

Playing the Manic Game

Interpersonal Maneuvers of the Acutely Manic Patient

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The acutely manic patient, with his ability to create interpersonal havoc with family and therapist alike, can be one of the most challenging, taxing, and difficult of patients. It is our purpose to describe the character structure of the acutely manic patient, to define his patterns of interaction and communication, and to emphasize the impact these qualities have upon those around him.

While previous studies have described the intrapsychic dynamics, pathogenesis, and character structure of patients suffering from manic-depressive psychoses,¹⁻⁵ the fashion with which the acutely manic patient deals with others, and the impact this has on them, has received sparse attention.

Dooley¹ described patients with frequent manic attacks as being headstrong, selfsufficient, know-it-all types of people who will get the upper hand of the analyst. Gibson² noted that while manic-depressive individuals appear remarkably insensitive to interpersonal subtleties on a conscious level, they can be extraordinarily perceptive on a subconscious or unconscious one. He felt that these patients are proficient in evoking and utilizing the feelings of others, especially guilt feelings, and that they are extraordinarily adroit at handling and manipulating other people. Four characteristics Gibson stressed regarding the manic-depressive character structure included: (1) difficulty in dealing with feelings of envy and competition; (2) strong dependancy drives; (3) the frequent use of denial as a defense; and (4) a value system based on social conventionality.

Fromm-Reichmann³ described manic-depressive patients as being more clever and successful in finding vulnerable spots than are the people who are targets of their hostility. She stressed their ability to become immediately acquainted with anyone they meet, establishing quick, superficial, contacts which are not accompanied by a genuine interest.

Cohen et al⁴ reviewed the psychoanalytic literature concerning manic-depressive patients. They summarized Abraham's ideas on the characterological features of manic-depressive patients as including impatience, envy, increased egocentricity, and intense ambivalence. Cohen et al further described hypomanic patients as being conventional-minded, independent, and possessing a certain social facility. They felt that a hypomanic's appearance of closeness is provided by his liveliness, talkativeness, wittiness, and social aggressiveness. They emphasized that, on close observation, the hypomanic can be seen to be carrying out a relatively stereotyped social performance, taking little account of the other person's traits and

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characteristics. They also noted that manics and depressives tend to have only one or very few close, dependent relationships. Cohen and her collaborators found that the concept of reciprocity is missing in manics and that they utilize others as they would possessions or pieces of property. The manic seemingly does not perceive others as full-sized humans, but rather as entities who are now good, now bad. Manics are described as good salesmen, who utilize hypermorality and conventionality as tools for bargaining. Cohen et al noted that aggressiveness in manics is motivated by need, dependency, and emptiness, rather than by hostility.

Methodology

This paper is derived from our collective clinical experience in treating a total of 15 acutely manic patients in a hospital setting. Patients included were judged to be moderately or highly manic during part of their hospitalization, as evaluated by the Bunney-Hamburg scale.⁶ Each patient was diagnosed as having a manic-depressive psychosis, manic phase, by two or more psychiatrists. All patients were hospitalized on a research unit designed for the study and treatment of affective disorders. The patients showed symptomatology including flight of ideas, insomnia, hyperactivity, grandiosity, strong denial of illness, high energy level, intense irritability, lability of affect, manipulateness, logorrhea, and assaultive behavior. Many required use of a seclusion room for management of uncontrollable activity.

The interactional styles to be described, as well as their impact on psychiatric personnel and family members, were evaluated in various ways. We listened to tape recordings of individual and group therapy sessions, reviewed physicians' and social-work treatment notes, and analyzed nurses' behavioral descriptions and ratings. These notes, ratings, and recordings were collected according to predetermined standards, not connected with this study. In addition, patients were directly observed and encountered in individual, group, and milieu therapy situations and in family-therapy sessions. The observations noted were thus distilled from personal experiences, rather than derived from a theoretical framework.

Observations

Possibly, no other psychiatric syndrome is characterized by as many disquieting and irritating qualities as that of the manic phase of a manic-depressive psychosis. These characteristics seem specific to the acute attack, and are less prominent during normothymic, hypomanic, or depressed phases of the psychosis.

