

## **WHAT IS MANIPULATIVE BEHAVIOR, ANYWAY?**

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One of the most common ways of characterizing patients diagnosed with borderline personality disorder is that they are manipulative. Clinical usage of the term varies widely but clearly carries a pejorative meaning. Furthermore, behaviors that look similar to those called manipulative in clinical contexts are not called manipulative in broader society. It is crucial to become clear on what manipulation is, because studies show that carers routinely perceive BPD patients as manipulative and so have less empathy for them. In this paper the concept of manipulativity is clarified and its scope narrowed by distinguishing it from a number of related concepts, and a number of reasons why manipulating others is morally objectionable are suggested. I argue that, while some BPD patients may be manipulative, much of their behavior can and should be understood in a different light. Moral and clinical values are conflated in carers' judgments of manipulativity, and clinicians and researchers need to clarify when and why manipulative behavior is dysfunctional, and when it is merely morally wrong. Separating these two domains will enable carers to be more empathetic and less blaming of their patients' behavior.

Manipulativity is not a diagnostic criterion for borderline personality disorder (BPD); nevertheless, it is ubiquitous in the literature when discussing and describing patients and this disorder. In fact, "so frequently does the word crop up in conversations and discourse about such patients, that it might wrongly be thought of as the major problem that such patients pose to psychiatric services, or the major defining criteria of their disorder" (Bowers, 2003, p. 323). Typical of the literature is the following description of the behavior of BPD patients.

[Their] behavior was judged as unadaptive to the interview. They did things to hinder the interview, such as asking questions irrelevant to its purpose, getting up and changing chairs, or refusing to answer questions. They behaved in predominantly angry ways, expressing anger toward a variety of targets, including the interviewer. They were argumentative, irritable, and sarcastic. Without tact or consideration, they were demanding and attempted to manipulate the interviewer to acquiesce to their wishes. (Perry & Klerman, 1980; p. 168)

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The described behaviors are at least different in degree, if not in kind, from self-injurious behavior or suicide threats, the *sine qua non* of BPD patients. Yet clinicians tend to equate BPD patients with manipulativity and to forewarn others about them. For example, one researcher claims to distinguish BPD patients from depressed or schizophrenic ones by “their angry, demanding, and entitled presentation,” and another warns that “any interviewer, whether with a clinical or research purpose, will be exposed to devaluation, manipulation, angry outbursts, clinging or appeal” (quoted in Mitton & Huxley, 1988, p. 341). Most bluntly, “borderliners are the patients you think of as PIAs—pains in the ass” (“The ‘Borderline’ Personality,” 1983, p. 51). As I will show, what clinicians and staff mean by manipulative behavior varies widely. Because *manipulativity* is a pejorative term, and because it refers to behavior that is thought to require management, the use of the term needs to be more precise. The aim of this essay is to isolate the behavior most appropriately called manipulative and to identify reasons why it might be a problem for patients to be manipulative. Current clinical usage collapses the distinction between moral values about wrong behavior and clinical values about psychological dysfunction, and part of the task is to separate those two domains.

To open the enquiry, let’s consider the following transcript. This exchange takes place the night before the first scheduled appointment between a therapist and a BPD patient, because the patient experiences a medical emergency. Here is the exchange:

**Ms. A:** You could be dying before you got any help around here! My arm is killing me! This place is crazy!

**Therapist:** Ms. A, I would like to introduce myself. I am Dr. Wheelis.

**Ms. A:** Oh, no kidding! I didn’t expect you. You’re a resident? Interesting. You must be either very good or very crazy to have taken me on.

**Therapist:** I can’t tell if that’s an invitation, a warning, or both [patient smiled at the comment], but we have an appointment tomorrow. Why don’t we discuss it then. For now, perhaps I should take a look at your arm.

**Ms. A:** No, it’s okay, just a little bang.

**Therapist:** Are you sure? You suggested that it was giving you considerable pain.

**Ms. A:** No, it’s fine, really. I’ll see you tomorrow. By the way, I hate being called Ms. A.

**Therapist:** How would you like to be called?

**Ms. A:** Lotta. That’s what everyone calls me.

**Therapist:** Very well, as you wish. (Wheelis & Gunderson, 1998, p. 114)

An echo of Perry and Klerman’s (1980) assessment of BPDs can be found in the discussion of the transcript provided by her therapist and the co-author:

Already in this initial interaction with Lotta's therapist-to-be, harbingers of the therapeutic challenges are evident. Ms. A demonstrates a manipulative style that predates the first interaction by seeking help through the exaggeration of a minor physical complaint. There is also the hint that Ms. A may be taking pleasure in suggesting to the therapist-to-be that working with her will be more than a small challenge. Her final request, to be called Lotta [rather than Ms. A] betrays her desire to bypass professional formality by requesting an immediate familiarity. (Wheelis & Gunderson, 1998, p. 114)

The commentary suggests that the therapist may have given more weight to the diagnostic category in which Lotta is said to fit than to the particular person who is Lotta. In such an encounter, the therapist sees markers of BPD: manipulativity, efforts to control others, repudiation of socially accepted boundaries, and resistance to socially approved conduct. But is it correct to characterize Lotta's behavior in this encounter as manipulative? And is her behavior dysfunctional, or just irritating?

