into depression or severely regressive/dangerous behaviors. These persons are often referred to as “narcissistic” (or mistakenly diagnosed as Bipolar), but there is a difference between this type of more benign (but still quite immature) level of narcissism, and the more malignant and dangerous paranoid narcissism of the earlier stage discussed above.

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Diagnostic Considerations: Borderline Disorders; Narcissistic Disorders with underlying borderline dynamics; superficially neurotic personality structures, who revert to borderline dynamics under stress

Treatment Implications:

- These patients have an ability to form a therapeutic relationship, but have very unrealistic expectations, and are prone to feel exquisitely hurt, frightened, sad, depressed and angry when their expectations of the other person (doctor, therapist, etc.) are disappointed.
- When feeling supported, these patients can “rise to the occasion” and be a “good patient”;
- But when disappointment sets in, there can be initial defensive attempts to restore the sense of Shared Omnipotence through supplicant expressions of neediness, whining, unconsciously-drive somatization, and/or use of drugs (licit or illicit) to avoid the painful emotions;
- When those defenses fail, in a vicious cycle, there tends to be an elaboration of even more dysfunctional, ineffective and self-defeating defenses of interpersonal manipulation, “splitting”, acting out of anger, neediness and dependency, substance abuse, somatization; with the potential for histrionic and/or malignant depression
- In light of the availability of psychoactive drugs to the populace, it should also be noted that persons fixated at State 3 are particularly vulnerable to becoming very dependent upon prescribed medications or illicit drugs. Various psychoactive agents can dull emotional pain and artificially instill a sense of well-being (i.e., omnipotence). Activating agents, such as amphetamines, cocaine, etc., tend to lead directly to an illusion of omnipotence; sedating agents such as tranquilizers, pain killers or marijuana can suppress emotional pain and fear. Thus, use of those agents is very enticing to persons who sense an emerging loss of Shared Omnipotence and who desperately want to maintain the illusion. While some psychoactive agents maybe able to aid in maintaining an illusion of Shared Omnipotence for a brief or even an extended period of time, since no pharmacological intervention (even therapeutic use of psychotropic medications) can consistently or “perfectly” maintain the illusion Shared Omnipotence, the use of prescribed psychotropic medications and/or illegal drugs can often paradoxically exacerbate a decompensation, when the effectiveness of the agent lessens or causes significant disruptive side-effects.

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- Effective mental health treatment requires understanding the nature of the pathology present and slowly and carefully encouraging the person to work through the developmental task at hand.

Prognosis after a trauma or injury:

- Very guarded.
- These persons may find that they actually receive more caring and support (and reinforcement of a fantasy of “Shared Omnipotence”) through maintaining a state of chronic illness and disability – and even chronic physical pain – than they ever received through previously relationships. Thus, these persons may reach a baseline at which they are constantly plaintive, but underlyingly actually emotionally “comfortable” – confounding the unsophisticated treating practitioner, who continues to futilely try to resolve the “symptomatology”, without realizing that to do so, is actually perceived as an *attack* on the person’s sense of new-found stability; and that what is truly desired is repetitive interventions to omnipotently rescue the person from the “misery of the moment.”
- However, without repetitive crises from which to be rescued, the illusion of omnipotence fades distressingly and the person may become extremely dependent upon “the system”, moving from treatment to treatment, repetitively establishing, becoming disappointed in, and then re-establishing, relationships of perceived “Shared Omnipotence”.
- These persons tend to act out dependently and manipulatively for primary psychological reasons, often on an unconscious or semi-conscious level, rather than overtly for secondary gain (although on a superficial level, they may be perceived as “malingering”).
- Physical injuries can easily lead to chronic invalidism; traumatic injuries, or feeling rejected in the course of treatment can lead to a re-emergence of long-repressed trauma, fear, grief and terror, developmentally related to the circumstances that prevented the person from having effectively resolved the wish for “Shared Omnipotence” – but with responsibility for the desperation and despair projected fully onto the focus of the immediate situation (i.e., the injury/illness and related medical care).
- Thus, for these people, any significant injury or trauma demands prompt and sophisticated intervention to prevent the establishment of circumstances of related to the illness/injury or medical intervention that implicitly gives promise of

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a sense “Shared Omnipotence” – but ultimately becomes a destructive and either failed or severely dysfunctional situation.

4) Developmental Stage of “Acceptance”

This stage involves developing a realistic sense that "I am a whole, but imperfect person. I am not a helpless, hopeless, incomplete person. I have imperfections. There are things that are wrong with me, but I am still basically a whole person. And in the world, there are other whole-but-imperfect people. Working with these other persons, at different levels – as colleagues, business associates, friends, family, doctors, therapists, as well as within intimate relationships – and we are all trying to take care of ourselves and others, and meet our own needs and each other's needs to the best of our abilities. There are differences between being disappointed, as opposed to being abused, neglected or rejected, and I can appreciate those differences"

*Traits: A relatively mature ability to accept the reality of what has occurred, and to accept responsibility for one's own behaviors and actions, “**I feel sad, and I have to get through this.**”*

The psychological task of this stage of development is to come to the acceptance of the real loss of the expectation that, "There is an omnipotent power that is going to protect me, keep me immortal, and take care of everything I need." There has to be a real grieving process regarding the loss of the possibility of omnipotence in life. It must be recognized that grief, or suffering, can be endless – but that through a process of mourning, a state of acceptance and comfort can be achieved.

