Title: Psychological masculinity, femininity and tactics of manipulation in patients with borderline personality disorder

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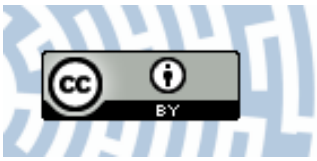

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Psychological masculinity, femininity and tactics of manipulation in patients with borderline personality disorder

Eugenia Mandal, Dagna Kocur

Summary

Aim. The aim of the study was a relation between the borderline personality disorder and psychological gender, and tendency to use various manipulation tactics in everyday life and therapeutic context.
Methods. The study used the Psychological Gender Inventory (A. Kuczyńska, 1992), and self-developed questionnaire for evaluating the tendency to use manipulation tactics and a survey evaluating manipulation in therapeutic contact. The studied group included: 30 patients with diagnosed BPD, 30 people a control group and 125 therapists.
Results. The study of psychological gender showed that in the patient group the level of masculinity was significantly lower. Results showed that 88% of the therapists participating in the study confirmed that they have experienced manipulation attempts from patients. The therapists assessed the tendency of patients to use manipulation tactics as greater than it was declared by the patients themselves. When compared to the control group, the patients indeed demonstrated a greater tendency to use the tactics of begging, threatening and threatening to break a close relationship and a lesser tendency to use the tactic of seduction. In the view of the therapists, during therapy patients most often used the tactics of lying and guilt induction.
Conclusions. Manipulation is frequently used by BPD patients both in everyday life and in therapeutic contact. The most common reasons for using manipulation is to obtain benefits and to avoid negative consequences. It is necessary to conduct further research in this field and educate those who work with psychiatric patients in order to make them develop the ability to detect manipulation attempts and cope with such tactics.

borderline personality disorder / manipulation / gender

INTRODUCTION

One of the most accurate definitions of manipulation during therapeutic contact was given by Hamilton and collaborators [1]. Manipulation was defined as "deliberately influencing or controlling the behaviour of others to one's own advantage by using charm, persuasion, seduction, deceit, guilt induction, provocation or coercion". When discussing the definition proposed by Hamilton, it should be noted that similar behaviour on the part of the therapist is evaluated as more positive and referred to as "skilful guiding of client behaviour". It is important to distinguish between the goals of the patient and the goals of the therapist arising during influencing conduct [2]. Taking into account the good of his or her patients, a therapist may in-

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fluence their behaviour using the techniques of persuasion. However, these exceptionally effective tools may prove dangerous if used in an inadequate manner [3].

Murphy and Guze [4] have identified a number of forms of manipulation most often used by BPD patients: irrational behaviour, taking control over the therapy and imposing own conditions, extorting promises, demanding special considerations, showing discontent and threatening with self-destructive behaviour. Manipulation used by BPD patients may also be a result of a number of misunderstandings in communication. Firstly, the patient may fear being assessed by the therapist; they may therefore distort some facts and omit information they are less comfortable with, trying to make a positive impression. Secondly, misunderstandings may be a result of differences in the evaluation of the importance of some facts by the patient and the therapist [5].

The relation between borderline personality disorder and the use of manipulation is rarely discussed in the literature of the subject, and when it is the opinions expressed are often contradictory [6]. Some authors claim that the BPD type of personality is particularly oriented at manipulating others and is characterised by the readiness to deliberately exert influence on other people while cleverly pursuing one's own goals, and skilfulness in doing so [6, 7, 8]. According to other publications, some types of behaviour of BPD patients only appear as manipulation, but in fact do not originate in malice or premeditation and are not pre-planned actions, their source being rather impulsiveness, fear, desperation and helplessness [9]. However, it is a common view among therapists that patients with BPD often use manipulation in order to achieve their own goals. This is confirmed by the study of Gallop & Lancee [10], which demonstrated that as many as 90% of nurses stated that they associated BPD patients with manipulation. Other research has also confirmed the conviction of specialists that there is a strong link between the BPD personality and manipulation [11].