The acutely manic patient is often able to alienate himself from family, friends, and therapists alike. This knack is based on the facile use of maneuvers which place individuals relating to the manic in positions of embarrassment, decreased self-esteem, and anxious self-doubt. Those dealing with the manic patient frequently find themselves on the defensive, attempting to justify their actions and motivations. Commonly, they feel "outsmarted" and "outmaneuvered." They may "know" that their judgment and actions are appropriate, yet be out-argued and manipulated into positions which they consider unacceptable. Ultimately, those close to a manic may find themselves withdrawing in anger and rage.

The ease with which the manic patient induces discomfort in those around him is in part based on the following five types of activity which were noted in the patients observed.

Type 1.-Manipulation of the self-esteem of others: sensitivity to issues of self-esteem in others, with the increasing or lowering of another's self-esteem as a way of exerting interpersonal leverage.

Type 2.-Perceptiveness to vulnerability and conflict: the ability to sense, reveal, and exploit areas of covert sensitivity in others.

Type 3.-Projection of responsibility: the ability to shift responsibility in such a way that others become responsible for the manic's actions.

Type 4.-Progressive limit testing: the phenomenon whereby the manic extends the limits imposed on him, "upping the ante."

Type 5.-Alienating family members: the process by which the manic distances himself from his family.

These are not the only behavioral modes used by the manic patient; and patients in other diagnostic categories also employ some of these maneuvers. Yet, the overall presence of these characteristics in the patients studied seems to be the hallmark of their interpersonal activity.

Manipulation of the Self-esteem of Others

The manic individual, with extroverted drive, is able to establish rapid, superficial liaisons with those around him. Initially, he seems friendly, bright, cheerful, resourceful, and entertaining. He is talented in sensing what form of attention or flattery appeals to others. Such flattery is usually presented in ways which seem quite sincere, probably because the patient, at least temporarily, believes that what he is saying is true.

Those interacting with the manic are usually intrigued by his manner and may develop fantasies of benefiting through him, as well as of protecting or rescuing him. Situations wherein the manic patient increases the self-esteem of others by appealing to their sense of self-importance are illustrated by the following examples.

One manic ended an hour with his new therapist with the statement, "I have never had such a wonderful physician. I think you really can help me."

Another manic patient told the social worker that he had always related better to women than to men. He emphasized that this was particularly true in the current hospital setting since the doctors were young and the social worker was obviously a therapist of great experience.

A manic's proposals are often sufficiently reality-based as to invite involvement by others. Because their ideas seem superficially logical, manics may stimulate rescue fantasies and appeal to one's narcissism. Others, be they therapist, family, or friends, get reinforcement from the patient in feeling that they represent someone who "can talk sense" or get the patient to listen.

Once an individual is invested in maintaining this new-found source of self-esteem (and this is difficult to avoid), he becomes a party to the manic's interactions, since he now has a narcissistic investment in maintaining his source of gratification. Thus, the manic's appeal is a seductive one, carrying the message that another is unique, useful, powerful, and needed. What is temporarily overlooked is the fact that the manic patient may reverse his stance, taking away as well as giving, and making another feel demeaned and degraded. The relationship is made open for exploitation by the patient, who titrates esteem offered against demands met. This "giving" and "taking" is illustrated in the following example.

In psychotherapy, a manic patient initially seemed inordinately insightful and introspective, eagerly complying with cues offered by his new therapist. Later, as he became disillusioned with his physician, he utilized progressively more denial in the psychotherapeutic sessions. The therapist felt increasingly

impotent, and, with frustration, described the patient as “shallow, willful, and uncooperative,” rather than psychologically incapable of introspection.

