Managing the ‘manipulative’ patient – a different perspective

Recent ideas about education suggest that all human behaviour can be seen as an attempt to manipulate other people or the environment. Nurses may use these ideas to find better ways of managing ‘manipulative’ behaviour.

Date of acceptance: December 30 1997.

Nicholas Gatward BSc(Hons), RMN, is Research Nurse, Eating Disorders Service, Brandon Mental Health Unit, Leicester General Hospital, Leicester.

‘Manipulative’ is a word often used to describe psychiatric patients. It is commonly used for patients with a diagnosis of borderline personality disorder (Linehan 1993a). It may also be used to describe someone with an eating disorder (De Laune 1991), as well as more generally.

‘Manipulative’ behaviour is usually understood as the patient’s conscious intention to gain a particular response from the nurse. The response may well be anger or rejection – those who are manipulated feel used and abused and both nurse and patient suffer.

THE CURRENT VIEW

Box 1 illustrates the effects that manipulative behaviour can have in a hospital setting. Morse (1991) suggests that: ‘The nurse becomes territorial about providing care: [she] thinks that she is the only one who can give proper and appropriate care to the patient’. Jayne can see this happening and is also angry with Debbie for creating this situation. By only asking and not searching Debbie for more razors after she had cut herself, Jayne has taken a risk to maintain some trust. Debbie has broken this trust. Staff have turned against each other and Debbie’s primary nurse has turned against her. De Laune (1991) said that: ‘Splitting (causing dissension among the staff) is a ploy often used by the manipulative client – manipulative clients are expert at identifying and capitalising on another’s area of vulnerability, which only adds to the other’s discomfort’. These are commonly described effects of such behaviour.

Dexter and Wash (1995) said that nursing such patients is a long and difficult process, during which ‘...unless the nurse is a paragon of virtue, many crises will have occurred’. They discussed the negative connotations of the word ‘manipulative’ and instead use the word ‘orchestrative’, which they describe as less ‘detrimental’.

Others suggest that the professional’s view of such behaviour may make things worse. Linehan (1993a) says that: ‘...the frequent interpretation of their suicidal behaviour as ‘manipulative’ is a major source of their feelings of invalidation and of being misunderstood’.

She agrees that such behaviour can make other people feel manipulated, but says that: ‘Inferring behavioural intent from one or more of the effects of the behaviour – in this case making others feel manipulated – is simply an error in logic’ (Linehan 1993a).

Taylor (1994) suggested that: ‘...frequently, descriptions of ‘manipulative’ patients are overtly slanderous’. He said that ‘manipulative’ implies that the patient is being deliberately negative, and proposes dropping the term because it is unhelpful and hazardous.

Nurses working on busy psychiatric wards have a difficult job. It is important for them to feel able to trust and rely on one another. Dissension caused by an inability to deal effectively with manipulative behaviour can seriously undermine teamwork and make a ward an uncomfortable place for staff and patients.

THE EVOLUTIONARY PERSPECTIVE

Since the publication of The Selfish Gene (Dawkins 1976), a psychology has developed that attempts to understand aspects of human cognition and behaviour by a perception of their origins. This suggests that the psychological adaptations that helped our ancestors survive and reproduce through millions of years of evolution are still with us.

This does not mean that there is a gene for manipulative behaviour. The relationship between genes and behaviour is complex and beyond the scope of this article.

The evolutionary view roots humans firmly in the animal world. Until the 1970s, zoologists saw animal communication as a means of conveying information. Since the advent of the ‘selfish gene’ view, it has become clear that: ‘...animals use communication principally to manipulate each other, rather than transfer information – once scientists had begun thinking in this way, they looked at animal social life in an entirely new light’ (Ridley 1993).

For animal social life, read human social life. Pinker (1994) said: ‘Human communication is not just a transfer of information like two fax machines connected with a wire; it is a series of alternating
Jayne is a staff nurse who has worked for several years on an acute psychiatric ward. Linda is a younger, recently qualified nurse on the same ward. They are primary and associate nurse respectively for Debbie, a 21-year-old woman admitted with personality and relationship difficulties, and a history of self-harming behaviour.