Despite over 80 years of research on the subject, borderline personality disorder still remains controversial and raises many questions [12]. What is characteristic for this condition is deeply rooted and consolidated patterns of maladaptive features. A person suffering from this disorder has an unclear or distorted image of himself or herself and his or her goals and preferences. As a result this person is incapable of establishing more profound emotional relationships. Such a person has a sense of loneliness and searches for intimacy, but at the same time cannot withstand intimacy for fear of abandonment [13, 14, 15, 16]. Borderline patients experience intensive and unstable emotions resulting in crises, which mean that their life is exceptionally dramatic and often involves the risk of self-inflicted injuries, suicidal attempts, sometimes of a manipulative nature. Among people suffering from borderline disorder the ratio of suicides and suicidal attempts is high (approx. 10%). It is estimated that 41% of patients staying in hospital emergency departments due to repeated suicidal attempts fulfill the criteria sufficient for diagnosing borderline disorder [12, 17, 18, 19, 20, 21, 22].

Symptomatically, most authors emphasise the fact that the borderline personality is more frequently found in women — 3-4 times more often than in men [23]. These authors suggest that there might be a link between BPD and gender, but this may also be a result of social and cultural patterns of behaviour which allow women to display weakness, mood swings and nervous breakdowns and prevent men from doing so. According to estimates, borderline personality disorder is most intense around the age of 25 while only 25% of those who suffer from this condition are over 40 years old. Probably mood swings and some patterns of behaviour tend to tone down with age [24, 25].

People with BPD are characterised by a clear tendency to act impulsively without predicting the consequences of their actions and capricious, changeable and unpredictable moods. They also have a tendency to emotional outbursts, are incapable of controlling impulsive actions and are prone to aggressive behaviour and conflicts with other people, especially when these actions are condemned or frustrated. Interpersonal contacts of borderline people are superficial and used for satisfying their own needs. These difficulties in building relationships are also reflected in the therapeutic relation and constitute an enormous challenge both for patients and for therapists. Patients with BPD often stand out as eccentrics and individuals with aggressive attitudes and unre-

alistic expectations towards therapists. They often cause conflicts, also among the medical staff [26, 27, 28, 29].

The literature of the subject rarely discusses the relation between the BPD personality and the tendency to manipulate in the context of the Machiavellian personality. However, the research of John McHoskey of 2001 shows that the best predicator of Machiavellianism proves to be the traits of the borderline personality such as: emotional imbalance, inadequate and uncontrolled outbursts of anger, impulsive self-destructive behaviour and strong but unstable relationships with other people [30].

AIM OF THE STUDY

The aim of this study was to identify issues related to manipulation and exertion of influence in therapeutic contact of borderline patients. The study was an attempt to research the relation between the BPD personality and psychological gender and the use of manipulation tactics both in everyday life and during therapy. The aim of the study was also to compare the opinions of patients and therapists on the subject of manipulation tactics used by BDP patients.

SUBJECTS AND METHOD

The studied groups was composed of 30 adult patients with borderline personality disorder. The qualification of patients to the treatment group was based on the diagnostic criteria included in ICD-10 (F.60.32). The average age of the patients was M=30.87 years (SD=11.23 years). Half of the treatment group (15 people, 50%) was between 21 and 30 years. The control group was composed of 30 people who have undergone no psychiatric treatment. The members of the control group were deliberately selected on the basis of their similarity of gender and age to the patient group. In both groups the majority was women, who constituted 93% of the participants.

The studied group included 125 therapists with a background in psychiatry, psychotherapy, psychology and nursing. Therapists were divided into two groups. Study 1 involved 37 therapists specialising in BPD therapy. Study 2 involved 88 therapists specialising in treating various personality disorders, neuroses and dependencies. Also this group was dominated by women (78%). The therapists represented various schools of therapy, mostly cognitive behavioural, psychoanalytic and Gestalt. The average age of the therapists taking part in the study was M = 38.61 years (SD = 9.87 years).