Smith⁷ has discussed the manner in which manic-depressive patients use conventionality in their communications. In interactions with others, the manic individual touches on needs to conform to social rules and to a pedestrian form of commonsense logic. Manics make statements which are often judgmental, critical, and moralistic. Their impact is to awaken, in others, uncertainties and conflicts about being morally “good” people. Thus, by appealing to the childish, rigid conscience of another, conflicts concerning being good, bad, right, or wrong may be awakened. An individual, encountering a manic, often finds himself experiencing feelings centering around earlier relationships with stern or critical authority figures. Thus, the manic patient effectively appeals to one’s need to maintain a positive conventional self-image.

Perceptiveness to Vulnerability and Conflict

Intimately related to the manic’s ability to appeal to the self-esteem systems of others is his extraordinary perceptiveness. In interpersonal encounters, the manic possesses a highly refined talent for sensing an individual’s vulnerability or a group’s area of conflict, and exploiting this in a manipulative fashion. This sensitivity may be utilized in dealing directly with a given individual or in focusing on areas of conflict between others. In either case, the manic patient is able to make covert conflicts overt, causing the person or group with whom he is dealing to feel discomfort.

When placing an individual with whom he is dealing on the defensive, the manic utilizes directly transmitted information and unconscious cues to rapidly formulate a caricatured version of the person in question. Although this version may not be accurate in presenting a balanced picture, the characteristics stressed are usually present in disguised, muted, or defended form. Herein lies the manic’s ability to upset those with whom he deals. What he says cannot be dismissed as untrue or unreal, for the areas attacked truly do exist and, indeed, are areas of vulnerability. In relating to an individual, the manic may make covert or unconscious vulnerabilities overt, or, alternatively, may bring into direct consideration, issues which are well known but have been suppressed. Problems related; sexuality, idiosyncratic behavior, prejudices, self-image, feelings of inferiority, aggressiveness, ethnicity, and self-esteem are commonly exposed.

The following sequence is typical. The manic may tell an individual or his associates about characteristics he finds undesirable. Usually, there is an initial feeling that one has been maligned and insulted and there is an immediate attempt to deny the manic’s observations. Seldom is the issue of how the manic came to his conclusions or the reality of the allegations considered. Those under attack often feel “found out,” revealed, exposed, and demeaned.

We feel that such offensive action by the manic throws those with whom he relates off guard. They quickly assume the “one down” role, becoming defensive and angry. Their therapeutic effectiveness diminishes markedly, since they are likely to be nonobjective and predominantly concerned about their own self-esteem.

The following examples illustrate manic attacks on vulnerability.

A manic patient stated that a Negro attendant was a prejudiced Black-Power advocate who hated Jews. She proclaimed that the attendant hated white people and that he was brutalizing patients because of race and religion. She referred to him as a “black bastard” and concentrated on demeaning him and questioning his ability to be helpful to her, based on his low educational level, lack of articulateness, and his presumed

prejudice. The nursing attendant, who had presented few overt problems before, became increasingly angry with the patient. He began to avoid talking with her. At times he began to refer to her as a “rich bitch.” He became defensive about his lack of education and began to wonder why so few Negro patients were admitted to the ward and whether Negroes were being treated fairly at the hospital.

A manic patient told the ward staff that she could not talk to her therapist because he was a phony. She justified this by citing that the therapist combed his hair forward to cover a bald area. In truth, the physician was self-conscious about his hairline and felt defensive about the criticism and angry at the patient for making a “ward issue” of the conflict. He began to reflect this in his feelings toward the patient.

A manic patient wanted a pass. She stated that her therapist was a rigid, overbearing, authoritarian individual, who was more interested in rules than in her well-being. Her therapist prided himself on his liberalism and, indeed, felt threatened by individuals who assumed the authoritarian role. Her attack caused the therapist to question his own role and motives, and to wonder if the patient were not correct in her assumptions.

The manic patient may utilize his interpersonal sensitivity to exploit covert or suppressed conflicts between individuals and within a group. Here, the manic deals with issues which truly exist, but which may not be recognized, or which have become taboo for consideration. The manic often will divide therapeutic staff members by pointing out objectionable qualities of one faction or individual to others, who usually are aware of the qualities exposed. Thus, the manic may divide staff into those who are “good” and those who are “bad.” He may be oversolicitous to those who are designated “good,” offering anecdotes and opinions which appeal to their prejudices and covert animosities. Staff members may find themselves agreeing with the manic’s judgments of other staff members, leading to a group or individual feeling attacked by peers. This phenomenon is similar to one which occurs when a child precipitates division between his parents by exploiting covert conflicts.