Jayne has noticed that Linda spends a lot of time with Debbie and that Debbie seeks Linda out but not Jayne or any other nurse. One late shift when Jayne is on duty and Linda is not, Debbie asks to go off the ward. No specific restrictions have been placed on her so Jayne allows Debbie to go. When she returns, Jayne takes her aside and asks if she has brought back anything she should not have, such as tablets or sharp objects. She decides it would be unnecessarily intrusive to ask to search Debbie’s bag. Not long after this, another member of staff finds Debbie sitting in the corner of a bathroom having made shallow but extensive cuts to her arm with a razor she had bought while she was out.

Jayne cleans and dresses the cuts and asks Debbie if she has any more razors. After consulting the on-call doctor, she tells Debbie she is on 15-minute observations and restricted to the ward.

The following morning, when both Jayne and Linda are on duty, Jayne is busy with another patient when Debbie approaches Linda, tells her she is feeling very upright and has another razor. Linda asks Debbie to hand in the razor and then spends over an hour with her. During the handover period Linda and Jayne discuss Debbie’s behaviour. Linda says that she feels Debbie should have more planned time. Jayne sees this as a criticism of her care. Jayne finds herself feeling angry with both Debbie and Linda, but only says that Debbie needs discussing further in Dr Smith’s ward round that afternoon.

Box 1. Ineffective manipulation

Jayne is a staff nurse who has worked for several years on an acute psychiatric ward. Linda is a younger, recently qualified nurse on the same ward. They are primary and associate nurse respectively for Debbie, a 21-year-old woman admitted with personality and relationship difficulties, and a history of self-harming behaviour.

Jayne has noticed that Linda spends a lot of time with Debbie and that Debbie seeks Linda out but not Jayne or any other nurse. One late shift when Jayne is on duty and Linda is not, Debbie asks to go off the ward. No specific restrictions have been placed on her so Jayne allows Debbie to go. When she returns, Jayne takes her aside and asks if she has brought back anything she should not have, such as tablets or sharp objects. She decides it would be unnecessarily intrusive to ask to search Debbie’s bag. Not long after this, another member of staff finds Debbie sitting in the corner of a bathroom having made shallow but extensive cuts to her arm with a razor she had bought while she was out.

Jayne cleans and dresses the cuts and asks Debbie if she has any more razors. After consulting the on-call doctor, she tells Debbie she is on 15-minute observations and restricted to the ward.

The following morning, when both Jayne and Linda are on duty, Jayne is busy with another patient when Debbie approaches Linda, tells her she is feeling very upright and has another razor. Linda asks Debbie to hand in the razor and then spends over an hour with her. During the handover period Linda and Jayne discuss Debbie’s behaviour. Linda says that she feels Debbie should have more planned time. Jayne sees this as a criticism of her care. Jayne finds herself feeling angry with both Debbie and Linda, but only says that Debbie needs discussing further in Dr Smith’s ward round that afternoon.

Box 2. Effective manipulation

A few months later Jayne is feeling fed up with her job. Someone else has been promoted to a ward position for which she has applied, and Jayne feels overlooked and undervalued.

A nurse specialist post is advertised in a specialty working with Dr Jones. Jayne decides to apply and asks Dr Smith for a reference.

Dr Smith is a good friend of Dr Jones and knows that he has a nurse on his ward lined up for the post. He likes having Jayne on his team as she is particularly good at dealing with patients who self-harm. He writes Jayne a reference and gives her a copy.

Jayne is impressed with the glowing reference he has given her. She begins to feel better about herself at work and finds her enthusiasm rekindled. She attends the interview and comes out feeling that she has presented herself well and that she might get the post – despite learning through the grape-vine that another candidate who already works with Dr Jones is hot favourite.

The following day she learns that this candidate has indeed been given the post. However, Jayne’s interview feedback is very good, and she returns to work, much happier with her current position and determined to do her best to achieve promotion there.

developments in order to induce the investment that would otherwise have been forthcoming. In short, it may be selected to give. Likewise it can withhold its smile until it has gotten its way’ (Trivers 1985).