If mourning does not occur, disappointment, sadness and grief cannot be transcended – and instead, they decay into constant self-righteous indignation, and/or misery and depression – or the constant search for one of the above forms of omnipotent existence. Mourning is a healing process that involves going through different stages of the process. The process is not the same for every person, (i.e., not every one follows the “stages of grief” made famous by the writings of Kubler-Ross), but in order to transcend interminable suffering, one must, in essence, learn how to mourn, that often requires a supportive environment, and some degree of ritualistic “cleansing”, that allows a natural healing process to occur.

In the healthy situation, the loss of the fantasy of Omnipotence is identified, grieved and mourned, with the development of an ability to accept disappointment and grief as inevitable aspects of life.

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However, even when mourning can be effectively accomplished for the most part, there may still be an inability to fully resolve the grief process vis-à-vis an acceptance of the inherent “unfairness” of life. At times, the rage against “unfairness” can result in acting out in an unconscious, but reasonably socially-acceptable manner – with a tendency to repetitively and self-righteously rail against whatever targets may appear to be causing “injustice”, in an attempt to “make things right.” At other times, while the person may be able to “move on” from the state of acute injury/grief – they maybe come fixed in a dysfunctional or disruptive state of co-dependency or self-righteous indignation. That is, the loss is identified and accepted, but there is then an attempt to “change” the situation to “undo” the loss or an unwillingness to forgo seeking revenge.

Diagnostic Considerations: “Neurotic”, obsessive-compulsive, histrionic personality traits; prone to anxiety disorders and less serious depressive states;

Treatment Implications:

- If there are not other complicating factors (cognitive or intellectual deficiency, social stigma, etc.) these patients can make good use of classical therapy and adjunctive use of psychotropic medications to address manifest symptomatology, and foster a completion of the mourning process.

Prognosis after a trauma or injury:

- Generally good, although with the risk of unresolved anger at “the unfairness” of life at times leaving the patient “stuck” at a level of partial impairment, that may be externally supported by the medical-legal system, a dysfunctional family system, or other institutions that foster rationalization and self-righteous indignation, as opposed to effective mourning and problem solving.

5) Developmental Stage of “Mutuality”

With full and effective mourning, a stage of “Mutuality” can be reached. This is a position in which one fully understands, both emotionally and intellectually, “This is the way the world is. I must effectively relate to other imperfect people – some of whom may be caring and supportive, while others may be dysfunctional or dangerous. I can form effective and healthy relationships, on different levels of intimacy (with family, friends, acquaintances, co-workers/supervisors, medical providers, etc.), so that we can work together to our mutual best interest – not towards ‘living happily ever after’, but so

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that we can tolerate inevitable frustrations, imperfections and resultant grief; and yet live a reasonably satisfying and contented, if imperfect, life."

Traits: A mature ability to evaluate situations, to accept what cannot be controlled, to take personal responsibility for one's behavior, and to complete a grief and mourning process in the face of loss. This results in the ability to form honest and empathic relationships in all spheres of life.

The psychological task of this stage of development is the completing the mourning of the loss of omnipotence in life and also the loss of an expectation that "life will be fair."

Diagnostic Considerations: Benign neurotic personality structures;

These persons can be prone to Adjustment Disorders with anxiety or dysphoria in the face of sudden losses, and they can experience classical post-traumatic symptomatology; but generally without tendencies towards malignant depression or substance abuse, and with a good responsiveness to appropriate mental health treatment.

Treatment Implications:

- These persons can be mismanaged by an overly superficial approach. Simple "supportive psychotherapy", or over-reliance on psychotropic medications, can encourage regression into a state of self-righteous indignation, rather than growth, through appropriate mourning, to *transcend* unremitting self-righteous indignation
- These persons are best served by a relatively brief but intensive, more classical psychotherapeutic intervention, with judicious use of medications

Prognosis after a trauma or injury:

- Good for compliance with medical care and a full return to emotional baseline.

Other issues impacting treatment protocols and outcome, at any stage of development:

PERSONALITY STRUCTURE and the TREATMENT
of PHYSICAL ILLNESS and INJURY

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Pre-existing or co-existent physical or constitutional (affective or psychotic) psychiatric impairment.

Ongoing dysfunctional family, relationship, marital, and/or parent-child issues.

Developmental issues of middle age or later life, that complicate effective acceptance and mourning.

Medical-legal pressures to obtain secondary gain from an injury.

Necessary dependence upon pain medications, which, even if medically indicated, can disrupt mature psychological functioning.

Financial issues that produce chronic stress and an ongoing sense of loss, fear and/or humiliation.

Iatrogenic effects of (Mis)managed care”

Lack of coordination between medical and mental health professionals;

Lack of coordination between prescribing physician and psychotherapist;

Ineffective or inappropriate psychotherapeutic intervention;

Inappropriate psychopharmacological intervention;

Referral to “work stress clinics” or “support groups” rather than development of an individualized treatment plan.