The manic causes staff divisiveness in another way. Because of his keen ability to sense areas of vulnerability, people find themselves becoming anxious and tense. Unproductive modes of relating, often well controlled in less stressful situations, frequently become manifest. For example, individuals may resort to obsessive or passive-aggressive defenses under the pressure of the manic attack. These modes of relating affect others, inducing hostility and anger. Thus, the manic patient is able to bring out the worst characteristics of the individuals in a group, leading to a fragmentation of working relationships. For example:

A patient complained to her physician-therapist that she could not communicate with the nursing staff. She also informed the nursing staff that they were poorly educated and not adequately trained to treat her. The therapist had some doubts about the abilities of the nursing staff to relate to manic patients, and they in turn felt that he was aloof and snobbish. The patient continuously repeated her distrust of the nursing staff and her admiration for the therapist. She insisted that her therapist had agreed with her assessment. The physician and the nursing staff became increasingly uncommunicative and hostile toward each other. The nurses stated that “he can take care of her, since he likes her so much and won’t tell us anything.” The therapist felt that the nurses were hostile and of limited use in managing the patient.

A therapist and another physician entered a room, where a manic had become disruptive. The patient ignored her therapist and began to appeal to the other physician to settle the problem. In the midst of her agitated behavior, she responded immediately and appropriately to suggestions made by the other physician. The therapist felt angry with his colleague for “interfering.” The subtle and probably usual competition between two physicians on the same staff was brought sharply into focus.

In the above examples, covert or disguised conflicts are made overt in ways that cause staff members to feel defensive and angry with each other. Often, therapeutic objectivity is lost, as areas of conflict are exploited and made overt. Anger is generated either among staff members or between staff members and the patient.

This series of maneuvers appears to serve a defensive purpose for the manic patient. Obviously, when anger is generated there is often a breakdown of coordinated therapeutic attempts. Thus, the above maneuvers serve as a diversionary tactic. Confusion is generated as individuals fight each other and themselves.

Projection of Responsibility

After initially becoming engaged with the manic, individuals may find themselves taking responsibility for his actions. This takes the form of accepting blame for plans gone awry and providing appropriate affect for the manic's foibles. Thus, if a manic loses his job, he reassures everyone that new employment is imminent. Nevertheless, the therapist and the family continue to worry. If a manic misbehaves in public, others are concerned while the manic denies that anything happened. If a pass from the ward ends in disaster, the therapist is blamed or blames himself for not having foreseen the unpleasant result. If a job is lost; the manic relates that the employer is prejudiced or unfair and the manic's associates easily share the indignation.

This deflection of responsibility seems related to several factors. First, there exist the narcissistic needs of those who deal with the manic. Once an individual's feelings of self-worth are based upon how well the manic does, there is a tendency for increasingly frequent efforts to effect favorable outcomes. A "significant other" may become progressively more invested in making sure that "things don't go wrong." Progressively, the patient and those around him accept the premise that he is incapable of assuming responsibility for his fate. At this point, a person relating to the manic feels responsible for unfavorable outcomes.

Basic to the manic's ability to project responsibility is his superficial "reasonableness." The manic patient is an exceptionally good salesman and is quick with a sound excuse when things go poorly. Like a child, he is able to present obviously illogical arguments or premises in a logical way. He usually seems very sure of himself, as though totally without ambivalence. The impact of these qualities, when found in an adult, is to cause others to question their own assumptions and to doubt their own reasonableness. Unlike the schizophrenic, who is often dismissed as "crazy," the manic patient's logic is more easily accepted. It may be possible that the much touted use of denial is central to this phenomena. By utilizing denial and thus lacking conscious ambivalence, the manic is so sure of himself that he convinces others. The following - example is illustrative.