He suggests that, as the offspring is at its most vulnerable when young, the parent is likely to respond most to psychological techniques used in infancy. ‘At any stage of development at which the offspring is in conflict with its parent, it may be selected to revert to the gestures and actions of an earlier stage of development in order to induce the investment that would have then been forthcoming. In short, it may be selected to regress when under stress’ (Trivers 1985).

Nesse and Lloyd (1992) linked this idea with the psychodynamic defence mechanisms. They suggest that ‘specific ego defences are specialised strategies for deceiving others’. Adults under stress may regress. ‘It would be reassuring to find that regression and other deceptive strategies are used mainly by children and pathological adults, but, in fact, children’s ability to use regression in the service of deception may be only an early and relatively crude precursor of manipulation skills that become so practised and natural in normal adults that they are easily overlooked’ (Nesse and Lloyd 1992).

Box 2 illustrates these ‘practised and natural’ skills. Dr Smith has manipulated Jayne, in this case to the benefit of both. Dr Smith has kept his valued nurse and Jayne is much happier in her job. It is unlikely though, that either would see themselves as using, or being used by, the other. Much adult manipulation works in this way. Under stress, adults can regress to earlier forms of manipulation. These are likely to be less successful and more easily spotted when used by adults. ‘Perhaps anger at adults who complain and act helpless reflects an intuition that such strategies are often exploitative’ (Nesse and Lloyd 1992).

SELF-DECEPTION

Manipulation involves deceiving others into giving more than it is in their interest to give. Deceiving others is difficult. Verbal deception can go astray because there is likely to be dissonance between the things a person is saying and his or her non-verbal gestures and expressions. People are good at reading non-verbal behaviour and tend to place more value on it than on words. Trivers (1976) suggested: ‘If deceit is fundamental to animal communication then there must be strong selection to spot deception and this ought, in turn, to select for a degree of self-deception, rendering some facts and motives unconscious so as not to betray – by the subtle signs of self-knowledge – the deception being practised.’

Trivers says that parents and their children manipulate each other. A human baby cannot control its parent physically, so it uses psychological methods – crying to draw its parent’s attention when it is hungry or in danger, and smiling to reward this attention. ‘Both parent and offspring benefit from this system of communication, but once such a system has evolved, the offspring can begin to employ it out of context. The offspring can cry not only when it is famished, but also when it merely wants more food than the parent is selected to give. Likewise it can withhold its smile until it has gotten its way’ (Trivers 1985).

He suggests that, as the offspring is at its most vulnerable when young, the parent is likely to respond most to psychological techniques used in infancy. ‘At any stage of development at which the offspring is in conflict with its parent, it may be selected to revert to the gestures and actions of an earlier stage of development in order to induce the investment that would have then been forthcoming. In short, it may be selected to regress when under stress’ (Trivers 1985).

Nesse and Lloyd (1992) linked this idea with the psychodynamic defence mechanisms. They suggest that ‘specific ego defences are specialised strategies for deceiving others’. Adults under stress may regress. ‘It would be reassuring to find that regression and other deceptive strategies are used mainly by children and pathological adults, but, in fact, children’s ability to use regression in the service of deception may be only an early and relatively crude precursor of manipulation skills that become so practised and natural in normal adults that they are easily overlooked’ (Nesse and Lloyd 1992).

Box 2 illustrates these ‘practised and natural’ skills. Dr Smith has manipulated Jayne, in this case to the benefit of both. Dr Smith has kept his valued nurse and Jayne is much happier in her job. It is unlikely though, that either would see themselves as using, or being used by, the other. Much adult manipulation works in this way. Under stress, adults can regress to earlier forms of manipulation. These are likely to be less successful and more easily spotted when used by adults. ‘Perhaps anger at adults who complain and act helpless reflects an intuition that such strategies are often exploitative’ (Nesse and Lloyd 1992).

SELF-HARM

One of the more difficult sorts of ‘manipulative’ behaviour nurses meet is when patients self-harm. This can provoke much anger and hostility. A link can be made between childhood temper tantrums and adult self-harming.
Trivers (1985) suggested that an extreme tantrum may make the parent fear that its offspring will harm itself. Linehan (1993a) described the sort of early emotional environment often found in people who go on to develop a borderline personality disorder. She says that: ‘...within such an invalidating environment, extreme emotional displays and/or extreme problems are often necessary to provoke a helpful environmental response’. As patients might, without being aware of it, view their nurses in a parental role, self-harm may be a regression to the extreme emotional display needed to gain a response in childhood.