The following research methods were used in the study:

Psychological Gender Inventory (IPP) of A. Kuczyńska (1992). This tool is composed of thirty five features. Fifteen of them form the Femininity scale (á = 0.78) related to the cultural stereotype of femininity, while another fifteen — the Masculinity scale (á = 0.78) which characterises the cultural stereotype of masculinity. The remaining five features are neutral buffer items placed in randomly selected parts of the inventory. Using a five-point scale, a participant declares the extent to which he is characterised by a given trait. On the basis of the number of points obtained in both scales the intensity of psychological masculinity and femininity is determined; the participant is then categorised within one of the four psychological gender types, i.e.: the sexually undefined, the feminine, the masculine and the androgynous [31].

Manipulation tactics used by patients — author's method. Two questionnaires were prepared for the purposes of the study. The first one was related to the manipulation tactics in everyday life, while the other one — manipulation tactics during therapy (The instructions were as follows: The survey presents some everyday-life behaviours. Please mark the answers which best describe you / the survey presents some behaviours appearing during therapy. Please mark the answers which best describe you). Both questionnaires contained a description of 10 various manipulation tactics (1. I sometimes use my charm, grace or sex appeal to achieve something, 2. I sometimes beg my closest relatives or friends in order to get something I want, 3. When I am annoyed or offended, I may refuse to speak to someone, 4. I sometimes force people to do things they do not want, 5. I sometimes get offended or sulky with my closest family or friends, 6. I sometimes intimidate or threaten my closest family or friends, 7. I sometimes

wound myself to attract the attention of others, 8. I sometimes lie or choose not to tell the whole truth, 9. I sometimes make others feel guilty even though they have done nothing wrong, 10. I sometimes threaten a close relative or friend to break up the relationship between us.). A participant declares how often he or she uses a given tactic using a 7-point scale where 1 means never and 7 — very often. The reliability coefficient for the questionnaire on manipulation in everyday life was á=0.756, while for the questionnaire on manipulation in therapy — á=0.768. This method was used in the study involving BPD patients.

Manipulation tactics used by patients according to therapists — author's method. The first part of the tool contained the following open question: "What methods of exerting influence and manipulation have you observed in persons with borderline personality disorder during therapy?" The other part contained 10 closed-ended questions indicating various tactics which may be used for exerting influence, analogous to those listed in the questionnaire intended for patients (1. Seduction, charming, 2. Begging, 3. Refusing to speak, 4. Coercion, 5. Sulkiness, getting offended, 6. Threatening, 7. Self-inflicted injuries, 8. Lying, misleading, concealing information, 9. Guilt induction, 10. Threatening to discontinue the therapy, mentioning it). The therapists evaluated the behaviour of patients observed during therapy using the same 7-point Likert scale. The reliability coefficient for the questionnaire for therapists was á = 0.778. This method was used in study 1 involving therapists.

Manipulation in the Therapeutic Context — studied using a survey with five open questions 1. Have you ever been manipulated by a patient? 2. What in your view was the reason why the patient manipulated? 3. In what way did the patient manipulate? This method was used in study 2 involving therapists.

RESULTS

In the patient group (M=39.03) the intensity of psychological masculinity was significantly lower than in the control group (M=48.00) ($p<0.001$) (see Tab. 2). Most people (50%) had a feminine identity, followed by androgynous individuals (30%) and the sexually undefined (20%). None of the patients had the masculine psychological gender (see Tab. 1).

Table 1. Psychological gender of women and men in the BPD patient group and the control group

IPP score		BPD patients		Control group		Total
		women	men	women	men	
N	Feminine individuals	14	1	14	1	30
%		46.67	3.33	46.67	3.33	
N	Masculine individuals	0	0	2	1	3
%		0.00	0.00	6.67	3.33	
N	Androgynous individuals	8	1	8	0	17
%		26.67	3.33	26.67	0.00	
N	Individuals with undifferentiated gender	6	0	4	0	10
%		20.00	0.00	13.33	0.00	
N	Total	28	2	28	2	60