A manic patient returned three hours late from her pass. She said she was late because her friend's car had broken down. The patient's original plans, previously worked out in a staff meeting, were that she was to travel to an appointment by public transportation. While waiting for a bus to return her to the hospital, she met a stranger who offered to drive her and she accepted. Since traveling by private car was less time consuming, she reasoned that they had time to stop at a bar for a drink. When they finally did start back to the hospital, the acquaintance's car broke down. The patient argued that she surely could not be blamed, for who could anticipate a car failure? The argument was presented in such a logical manner that it was only with difficulty that staff members focused on the previously negotiated pass rules-namely, that the patient had agreed to return by public transportation. However, even when staff members could define the

original breach of agreement, they had the feeling that they were “nit-picking,” that they were inflating a minor issue, and that the patient might really be blameless.

Characteristically, the manic always views himself as blameless. When he speaks about issues which involve self-discipline and responsibility, there is detachment from the situation. When unfortunate situations arise, they are reported as if the patient were not an active participant. For example, one patient, speaking about her promiscuity, stated that she never knew she was going to bed with a man until she got there and then “it just happened.” Thus, the manic often gives a self-portrayal of an innocent victim, passively buffeted by fate, not responsible for his life events.

Furthermore, and perhaps most significant, is the realistic fact that the manic patient often places those close to him in positions whereby they have no choice but to take responsibility. The manic may enter into grandiose schemes, spend too much money, incur bad debts, or make commitments which, although he may feel able to handle them, are obviously not personally resolvable. In this situation, it often falls on the family members and those in therapeutic roles to “bail out” the patient. As neighbors, creditors, and representatives of the law converge with a barrage of complaints and demands, those affiliated with the manic may find it difficult not to accept responsibility.

Progressive Limit Testing

A phenomenon observed in all the manics studied was the progressive testing and challenging of set limits. The manic’s ability to seem reasonable, to exploit another’s feelings of ambivalence or guilt, and to engage people appears central to this characteristic. The first of a series of requests may seem quite reasonable. However, once a minor concession is made and it is established that a limit may be challenged, the manic patient very gradually increases the “ante.” Each step appears to be a minor addition and in itself seems quite reasonable. Each incremental request is stated in such a way as to make the other person feel that if he does not meet the patient’s demands, he is rigid, unfair, petty, and unreasonable. Furthermore, implied in the setting of limits is the possibility of antagonizing the manic and thus converting superficial charm and ingratiation into a frontal attack on one’s self-esteem system. The following examples are illustrative.

A patient asked a nurse if she could browse in a gift shop. The nurse consented. The patient then asked if she could buy some gum with her own money. Again, the nurse agreed. Next, the patient decided that she wanted to buy a newspaper and candy for all of the patients and staff members on the ward. Since she did not have enough money, she asked the nurse to lend her some. When refused, the patient accused the nurse of trying to destroy her relationship with the other patients. The nurse, who did not want to deal with a scene in public, was placed on the defensive and felt quite uncomfortable. She wondered if she should not have capitulated to the patient’s demands, since they did not seem too unreasonable.

A patient, placed in the seclusion room, was scheduled for a five-min interview with her therapist. She understood the terms of the meeting. After 4 1/2 minutes of banal chatter, she began to discuss her sex life and her relationship with her husband. When five minutes had passed, the therapist said he was leaving. The patient said, “but doctor, I was just beginning to get into the heart of my problems; don’t you want to hear them?” As the doctor walked out of the door, she said, “alright, if you don’t want to learn about my affairs, that’s your concern.”

A manic patient, darting around the ward, was told either to sit in a chair or go to her room. The patient walked to the chair and stood by its side. Staff members felt ambivalent about how to handle the situation because they did not want to be overly rigid, yet had stated a mandate. After the patient was ignored and allowed to stand by her chair, she began to walk across the room, progressively resuming her hyperactivity.