### **CONCEPTUAL CLOUDINESS**

We cannot answer the question of what is wrong with manipulativity until we know what it is. To begin with, I present several examples of the way the term is used with an eye to showing how sloppy its application is. Then I offer a cleaner definition but one that leaves crucial questions unanswered about the distinction between dysfunctional and morally objectionable behavior. The latter half of the paper addresses these issues.

### **CLINICAL USES OF THE TERM *MANIPULATIVE***

Little research has been conducted on how the term *manipulation* is used in a clinical setting, but what has been done suggests that people mean many things, all of them negative.

In one study, six different types of behaviors—ranging from bullying, intimidation, and physical violence to building special relationships in order to secure clinician compliance to conning and lying—were labeled manipulation by nurses. (Bowers, 2002)

In the Hare Psychopathy Checklist (cited in Bowers, 2002), lying and making false promises are distinguished from manipulativity, where manipulation is defined as deception used for personal gain, without concern for victims.

The Fallon Inquiry (cited in Bowers, 2002) included, as manipulative behavior, patients who threatened to make official complaints if they were not treated the way they thought was right.

Bowers (2003) offered a definition of manipulation that takes into account this broad array of behavior yet distills it so that it has some clarity: Manipulativity is activity that aims “to achieve a desired goal (perverse or

normal, symbolic or real) using deception, coercion and trickery, without regard for the interests or needs of those used in the process" (p. 325). Gunderson (1984) defines manipulation as "those efforts by which covert means are used to control or gain support from significant others. Typical ways include somatic complaints, provocative actions, or misleading messages, as well as self-destructive acts" (1984, p. 5).

Other researchers classify manipulation as a type of covert or indirect aggression, where the aggression is disguised, and they define *aggression* as "a response, the intent of which is to injure another person" (Kaukianinen et al., 2001, p. 363). Indirect aggression typically is circuitous, and the aggressor tries to "hide his or her overt intentions to harm others by applying strategies, which disguise aggression in the form of discreet or malicious insinuations" (p. 363). Examples of covert insinuating aggression include use of negative glances and gestures; do-not-speak-to-me behaviors; interrupting someone on purpose; imitating an employee's style of walk, expressions, or gestures in a derogative manner; refusing to listen to the other person; and hinting that the other person has mental problems (Kaukianinen et al., 2001). One question, then, is whether manipulation is a type of aggression or other deliberately injurious behavior and, in particular, whether the behavior of patients diagnosed with BPD should rightly be conceptualized this way. But the more difficult problem is that the concept of manipulation has such broad meaning in the clinical lexicon and it is not clear what behavior clinicians are objectively observing that should count as manipulative.

#### USES OF THE TERM IN BROADER SOCIETY

Here I want to pose examples drawn from nonclinical situations. Some of these examples are claimed, by the writer, to be forms of manipulation. Others may fit a definition of manipulation but are not called that. This section illustrates differences in how the concept of manipulativity is employed in clinical settings from broader society and presents more puzzles about what sort of behavior should be called manipulative.

The first example involves a stripper and her customer, an interaction which "is a complicated mixture of manipulation and control of emotions and communication" (Pasko, 2002, p. 63). Pasko argues that strippers are experienced at managing the emotions of their customers in order to earn a monetary reward. They play two roles: sex object for their customers and impersonators of "counterfeit intimacy" (p. 56). But how they play out those roles depends on the individual customer's needs, so skillful strippers are adept at reading their customers. "Knowing when to act seductive, when to remain still and simply be nude, when to shock a shy customer with a sudden revelation of nudity and when to be talkative, come from a dancer's ability to decode men's sexual wishes" (p. 58).

Prima facie, it may be right to characterize strippers as manipulating the emotions and desires of their customers. But this kind of interaction is

importantly different from behaviors like lying and deceiving, because the customer has come to the strip joint for the purpose of having his fantasies played out. The stripper and the customer are aware that the stripper is playing a role and that, to do so successfully, she must intuit his needs sufficiently to satisfy him. The customer knows that the stripper is working to earn a tip, although he brackets off that knowledge in order to participate in the game. So this kind of interaction is more like socially agreed-upon moves people make in a given context. In other words, I am arguing that some forms of behavior that might appear to be manipulative involve complex negotiations of people in social roles, or are entered into with an implicit understanding.

