

A PERSONAL VIEW

The Manipulative Patient

By: M. Shehab

A psychiatrist is occasionally confronted with a patient demanding a particular action on the part of the doctor, refusing any alternative to his particular request. This is commonly referred to as "manipulative behaviour": When faced with such a patient, the inexperienced psychiatrist may find it difficult to retain control of the management of the patient.

Manipulative behaviour may take many forms and may be direct or indirect. It is essentially a strategy for achieving power, in the context of a role which does not normally provide it (A. Okasha, 1977). The patient is usually skilled in getting what he wants from other people by using a variety of maneuvers such as threats to produce a fit of temper, attempting suicide that is aimed at influencing others rather than being self-destructive; and behaviour that plays on the guilt of others (*Kaplan et al.* 1975).

Early recognition of the manipulator makes management easier. Certain characteristic behaviour, usually appearing in the first interview, may alert the psychiatrist. Any of the following should at least raise the possibility that the patient uses other manipulative techniques as well:

1. Demanding medications in a way that offers the doctor no alternative.
2. Asking for reassurance and promises of help.
3. Telephoning or asking permission to telephone about symptoms.
4. Setting conditions for treatment.
5. Threatening unwise or self-destructive behaviour.
6. Expressing disappointment in the doctor; or describing treatment received at the hands of another physician.
7. **Asking** questions about the doctor's personal life.

The patient's requests commonly appear so warm and innocent that the doctor can see no harm in gratifying them (George Morphy, 1972). Some time will pass before the doctor begins to suspect that all is not as it seems, and that he has lost control of the situation.

Thus, the psychiatrist must set limits to his patient. Those limits involve what behaviour the doctor will or will not accept from the patient, and what demands of the patient will or will not be met. They must be first clear in the doctor's mind and ~~then-when~~ needed—can be told to the patient verbally or expressed behaviourally ~~as~~, for example, not responding to an inappropriate remark by ~~the~~ patient. At times one may simply ignore the patient's demands. ~~Alternatively~~ a direct explanation for refusal can be offered. When ~~pressure~~ from the patient includes threats, the doctor must decide how likely the patient is to behave in a seriously self-injurious manner.

One must be careful in answering patient's inquiries **and judge** them according to individual patients. When ~~a~~ patient with agoraphobia or obsessive compulsive illness asks the doctor, "will you be able to help me"; a safe answer seems to be, "I will **be** glad to try" or "I will do my best". An outpatient who asks if he or she may telephone if he feels worse must be regarded with **caution**. Apart from some exceptions very limited help, if any, can be offered by telephone, while if permission is granted it may only lead to dissatisfaction of both patient and doctor.

Manipulative behaviour is most commonly seen in personality disorders, conversion reaction, obsessive compulsive neurosis and in depressed patients. It is often of lifelong standing, although an individual patient may exhibit this technique only when otherwise upset as in a depressive episode.

REFERENCES

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