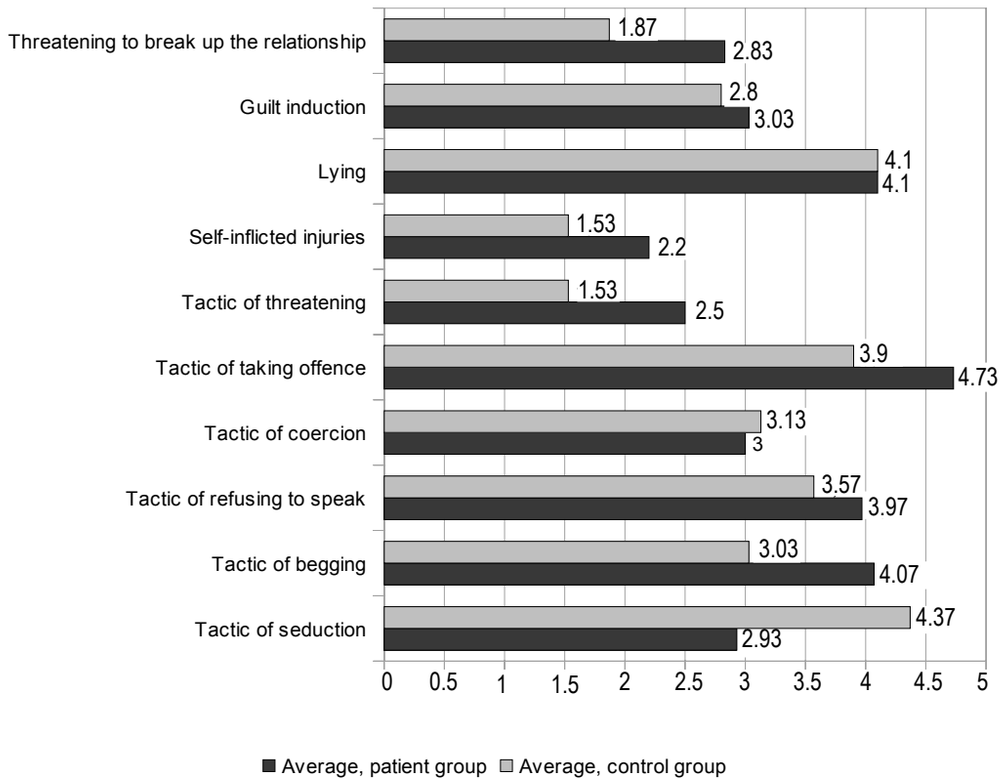
Table 2. Femininity and masculinity in the BPD patient group and the control group

Psychological gender	Group of BPD patients		Control group		t	p
	M	SD	M	SD		
Masculinity	39.03	12.06	48	7.48	-3.46	0.001
Femininity	55.13	6.03	55.03	6.58	0.06	0.951

The results of research showed that BDP patients most often admitted using the tactic of taking offence (M=4.73), the tactic of lying (M= 4.10), begging (M = 4.07), refusing to speak (M=3.97), guilt induction (M = 3.03), coercion (M=3.00), seduction (M=2.93), threatening to break up the relationship (M=2.83), threatening (M=2.50), and least often — the tactic of self-inflicted injuries (M=2.20). The members of the control group, on the other hand, most often admitted using the tactic of seduction (M=4.37), followed by the tactic of lying (M=4.10), taking offence (M=3.90), refusing to speak (M=3.57), coercion (M=3.13), begging (M=3.03), guilt induction (M=2.80), threatening to break up the relationship (M=1.87), and least often — the tactic of threatening (M=1.53) and self-inflicted injuries (M=1.53) (see graph 1).

Statistically significant differences related to the tactic of seduction were noted (p=0.002) more rarely used by the patients than the persons from the control group, and the tactic of threatening (p=0.002), threatening to break up the relationship (p=0.043) and begging (p=0.05) more often used by patients. A statistical tendency was also noted with regard to the tactic of taking offence (p=0.06), which was more often used by the patients. The study revealed a statistically significant negative correlation between the age of the patients and the tendency to self-inflicted injuries (=-0.58, p<0.05) and a positive correlation between the use of manipulation in everyday life and the use of manipulation during therapy (r=0.375, p<0.04).