Alienating Family Members

The manic patient executes a series of characteristic maneuvers which distance him from his family. The previously mentioned behavioral patterns, considered in the context of the therapeutic relationship, are present in the manic's family relationships as well, and serve as a source of marital alienation. Characteristic interactional patterns of the manic individual and his spouse appear repeatedly. These will be considered from the vantage point of the impact of manic behavior on spouse and family.

The attitudes of spouses toward the manic-depressive patient is significantly different from that of spouses of depressed patients who do not have a manic component to their illness. In contrast to the spouse's feelings concerning the unipolar depressed patient, which include anger toward clinging dependency, sympathy for the suffering of the patient, and occasional guilt concerning personal contribution to the patient's depression, the spouse of the manic patient is often motivated to dissolve the marital relationship. In the case of unipolar depressive illness, there seems little question that the partners will remain together, whether or not the marriage has been gratifying. In contrast, all of the observed cases of married manic patients had spouses who spoke of separation and who, in several cases, carried out this threat. These spouses showed increased anger and thoughts of marital dissolution which were most prominent during manic phases of the illness, but also occurred to a lesser extent when the patient was depressed. Of the 11 married patients in our sample of 15, the only exception to this pattern was noted in a female spouse, age 62, whose manic husband had his first episode of mania following 25 years of what was described as an ideal marriage. This spouse stated that the memory of those 25 years prevented her from entertaining ideas of separation. She dealt with her husband's mania by sending him out of town on vacations during his manic phases.

The discussion of separation in the marriages of manic patients occurred so frequently as to be a diagnostic differentiator between patients with manic-depressive psychosis and those with unipolar depressive illness. Significantly, none of the spouses had known the manic patients during a manic episode prior to marriage.

Diametrically opposed styles of marital relating, occurring during depressed or manic phases respectively, seem intolerable to the spouse. The depressive phase is usually viewed by the spouse as an illness over which the patient has little control. Here, spouses offer significant physical care and emotional support. The patient, during the depressive phase, often expresses much guilt and self-blame and sometimes speaks of the spouse in laudatory and absolving terms. The "well" partner, along with angry, guilty, and negative feelings, also feels augmented self-esteem, feeling important and relevant to the patient. For example, a patient said, "my husband is a wonderful man who has to put up with a lot from me. I know he loves me and only wants the best for me, but I am so depressed right now, I can't even care about that, I just feel empty." Often, a spouse will feel that the patient is correct and is describing the relationship accurately. There is a tendency to attribute the patient's guilt, sadness, and inactivity to illness, rather than to feel that any willful component exists.

In contrast, the attitude of the spouse undergoes a marked change when the patient is manic. The manic phase is perceived as a willful, spiteful act. Lip service only is given to seeing the mania as an illness. There is always an underlying feeling that the manic can control his actions, and does not do so out of maliciousness, selfishness, and lack of consideration. This impression is fostered by the fact that the manic often has periods of seeming reasonableness. Calm logical discussions take place, promises are made, and programs for working out problems are developed. The spouse may optimistically feel he has scored a temporary victory. Often, the spouse may agree to concessions during these discussions and try earnestly to live up to the bargains made. When, shortly thereafter, the manic has distorted or ignored all plans, the spouse feels duped. At this point the manic out-talks the spouse, turns defense into offense, and angrily

shifts the blame and responsibility for his actions. One spouse complained that he never was quite able to define when reasonableness changed to unreasonableness, when a rational or realistic plan became unrealistic, and he ended up feeling exploited, his trust betrayed. It is this feeling of having been lulled into temporary security, only to confront blatant insecurity, that is intolerable.

In contrast to the depressive phase, where the spouse feels venerated, he often becomes the villain or the “bad parent” during the manic phase, seen as a hostile, unperceptive opponent. He is the primary recipient of the patient's anger. He is blamed for all troubles, considered the one who hinders and belittles all achievements; and thought of as one who exaggerates trivial problems.