A similar case can be made for flight attendants. In a training program for airline flight attendants, the trainees were told:

You think how the new person resembles someone you know. You see your sister's eyes in someone sitting at that seat. That makes you want to put out for them. I like to think of the [airplane] cabin as the living room of my own home. When someone drops in [at home], you may not know them, but you get something for them. You put that on a grand scale—thirty-six passengers per flight attendant—but it's the same feeling. (Hochschild, 1983, p. 105)

Hochschild does not identify this thinking as a precursor to manipulativity but does argue that flight attendants and other service workers are explicitly taught to manage the emotions of customers (and themselves.) The flight attendant, for example, is expected to act pleased to serve the travelers and to experience pleasure from her or his job. But, as with the example of the stripper-customer interaction, I argue that managing others' emotions to gain an outcome one desires is not always manipulative. Travelers are not fooled by gracious and pleasant behavior into thinking that each of us is special and brings a warm glow to the flight attendant who serves us; this interaction, too, is based on social understandings of roles and norms for behavior in a particular context. In neither the case of the stripper nor the flight attendant are the behaviors malicious or deliberately injurious. They are socially prescribed interactions that are entered into with tacit agreement of the norms of interaction in those exchanges.

Con artists are called manipulative, but their interactional relation is different. What distinguishes this case from the examples above is that the con game can only work if the victim is ignorant of what is truly occurring. "The confidence game is an act of trust development, fake pretenses and duplicity in order to acquire some kind of gain, usually monetary. The confidence game, like many acts of deception, is an assumption of power. . . . The confidence person, or swindler, often enjoys the development and exercise of power over their victims, repetitively proving his or her cleverness and superiority" (Pasko, 2002, p. 52). Con artists depend on deceit to fool their victims, and their explicit aim is to gain something from the victim that he or she would not otherwise have surrendered. This case does seem to fit the general idea of manipulation as bad means to achieve one's

ends, but I will argue later that deception and manipulation are analytically separate concepts. For now, let me offer two more examples from broader society that are a bit messier.

In a novel about a middle-aged woman having an affair with a young boy, the narrator says of the boy:

It is pretty clear to me that there was a strong element of calculation in these little bursts of wistfulness and wonderment. By which I do not mean to imply that the boy was cynical exactly. Simply anxious to please. He had observed that Sheba liked him best when he was saying sensitive things about paintings and so on, and he was beefing up his moony ponderings accordingly. If this is cynical, then we must allow that all courtship is cynical. Connolly was doing as all people do in such situations—tricking out his stall with an eye to what would best please his customer. (Heller, 2003, pp. 46–47)

Courtship rituals, although culturally varied, typically include the assumptions that the other is presenting his or her best, downplaying or perhaps suppressing one's bad tendencies, and attending to the beloved with an aim to please. Do people's interactions when entering into new potential intimacies involve a kind of manipulation? It depends. On the one hand, courtship is similar to the stripping and service industries in that it involves a tacit understanding of the rules of romance. It seems best viewed as a social negotiation that both parties know involves some exaggeration and some disguise. If Sheba likes daffodils and Connolly brings her a bouquet, most people would not see that action as manipulative. On the other hand, deception can run deep. Connolly could be posing as a lover when he really wants access to her money, or her younger sister. But then why not just call it deception or exploitation? Courtship *per se* isn't manipulative, and it's the context of the situation that will determine how to evaluate an interaction.

The last example also makes this point. Recall that, in clinical literature, one type of behavior that counted as manipulative was patients who threatened to make official complaints if they were not treated the way they thought was right. But consider this type of behavior in another context. The United States has had a long history of nonviolent strikes and other forms of protest over unfair labor conditions. For example, "In the women's garment industry, as far back as 1910, workers have ceased operations without leaving the shop. Partly this has been done when a contract forbade strikes, the workers arguing that a mere stoppage was not a violation" (Lynd & Lynd, 1995, pp. 142). Protests and strikes occur when people are experiencing injustice or a violation of their rights and other forms of redress are unavailable. When power imbalances exist and the more powerful party refuses to negotiate in good faith, the less powerful may threaten other actions such as strikes or protests. Are threats always manipulative? A threat to strike may simply be the next move in a frustrating attempt to be taken seriously. In our society, we do not ordinarily talk about threats to strike as manipulative (although employers might frame

it that way). Furthermore, it's not clear that attempts to claim a right to be treated fairly should fall into the category of "intent to harm."

This example raises the question of why BPD patients who are similarly less powerful and need pathways to ensure fair treatment are called manipulative when they threaten to take advantage of those securities. Bowers (2002) argues that, while some complaints are justifiable and for good cause, others seem to be done spitefully or over trivial matters. He says that "the formal complaints procedure can be very destructive, can cause much worry even among those who have only witnessed what it has done to others, and is costly in terms of management time, suspensions, illness and resignations at a time when nursing staff are a scarce resource" (p. 62). Putting Bowers' ideas together with the above argument, I would say that manipulativity in patients who threaten to make official complaints would not consist in the activity per se but in a cluster of other issues that must be viewed in context, such as what a particular patient's motives are, what events preceded the complaint, how dysfunctional the patient is, and so on. In other words, the act of threatening to make an official complaint does not entail manipulativity any more than the act of threatening to strike does.

