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Special Series

From behind the couch - 'Manipulation'

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"Pamela was assessed by the crisis team at home late at night. She had been discharged from the inpatient unit only two days previously. Pamela was threatening to set fire to herself and was wandering around her flat in her bedclothes aroused and waving a lighter. She said her bed was soaked with meths. Pamela said she had debts and there were dealers to whom she owed money who were coming round to get her. She said she did not feel safe in her flat. The crisis team were pretty sure that Pamela had been drinking and taking amphetamines and felt that she was a serious risk to herself and others. Fortunately she agreed to be admitted. By the time she arrived on the ward she was calmer and she seemed to settle quickly. A couple of days later Pamela wanted leave to go to her flat and look after her dogs. She was given 4 hours leave but did not return on time. When she returned late she seemed intoxicated. Staff felt she was abusing the ward and asked for a review with a view to discharge. When Pamela saw the doctor she said she was suicidal and was planning on taking her own life but she denied having drunk alcohol. Pamela was not willing to stay on the ward and so had to be detained she was placed on continuous observations but then managed to cut her self using a concealed razor blade while in the lavatory. Staff negotiated an agreement that Pamela would talk to them if she felt distressed and asked her to hand in any further blades. That evening Pamela had a long conversation with a junior nurse and, after some persuasion handed in some razor blades. She went back to her room and ten minutes later, again despite being on continuous observations managed to cut herself again very severely with a razor blade. The following day in the hand over Pamela was characterised as "manipulative and deceitful". The ward was very full and Pamela was "using up a bed".

Staff often feel as though they are being manipulated by patients or describe their behaviour as "manipulative" and yet this term probably adds little to the management of patients other than the expression of dislike because a wide variety of disapproved of behaviours tends to be grouped under this term. An insight into its meaning and use can be gained by noting that patients with psychosis or melancholic depression do not often attract the appellation. Instead people who are drug and alcohol dependent, people with personality disorders and some depressed patients with atypical symptoms. The key is a sense on the part of the staff that the individual has some voluntary control over their behaviour and that they could change it if they so desired. Another feature is the sense that something is being extracted or demanded in an underhand way. Another feature of situations in which patients are described as manipulative is one where resources are scarce and, for reasons of rationing staff are under pressure not to accede to requests that have resource implications.

In thinking about situations in which staff are tempted to use the idea of manipulation it is probably a good idea to distinguish three potential situations from each other.

In some situations some patients are genuinely manipulative in their intentions. That is to say they are willing to tell untruths or to create situations that persuade or force other people to do things they want without having to ask for them directly. Often patients do this when they judge that were they to ask directly they would not get what they were asking for. If Pamela had asked directly for admission to hospital to avoid her creditors and the drug dealers who were chasing her there is little doubt that this would have been refused. So some part of her aroused behaviour may have been part of a conscious plan to obtain admission to the ward where she would feel safer.

In other situations patients appear manipulative because their actions seem inconsistent or disingenuous but no covert intention exists. So, for example when Pamela says she is going home to look after her dogs that may well have been her real intent. The fact that she then got drunk and returned late is not certain to have been a conscious part of her planning when she asked to leave the ward.

A third group of situations are those in which staff feel that they have been "used" or treated in an unfair way. This is very likely to have been the case in relation to Pamela's cutting behaviour. She is sneaky,conceals blades and evades the nurse who observes her and later she reassures another nurse after receiving a good dollop of care but then immediately cuts herself again. Patients who evade ward observations make nurses understandably angry because they place the nurse at risk of censure and because they are difficult to look after. While this behaviour is annoying and while it may result in increased or prolonged periods of nursing observation it is unlikely to be manipulative. When questioned patients talk about concealing their self harm far more than they reveal it. Thus the aim of the behaviour is to evade control rather than to have an effect on staff.

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A final situation in which patients can be labelled manipulative is when they are perceived to be using resources to which they have less claim than others or when they are thought not to be "taking responsibility for their behaviour". Such is the final accusation against Pamela. At such times what they do is labelled as "behavioural" or the decision made about them is that there is no evidence of genuine mental illness.

There are several serious difficulties with this way of thinking about this sort of patient. Such patients are generally thought by the public and the government to be suffering from a mental illness and characterise themselves in this way. They are clearly suffering and also clearly making a hash of their lives. Another problem with this line of thought is that it marks the end point of questioning enquiry about what is going on and often also the end point in relation to creative problem solving designed to improve the situation. Staff and the system turn from therapy to exclusion or expulsion as their main objective. Neither of these objectives turn out to be effective for psychiatric services since patients in this group return despite their ejection and, because of a failure of creative thought their problems remain in status quo.

COMPETEING INTERESTS
None Declared

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NEXT ISSUE.

So what should I do then? - Managing manipulative patients.

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