Additionally, the spouse rapidly becomes a buffer between the patient and the community. The environment demands that he control the patient and he feels frustrated by his inability to do so. For example, one man related extreme discomfort at having neighbors call to complain about his wife, who had walked into their house and taken some of their belongings. The neighbors turned to the spouse, asking him to “keep his crazy wife off their premises.” Other spouses described situations where they were hounded by creditors for large sums or for uncovered checks, written by the patient. They felt helplessness and embarrassment in trying to extricate themselves from these situations. They became concerned about salvaging their own good names, as well as trying to forestall what they perceived as ruin for the entire family.

Related to issue of the spouse feeling betrayed and experiencing diminished self-esteem is the problem of marital infidelity. Often, manic patients speak of divorce, make sexual advances to other people, become engaged in affairs, and graphically point out to their spouses that there are other fish in the sea-bigger ones. This often is seen as a final affront by the spouse, who significantly, is not prone to engage in extramarital affairs. Thus, there is a great temptation to go along with the sick partner, readily agreeing to divorce plans, hoping that someone else will eventually be in the position of taking responsibility.

Spouses of manic patients often chose withdrawal as a way of coping. One spouse, for example, related that she found it impossible to participate in any social activities with her husband during his manic episodes, in spite of his frequent urging that she do so and his angry accusations of rejection when she refused. She said that she could not tolerate the embarrassment of getting on a bus with him, having him argue with the driver, or going to a meeting and repeatedly hearing him interrupt the speaker. While she could see these activities as relatively harmless, she simply could not stand the embarrassment of being identified with him. Another spouse spoke of how he avoided social situations with his wife during her mania, since she would take delight in revealing intimate details of their marriage to others and berate and belittle him in front of significant associates.

In all these situations, the spouses felt trapped in what they perceived as an impossible situation. They felt caught in a whirlwind of activity, personally threatened, powerless to enforce limits, and often uncomfortable in situations that called for marital role reversal. Their moods and feelings were intimately related to the disease state of the sick partner, rather than controlled by more personal considerations. They found themselves unpredictably switching from the benevolent caretaker role to that of the adversary. They were first extolled, then berated-unable to find a stable system of relating to their spouses, whom they viewed as alternately “sick” or “bad.” The spouse's most frequent reaction to this confusion and ambivalence was to try to distance themselves from the patient and to withdraw.

Comment

In summary, the behavior of the manic patient is based on a series of personality characteristics which include the ability to seem reasonable, to make rapid, intense although superficial object relationships, to

appeal to the self-esteem of others, and to sense areas of conflict and vulnerability in others. These characteristics allow the manic patient to successfully test imposed limits and to project responsibility.

Why is all this disorder necessary and what purpose does it serve? It is impossible to answer this question with certainty. However, we wish to propose some hypotheses which may be relevant to understanding the manic's interpersonal behavior.

We feel that a major issue concerning the manic-depressive patient is related to the need to be taken care of. During the depressed phase of the illness, this is often expressed in terms of the patient's professing helplessness, uselessness, and unworthiness. Others are placed in the position of supporting and caring for the patient in his inadequacy. The severely depressed person may refuse to eat, ostensibly because he feels unworthy, and may thereby unconsciously force others to interact with him in a caring way. Similarly, with the manic patient a primary issue seems to be the fulfillment of dependency needs. However, a manic often feels that it is threatening, unacceptable, and dangerous to rely on others or to wish to be taken care of. As a way of maintaining self-esteem, and feelings of power and strength, the manic instigates a situation in which he is able to control and manipulate those people on whom he must rely. Ostensibly, he is ultra-independent, needing no one. He may appear to be taking care of others as, for their benefit, he proposes grandiose schemes. He professes to be totally autonomous and self-sufficient; yet his actions belie his words. By constantly testing, racing, manipulating, dividing, overcommitting, and expanding the manic patient increases his "independence" to a point where he involves the resources and life styles of those around him so that they have no choice but to control and take care of him. Thus, the manic assumes the dependent role while chafing against all external restraints and the ego-dystonic wish to be cared for is gratified without his having to consciously acknowledge his needs.