Considering these examples, one finds considerable messiness in the usage and meaning of manipulative in broader society as well as in clinical contexts. There appear to be two problems in the use of the term *manipulation*. One is that, even in the restricted domain of clinical contexts, the class of behaviors is over-inclusive. Research suggests that clinicians include under the umbrella term of manipulativity everything from bullying, intimidation, physical violence, building special relationships, conning and lying, using deception for personal gain without concern for victims, to threatening to make official complaints if a request was not met (Bowers, 2003). With such a range of behaviors, the primary message seems to be a negative judgment—vague in content but powerful in effect. Clinicians use the term as a superordinate category under which morally wrong ways of interacting are included. But lumping all these behaviors together is not therapeutically useful, because it doesn't allow for differentiation between kinds of behavior that vary among BPD patients. Furthermore, moral wrongdoings (such as lying) are distinguished from other kinds of wrongdoing (such as being divisive) both in moral theory and in ordinary language; the action, intention, and type of harm done are part of the evaluation of what makes each action wrong, and the identifying features of each of these moral wrongs are importantly different. So it is a mistake for clinicians to group all these behaviors under a general heading of manipulativity.

The second problem is that a mismatch exists between the meaning of the term in everyday settings and in clinical settings. Clinically, the term refers to behaviors such as lying, bullying, intimidating, demanding fair treatment, creating divisions, and corrupting others. In ordinary life, many similar behaviors are not called manipulative. Is this mismatch war-

ranted? Are all of us more manipulative than we think—and, if so, what would that finding indicate about the ordinary person's mental health? Or are BPD patients being held to a higher standard of behavior and interaction than are others?

Most people occasionally deceive, are indirect about what they want, disguise their true feelings, and intimidate others (Goffman, 1952). But BPD patients are routinely characterized—pejoratively—as manipulative. Why are patients viewed through this lens rather than seen as participants in an acceptable social-role interaction in the context, or engaged in a type of persuasion, or as making a move in a negotiation? How can we distinguish normal manipulative behavior from pathological, especially with the apparent variations between behavior and usage?

Let me take the latter question first. We might conclude that manipulation is a matter of degree: a continuum from “normal *quid quo pros* of everyday social life” (Bowers, 2003, p. 326) to habitual, deeply ingrained patterns from which everything flows. This move would require us to distinguish manipulative *acts* from manipulative *character*. The borderline personality, then, would have a manipulative character.

This move is too quick, though, because one cannot rule out the possibility that patients perform complex negotiations in their relationships with clinicians and that those interactions are socially encoded in the patients' view. The patient role is a core function of health care and, although Internet access has empowered some patients to a degree, the social expectations for behavior of those in the patient role are still that of subordination to expertise and authority, compliance, and a bit of humility. Patients who challenge the traditional norms of the role are seen as noncompliant and, as in the opening transcription between Lotta (“Ms. A”) and the therapist, as indicators of the patient's disordered personality. An alternative would be to consider how the patient is attempting to navigate clearly delineated relations of power and to negotiate shifts in social roles so as not to feel powerless and beholden.

Another approach to distinguish between everyday and pathological manipulativity is to identify what forms of manipulativity are dysfunctional or maladaptive. Numerous clinicians, in describing the BPD's noncompliant, self-injurious, and manipulative behaviors, refer to such behavior as maladaptive (cf. Harvey & Watters, 1998). To call BPD manipulativity maladaptive, though, merely pushes the question back: why, and when, is manipulativity maladaptive? If I am right that behavior that is called manipulative in clinical settings is condoned, expected, or not even noticed in nonclinical settings, we need to have a noncircular way of identifying pathological manipulation. I return to this point later.

For now, let me address the second question: Why *are* patients viewed through a lens of dysfunctional manipulation rather than seen as participants in tacitly understood social interactions, or engaged in a type of persuasion, or as making a move in a negotiation? The reason is that clinicians are as likely to perceive manipulative behavior based on preconceived no-



tions of BPD patients as they are to base judgments on clear and objective perception. That is, their perceptions may be based on stereotypes of BPD patients. For example, researchers Gallop, Lancee, and Garfinkel (1989) asked: "Do patients diagnosed with BPD receive qualitatively different care from patients diagnosed with other [non-personality-disordered] diagnoses?" (p. 815). Hypothetical vignettes in which the only variable was presence or absence of a diagnosis of personality disorder suggested that stereotyped perceptions play a crucial role in how the behavior of BPD patients are interpreted and responded to. "The difficult behavior of the patient with borderline personality disorder is often seen as 'bad' and 'deliberate' rather than as 'sick.' . . . The schizophrenic patient, on the other hand, is not perceived as having this control" (p. 815). Schizophrenic patients are perceived as ill, whereas "borderline patients . . . do not meet the criteria of 'good and attractive' patients. They are not perceived as sick, compliant, cooperative, or grateful" (p. 819). The researchers conclude that "the label [BPD] is sufficient to diminish staff's expressed empathy" (p. 815). Nurses were more likely to give responses that indicated affective involvement if the patient's diagnosis was schizophrenia, and were more likely to give responses that were belittling or contradicting if the patient's diagnosis was BPD. The researchers suggest that clinicians and staff may believe that BPD patients deserve less empathetic treatment and that their diagnosis is bad or manipulative (Gallop et al., 1989). Research by Bowers (2002) returned similar responses: nurses were virtually unanimous that these patients are to blame for their behavior. The nurses reason that, unless a patient is deluded or hallucinating, or confused or muddled, the patient knows what she or he is doing and is therefore responsible for those actions.