WHAT CAN WE LEARN?

We can alter our perspective so that we think of a manipulative patient as one who is inexpert at getting people to do what he or she wants — and like doing it, rather than expert at exploiting others. Staff can then react in a more positive way, causing themselves and the patient less discomfort and anger.

Nurses could also help themselves by becoming aware of their own effective manipulation skills. One highly valued quality of all nurses is empathy. Nesse and Lloyd (1992) suggested that the ability to put oneself in the shoes of others enables people to accurately predict the needs of others and allows effective manipulation. Stuart and Sundeen (1987) recommended for future research: ‘...relationships between nurses’ attitudes towards manipulative behaviour, their own use of manipulations, and their ability to intervene effectively with manipulative behaviour’.

Gross (1992) used the term ‘impression management’, to describe the way people try ‘consciously or otherwise’ to influence how others see them. He describes impression management as ‘a manipulation of the public self’ that requires us to empathise with others so that we can see how our impression looks to them and alter our behaviour accordingly. Manipulative people may not be good at empathising and are therefore less aware of how they look to others. This might explain why, despite wanting aid from others, they act in anger and hostility rather than care.

An intervention here would be to help patients to gain some insight into why they behave as they do and why that behaviour can produce such negative reactions. It might be helpful to explain to the patient the underlying theory — that much human behaviour is manipulation of others. The nurse could suggest to the patient that the patient’s behaviour makes the nurse feel used.

Another intervention could be to help patients learn more effective skills. Successful manipulation skills are usually unconscious and they may be very difficult to learn as an adult. But surely ‘assertiveness training’ has this as an element? The dialectical behaviour therapy (DBT) developed by Linehan includes teaching interpersonal effectiveness. In her skills training manual, Linehan (1993b) said: ‘Although people often say that borderline individuals are manipulators, a really good manipulator makes other people like giving in. The premise in DBT is that borderline individuals need to learn to be better at manipulating — inducing others to do what they want them to do.’

If in Box 1 Jayne had viewed the situation from this perspective, how might things have been different? Jayne could have intervened earlier when she noticed that the patient, Debbie, had been seeking out the inexperienced nurse, Linda, rather than Jayne. She could have discussed this with Linda and helped her understand what was happening.

She could have explained that although it feels good to be the one that a patient wants to speak to, it may indicate a particular difficulty of the patient’s. Nurses sometimes need to look beyond the surface aspects of behaviour, even if that behaviour feels rewarding.

After restricting Debbie to the ward, Jayne could have spent time with her to explain that although cutting does get her attention, it tends to be of the wrong sort. She could, if she felt it was appropriate, have briefly outlined her view of the origins of such behaviour and perhaps linked it to her knowledge of Debbie’s past. She could have explained that while, given her history, it was understandable that Debbie should behave in this way, she could learn to ask for help in relieving her distress without needing to go to such extremes.

During the handover period when Debbie’s behaviour was being discussed, Jayne would have felt less angry with either Debbie or Linda. This would have helped to maintain staff cohesion and reinforced Jayne’s positive relationship with Debbie. If anyone had described Debbie as ‘manipulative’, staff could have discussed the use, meaning and unhelpful nature of this term.

At the ward round Jayne could have suggested that Debbie be referred for assertiveness or skills training or offer to work on this area with Debbie herself, explaining why she thought this might help.

CONCLUSION

Understanding the evolutionary origins of human behaviour is not proposed as a simple solution for all the problems nurses have in dealing with ‘manipulative’ patients. Such people, who have generally had very difficult lives, will still be a challenge to manage, particularly in the environment of a psychiatric ward.

Many nurses are highly skilled at dealing with self-harm, staff splitting and their own reactions. Neilsen (1991) makes a number of relevant suggestions based on a psychoanalytic perspective. The evolutionary perspective can perhaps reframe manipulative behaviours and help reduce the uncomfortable effects on both staff and patients.