It may be that via lack of self-control and ability to confer interpersonal havoc, the manic patient is seeking the perfect other: someone who will not be miffed by his antics and who will supply the controls he does not possess. Through this association, he may hope to attain the perfect dependency relationship in which he is restrained and taken care of by a strong caring parental figure without having any requirements for reciprocity and without having to admit to himself that he is, indeed, dependent. In fact, in such a relationship he is able to give up responsibility while maintaining the illusion, belied by his actions, that it is he who gives to the other-that the other is dependent upon him.

From another perspective, it is quite possible that the manic (as well as the depressive) mode of interacting represents a compromise in the issue of achieving intimacy. When the manic is interacting, there is no question that a relationship exists. Those who deal with him contend and relate in a profound way. However, such a relationship lacks reciprocity and maturity. Lying between the poles of social isolation and loneliness characteristic of the schizophrenic and the intimate relationships of the mature individual, the manic's interpersonal maneuvers are simultaneously cementing and distancing.

Therapeutic Implications

The difficulty of treating manic individuals with psychotherapy has been emphasized by previous workers.¹⁻⁴ While the efficacy of medications such as lithium carbonate in controlling acute manic symptoms⁸⁻¹⁰ can be viewed as a major therapeutic advantage, this compound does not supply complete answers to treatment problems. Although patients treated with lithium carbonate are increasingly able to make constructive use of psychotherapy,¹¹ the patient and his family are often initially disappointed that this drug does not solve all problems. Indeed, sometimes it creates new ones.¹² Family friction, which has previously been ascribed to the illness, often continues to exist, with mood swings no longer the convenient scapegoat. Family roles change and new adaptational patterns need to be established. The patient himself

often misses his mania and is skeptical about the trade he has made-less grandiosity, hyperactivity, and narcissism, for more insight and the hope of ultimately closer and more mature relationships with those around him.

Psychotherapeutic nihilism with the acutely manic individual, exclusive reliance on medication, and even a sincere desire on the part of the therapist to see his patient shift to a depressive mood state, so he will be ostensibly easier to work with, may hinder the optimal establishment of a working therapeutic relationship. We feel that a knowledge of the interactions characteristically used by manic patients is a crucial part of psychotherapeutic work with them, regardless of subsequent mood shifts. Certain patients in therapy, through the course of manic, depressive, and interim states, recall therapeutic work accomplished during manic states. One woman remarked, "you accepted me when I was high, and that enabled me to trust you."

We have found that a logical system of conceptualizing manic interpersonal activity has been useful in serving as a framework for interpreting and reacting to the manic's style of relating. Expecting the manic patient to divide staff members, assault self-esteem, progressively test limits, project responsibility and distance himself from family members, allows anticipation of these activities, with the possibility of formulating concrete responses and plans. It is most important for those in therapeutic positions to consider their own roles in interacting with manics. How they may unwillingly allow the manic to manipulate their self-esteem or how they may become defensive when the manic attacks their self-image is worthy of consideration.

We feel it is important to acknowledge conflicts when dealing with the manic patient, thus deflating his tendency to manipulate. Frequent staff meetings, centering around manic interactions, may undercut the ability of the manic to divide; for it is in the context of faulty communication that he is most effective. It may be useful to view the manic's ability to perceive covert conflict as a positive attribute, to be used as a diagnostic tool to unearth and externalize interpersonal dissension.

It is worthwhile to focus on the feelings, realities, and affects which underly a manic's behavior, rather than to become caught up in a characteristic battle of semantics. When a therapist agrees to engage with the patient in semantic quibbling, he has, a priori, abdicated his objective usefulness to the patient by allowing a shift of focus to an arena in which the manic will be successful in avoiding therapeutic work.

Finally, we have found that the unambivalent, firm, and rather arbitrary setting of limits and controls is most useful in decreasing manic symptomatology. It seems that when the manic is unable to successfully divide staff members, exploit areas of conflict and vulnerability, and exceed set limits, manipulative and uncontrolled behavior decreases. It may be that the psychotic manic patient hears most easily the nonverbal communication implicit in the setting of limits-the statement that indeed, the patient is controllable and that the therapist cares enough and is powerful enough to protect him from his self-destructive activities.

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