This discussion thus points to three questions. (1) Are clinicians seeing something objectively real in BPD patients? (2) Is that behavior best described as manipulative? (3) Given the pejorative use of the term when referring to BPD patients, *manipulative* is being used to convey strong disapproval. But what is wrong with patients manipulating their clinicians and staff? The second half of this essay considers possible answers to this last question and shows how moral values and values of psychological well-being are conflated.

### **WHAT IS WRONG WITH BEING MANIPULATIVE?**

There are a number of responses to the question "What is wrong with being manipulative."

#### **RESPONSE 1: IT DEPENDS ON WHAT WE INCLUDE IN THE CATEGORY**

If clinicians were to have a more precise and widely accepted definition, they would apply it less frequently and less sweepingly to BPD patients. Let me try to focus the term by distinguishing it from a cluster of related

behaviors that include coercion, manipulation, and persuasion. (By doing so, I am disagreeing with the broad scope that Baron [2003] gives to manipulation.) The connected thread of these concepts is that each is used to produce belief or action in another. In other words, the superordinate genus is “behavior that is used to produce belief or action in another” and manipulation is one of the types of behavior. According to Mills (1995), manipulation is the aim of effecting change in another’s internal states; it works on our beliefs and desires—and especially our emotions—in an indirect way. Manipulation results in a person holding desires and beliefs that (a) do not grow in any natural way out of previous beliefs and desires and (b) “are produced in a way that bypasses all . . . ordinary cognitive and affective processes” (p. 100).

Mills’ idea is useful. If clinicians were to follow this understanding of manipulativity, only those behaviors that work indirectly and on the level of the other’s beliefs and desires would count as manipulative, and many behaviors now counted as manipulative would be reclassified. But her suggestion of what manipulation is doesn’t help us understand why it is normatively less desirable than what she calls persuasion. What is wrong with being indirect? And when?

If being indirect is the marker for what is wrong with being manipulative, we need to turn to means-ends analyses. The idea seems to be that being direct with others when trying to produce beliefs and feelings is better than being indirect. The sense of “better” or “preferable” is both moral and epistemological, because indirect behaviors such as lying about one’s feelings are typically judged as morally wrong as well as epistemically irresponsible to the other. A negative judgment of manipulativity is based on the norm that the means to one’s desired end should be achieved as directly as possible while allowing the other to participate in rational evaluation.

While this seems right, reliance on such a norm is fairly superficial. For one thing, it ignores norms for interaction where complex negotiations of social roles may appropriately demand subtlety and finesse. Second, as Walton (1998) argues, different dialogical contexts call for different interactional styles. Third, what counts as indirect or covert is culture-bound. What are the underlying values that lead us to object to indirect and covert means of interacting? Since we sometimes do not object (we prefer the flight attendant to pretend to love the job of serving us), what is it about the clinical context that seems to demand directness?

This leads me to think that Mill’s definition is still too broad. The definition of *manipulativity* that I offer is a behavior that exaggerates or dramatizes an emotion or need that the manipulator is experiencing and that targets a perceived vulnerability in the other (cf. Baron, 2003, p. 44). It is typically indirect in that it highlights emotions or needs in ways designed to effect desirable responses in the other rather than asking for what the speaker wants without dramatizing it. One is not deceiving the other, exactly, but instead is making the most of emotions and needs. The speaker performs his or her emotional state in a way that makes it difficult to get a foothold in more reasonable dialogue. The listener feels trapped because

there is the perceived necessity to take the speaker seriously even though the listener thinks the emotion or need is being overdone.

This definition may be narrower than previous ones, but it is still not very specific. And it does little to advance our understanding of why behavior called manipulative is objectionable. Is it wrong—or dysfunctional—to exaggerate one's needs and emotions?

*Manipulativity and Blame.* The difficulty for clinicians who work with BPD patients is that “the concept of manipulation itself can become a scheme of interpretation” such that clinicians “habitually seek out and impute manipulative motives to others” (Bowers, 2003, p. 327). Perceptions of manipulative behavior combined with the strong feelings it arouses leads clinicians and staff to be less empathetic toward BPD patients. It is crucial for those working with BPD patients, therefore, to interrupt global assessments of manipulativity and critically to evaluate assumptions about what constitutes manipulative behavior. Furthermore, it is important to remember that feeling manipulated is not evidence that one has been manipulated: Manipulation has an objective aspect, and judgments of manipulativity should not be made wholly on a subjective basis. Nevertheless, BPD patients do tend to push people's buttons, and I think sometimes clinicians are seeing behavior that is indirect and covert in frustrating ways. Consider the following brief case study.

Ms. B was a 35-year-old disheveled, agitated, overweight single woman who appeared for her first clinic appointment. She promptly stated that she was grateful to “now have a therapist,” and that she had needed one for 3 years. Even as the evaluating clinician felt uneasy about the role assigned by the patient, Ms. B went on to say she felt very suicidal. In response to the clinician's inquiries, she reported that she had been suicidal “off and on for many years” and had already had 31 hospitalizations.

**Clinician:** What has caused you to become suicidal now?

**Patient:** I don't know; what difference does it make? (*now becoming irritated and defensive.*)

**Clinician:** Has anything happened in your life recently? (*Clinician is skeptical about the patient's lethality and hoping to isolate specific events that can be addressed but already feeling highly anxious about the patient's volatility and potential flight.*)

**Patient:** All I know is that I visited my parents and became very upset and had to leave. No, I don't know why. No, they didn't say anything. Yes, it's happened before, and last time I nearly killed myself.

**Clinician:** What happened?

**Patient:** I drank a quart of vodka, and then took any fucking pills I could find. . . . I would have been dead if my landlord hadn't noticed that the TV was on all night.

**Clinician** (*not convinced that the patient is dangerous, but still feeling coerced into suggesting hospitalization*): Are you feeling that way again?

**Patient:** I just want to get control of myself. If I can't, I'm going to slash my neck. This time I don't want to fail.

**Clinician:** Would you like to go into the hospital?

**Patient:** Yes, I need to. (Gunderson, 2001, pp. 97–98)

Gunderson comments that this situation is a typical one for clinicians treating BPD patients and that the clinician will usually feel coerced, manipulated, and helpless. Regardless of whether or not that judgment is warranted, clinicians are wary and easily aroused by perceived manipulation. A central aspect of such feelings of anger and entrapment is the attribution of choice and responsibility to the patient.

In slowing down a knee-jerk response to a patient who seems manipulative, we need to question the assumption that the client's means of reaching his or her goals are deliberately manipulative. It's a fundamental principle of moral philosophy that we don't blame people for things that are beyond their control; and our primary defense mechanisms such as projection, denial, and dissociation are part of our unconscious, so not subject to our will. Furthermore, the notion of choice and control is notoriously complex when it comes to socialization processes and learned styles of communicating. On what basis might we objectively determine that someone has chosen a manipulative style of interaction?

#### RESPONSE 2: MANIPULATIVITY IS NOT BLAMEWORTHY WHEN BPD PATIENTS DO IT

It might seem that I am suggesting that BPD patients cannot help what they do and so should not be judged so harshly. The warrant for this view would be that this behavior is part of the dysfunctionality of BPD; but that's too simple. Responsibility for our actions is a moral attribute we grow into as we gain insight into behaviors previously done unthinkingly or unconsciously. When we understand that we are behaving in hurtful or difficult ways and begin to see how we can change undesirable patterns of interaction, then we are blameworthy if we do not try to make those changes. In the therapeutic context, patients learn over time to evaluate behaviors as undesirable and acquire skills to intervene in learned maladaptive behaviors. We might, therefore, modify the response to address that point.

#### RESPONSE 3: MANIPULATION IS NOT BLAMEWORTHY WHEN BPD PATIENTS DO IT, UNTIL THEIR THERAPEUTIC DEVELOPMENT IS SUCH THAT THEY HAVE WITHIN THEIR POWER A FOUNDATION FOR SELF-INTERVENTION IN UNDESIRABLE MANIPULATIVE BEHAVIOR

This sounds right. Such a view would at least require that clinicians not be judgmental and rejecting about perceived manipulation until they have

adequately assessed the level of treatment and its success for an individual patient. But this response doesn't so much tell us why manipulation is objectionable behavior for patients to engage in, but at what point in treatment it can become a matter of blame rather than excuse. So let me suggest other reasons why BPD manipulativity might be wrong.

**RESPONSE 4: MANIPULATING OTHERS IS WRONG  
BECAUSE IT CAN LEAD TO BAD CHARACTER TRAITS  
(VIRTUE ETHICS ARGUMENT)**

Our actions, over time, create the sorts of persons we become, and the character we have then directs our aims and goals such that our actions become informed by our character. If a person regularly uses manipulation as a method to achieve one's ends, the long-term result is that it entrenches the disposition to manipulate others in order to get one's way. As a character trait, manipulativity is undesirable because it constrains and frustrates interactions with others and undermines trust. We might say, then, that the BPD patient has a manipulative character. This response classifies dispositional manipulativity as a vice.

But this move is too quick. As I indicated earlier, we cannot rule out the possibility that patients perform complex negotiations in their relationships with clinicians and that those interactions are socially encoded in the patients' view. Are patients manipulative in all contexts? Or is manipulation a sociological phenomenon that occurs particularly in response to clinicians? Are patients enacting a social role that is common among people who experience themselves as relatively powerless? Answers to these questions would be fruitful in evaluating manipulative behavior.

**RESPONSE 5: MANIPULATING OTHERS IS WRONG BECAUSE  
IT IS A WRONG MEANS TO AN END (MEANS/ENDS ARGUMENT)**

It is a truism that, even when the ends are good, not all ways of achieving those ends are equal. To take one criterion of BPD: self-injurious behavior. Even if the end of relieving stress, or feeling pain, or getting attention, is a good aim, concerned others typically do not want the patient to relieve stress or get attention by self-injurious behavior. But what counts as acceptable means to various ends is normative, and I am reluctant to endorse "indirectness" or "performative exaggerated emotions" as wrong means without sociopolitical analysis of norms. And those norms will be relative to contexts, not universal norms. As I argued earlier, the context in which behavior occurs is crucial to the evaluation of that behavior.

**RESPONSE 6: MANIPULATING OTHERS IS WRONG BECAUSE IT  
TREATS OTHERS AS SIMPLY AS MEANS (KANTIAN ARGUMENT)**

The manipulative behaviors we should judge most harshly are the ones where not only the means are wrong but the ends are objectionable. For

example, if the goal is to extract money with glee, as con artists do, then the means of deception is wrong and the goal of pleasurable exploitation is wrong too. Such behavior is wrong both on utilitarian and Kantian grounds, but here I highlight the Kantian view. Treating others simply as means to one's own ends, according to Kant, violates the Third Formulation of the Categorical Imperative. To exploit others in order to achieve one's own ends is to treat them simply as a means to one's own goals or as a being-for-others. It is morally wrong to get others to do things that they cannot rationally consent to or refuse, because it violates their ability to be autonomous.

But it doesn't seem that BPD patients are treating clinicians simply as means. According to the more empathetic clinicians, when a patient is behaving manipulatively, the primary aim is to express a deep need for relationship (Gilligan & Machoian, 2002). Seeking relationship can, of course, fail—as when a man stalks a woman he desires. Stalking would, indeed, violate Kant's moral principles, as it imperils the victim's autonomy. But clinicians typically do not lose their autonomy in virtue of the behavior of BPD patients (unless the patient stalks the therapist, which then is stalking, not manipulativity). For BPD patients, efforts to seek a relationship should be morally less troubling even if the way they go about it is less than optimal.

#### RESPONSE 7: MANIPULATING OTHERS IS WRONG BECAUSE IT VIOLATES NORMS OF RELATIONSHIP (ETHICS OF CONNECTEDNESS ARGUMENT)

There may be another reason why there is so much blame going around when it comes to manipulative patients. BPD patients, when they do manipulate, are typically looking for relationship. In discussing a particular case, Gunderson (2001) notes that “as usually the case, she as a borderline patient has trouble saying what is wanted. Unspoken is the fact that she wants concerned attention” (p. 96). Gilligan and Machoian (2002), too, suggest that what girls who are self-injurious or threaten suicide really want is “the possibility of a confiding relationship” (p. 323). It seems misguided to impute blame on someone for wanting attention and not feeling able to ask for it directly. And, as Linehan (1993) points out, some BPD patients are uncertain about what they are feeling and wanting.

Norms of relationship, like other norms, are contextual. But at the core of relationship is the concept of *connection*, a quality that is both moral and psychological. I have argued elsewhere (Potter, 2002) that human flourishing is constituted in part by a sustained, connected relationship. Being in relationship “is an ongoing process of making and recognizing reciprocal efforts to sustain connection and repair disconnections” (Potter, 2002, p. 206). People are connected through the interplay of their feelings and their thoughts, thereby creating something new together that is built by both of them. This bridging experience is the “connection between”

(Miller, 1986, p. 9). Manipulating another can disrupt the connection needed for a relationship to be sustained, because when one person manipulates another, it is difficult for the other to trust either their own perception of the situation or the other's presentation of self. Sustaining connection and repairing disconnections, then, is part of being in relationship in morally and psychologically healthy ways.

Many BPD patients experience great difficulty in maintaining relationships and, as a result, do not have the connectedness necessary to human flourishing. This loss, and the inability to know how to correct the problem, is one of the causes of these patients' great suffering (Zanarini et al., 1998). Manipulativity may be one way patients try to get these needs met; unfortunately, it is self-defeating.

The point that manipulation may be about relationship also might explain why clinicians react negatively when feeling manipulated. Extrapolating from a study done by Lawson (2000) on how it feels to be lied to, I believe that being manipulated *calls into question the meaningfulness of the relationship*. Clinicians invest tremendous energy and time in working with their patients, including the development of a trusting and therapeutic relationship. When it looks like they value the patient/clinician relationship more highly than their patients do, it arouses resentment and anger.

I am partial to the last explanation, because it captures the paradoxical quality of manipulative behavior while acknowledging clinicians' responses as sometimes reasonable. The irony, for patients, is that the very thing they seek—relationship—is undermined by the means they employ to obtain it. Manipulating behavior estranges others over time: it suggests to the clinician that the relationship is not valuable enough to the patient to cease performing pain, anger, and fear and to let the relationship be experienced straight on.

I am not arguing that the only reason BPD patients manipulate others—when they do—is that they are seeking a relationship; people, including patients, manipulate for a variety of reasons. My aim has been to suggest what is objectionable about manipulative behavior, and I have offered several arguments to that end. The point of this last response is to offer another explanation of why clinicians would view manipulative behavior as wrong or bad.

Nevertheless, even this last response fails to address a crucial problem with judging manipulativity: the conflation of moral values with clinical values.

### **MORALITY AND MENTAL ILLNESS**

Meaningful relationships are central to living a flourishing life. It is hard to imagine a moral life without friendships, love, and companionship; personal attachments are part of morality as well as of well-being. One indicator of mental illness is the relative absence of meaningful relationships, or difficulty in maintaining them. People diagnosed with borderline personal-

ity disorder often have unstable interpersonal relationships, and this difficulty is likely to cause the patient significant distress and suffering. This anguish is both psychological and moral, because relationships are both psychological and moral. A link does exist between moral life and mental health.

For this reason, it is possible (easy, even) to let moral judgments about patients stand in for clinical judgments. If manipulating others is a dysfunction, it must be shown to be one. I can imagine such an argument, for a disposition to manipulate others can erode relationships and undermine trust, as I have argued above. When someone aches for relationship and connection but characteristically behaves in ways that prevent that person from sustaining them, the behavior is dysfunctional with respect to a vital human need. But I can also imagine a defense of behavior that is manipulative, for direct access to power and voice are not equally available to all of us, and manipulation may be a survival skill. If manipulating others cannot persuasively be viewed as a dysfunction, it should not occupy such a central place in the clinical literature on BPD. Three of the arguments against manipulativity that I have examined—from virtue ethics, means-ends analyses, and Kant—are all moral arguments (for example, to call manipulativity a vice is to identify it as a moral failing, not a dysfunction.) The last argument, that manipulativity violates the norms of relationship, is both moral and psychological. But if manipulating others is a moral failing (and I think it can be), it should be viewed as just that: psychiatry is not in the business of pronouncing moral judgments. Furthermore, I have argued that we cannot a priori determine whether behavior is manipulative or not, whether it is blameworthy or not, or whether it is dysfunctional or not; these judgments require attention to the context, the persons involved, and their history.

Psychiatry is not free from values, nor should it be. But the values that are endorsed must be carefully and reasonably chosen, not recycled from unexamined stereotypes or objectionable behavior.

## **CONCLUSION**

Let's return to the opening exchange between Lotta (Ms. A) and the therapist. Does Lotta's behavior fit the working definition of manipulativity? To some extent, yes. She seems to have exaggerated her pain in order to get the therapist to pay her a visit. She wasn't particularly indirect, though. The discussion that the authors provide of the case raises the question of whether the researchers are reading too much into the initial encounter. As I have argued, research suggests that BPD patients are perceived from the outset to be difficult and manipulative, and that carers dislike such patients because they are not compliant and cooperative. The worry is that Lotta and the therapist are caught up in this dynamic. Another reading of the encounter is that Lotta is taking the initiative to begin shaping the therapeutic relationship because she is anxious about it and does not



want to feel that it is out of her control. In doing so, she draws upon not only dramatic ability (“You could be dying before you got any help around here!”), but humor (“You must be either very good or very crazy to have taken me on”) and directness (“By the way, I hate being called Ms. A.”) It does seem that Lotta is not following social norms for behavior in clinical encounters. Attempting to joke or asking to be called by her first name may be inappropriate in this setting, especially given the emergency call. But it is too quick to decide that “[a]lready in this initial interaction with Lotta’s therapist-to-be, harbingers of the therapeutic challenges are evident” (Wheelis & Gunderson, 1998, p. 114). Inappropriateness in behavior suggests social ineptness, not necessarily dysfunction. And inappropriate behavior is sometimes the outcome when someone is challenging conventions and norms that are subjugating. Perhaps Lotta is actively resisting (in the political sense) the patient role as subservient, compliant, and subjugated. All this behavior could turn out to be dysfunctional for Lotta, but one encounter is insufficient to assess her. In order to know whether Lotta is dispositionally and pathologically manipulative, more time in interactions with her is needed, more context needs to be developed, and more attention to clinicians’ perceptions and assumptions needs to be paid.

The question I have been addressing is whether clinicians are justified in taking a pejorative and judgmental stance towards BPD patients. While a violation of norms for relationship might provide an *explanation* of why clinicians react negatively to BPD patients, it doesn’t provide *warrant* for sweeping labels of manipulativity or the negative attitudes that are entailed. Such attitudes do not satisfy therapeutic and moral norms that clinicians are expected to follow: namely, that clinicians need to develop empathy for their patients’ suffering and distress. When clinicians view patients’ primary character as morally objectionable, it’s difficult for clinicians to feel empathy and for patients to either receive or elicit it.

Clarity and carefulness in applying the term *manipulation* will aid clinicians in intercepting negative perceptions, a necessary correlate to being empathetic. BPD patients are suffering and need responses from clinicians that do not exacerbate their distress, and the pervasive attribution of pejorative and blaming manipulativity does not further their healing process.

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