An analysis of the data of study 1 received from the therapists (N=37) indicates that in the



Graph 1 — Manipulation in everyday life in the BPD patient group and the control group

view of the therapists patients undergoing therapy most often use the tactics of lying (M = 5.51), guilt induction (M = 5.43), seduction (M = 4.97), followed by coercion (M = 4.86), threatening to discontinue the therapy (M = 4.70) and self-inflicted injuries (M = 4.38). Least frequently the therapists pointed to the tactics of: threatening (M = 3.95), refusing to speak (M = 3.86) and begging (M = 3.49). An analysis revealed that the therapists (M = 46.8) pointed to the patients' use of manipulation tactics during therapy significantly more often than the patients themselves (M= 24.93).

The views of the patients regarding the most readily used manipulation tactics during therapy were different than the views of the therapists. The patients pointed to the following manipulation tactics as the most commonly used: refusing to speak (M=3.70), taking offence (M=3.33) and lying (M=2.43). These tactics were followed by the tactics of: begging (M = 2.37) and coercion (M=2.37), guilt induction (M=2.33) and threatening to discontinue the therapy (M=2.33). The least frequently mentioned tactics included self-inflicted injuries (M=2.20), seduction (M=2.00) and threatening (M=1.87).

An analysis of the scores obtained by the therapists indicated a positive correlation between the therapists' years in practice and their belief in the frequency of using manipulation tactics by patients with BPD ($r=0.518$, $p<0.001$). The number of patients with BPD treated by a given therapist was in a positive correlation with the assessment of how frequently the patients used the tactic of begging ($r=0.372$, $p<0.02$) and the tactic of coercion ($r=0.340$, $p<0.03$).

The majority of the therapists in study 2 (N=88) admitted having experienced manipulation by a patient during therapeutic contact. Affirmative answers were given by 88% of participants, negative ones — by 11%, and the answer "I don't know" was selected by only 1% of the participants.

The reasons and goals of manipulation most frequently indicated included: obtaining benefits (48%), avoiding consequences (11%) and taking control (9%). Some therapists underlined that manipulation used by patients is a consequence of their disorder (9%). The therapists described in detail various kinds of benefits obtained by patients due to their use of various manipulation methods. The most common included: financial benefits (38%), certificates of various kinds (25%), prescriptions / medicines (16%), passes / sick notes (16%) and others (5%) (see Tab. 3).

The most common manipulation tactics used by patients include: lying or concealing information (23%), compliments (16%) and broadly understood verbal manipulation (puns) (11%). Examples were also given of patients describing symptoms which they were not experiencing, using the vocabulary learned from the literature of the subject (9%) (see Tab. 4).

In the examples given by the therapists concerning the use of manipulation during therapy, the following types of behaviour were mentioned most often: strategy "yes, but...", cancelling the session at the last moment or leaving before the end, being late, prolonging the session, attempts to induce the feeling of guilt in the therapist, emotional blackmail, harassing phone calls, gifts, shortening the distance, creating the appearances of a significant improvement, attacks, aggressive undermining of the therapist's competences, criticising the therapeutic setting and therapeutic contract, especially if it included a provision preventing the patient from committing suicide in the course of the therapy. Other examples included: idealisation of the therapist and crossing borders, e.g. the patient emulates the therapist or identifies with him of her, obtains information on his or her private life. In the view of the participants, the mechanism of projective identification used by the patients was meant to control the therapy process and the therapist.

Table 3. Reasons and goals of manipulation used by patients in the opinions of the therapists (N=88)

Reasons and goals	N	%
Obtaining benefits	56	48
Avoiding negative consequences	13	11
Domination and control	10	9
Results of illness	11	9
Self-presentation	9	8
Lying / concealing information	8	7
Receiving interest / sympathy	6	5
Fear	4	3

Table 4. Manipulation methods used by patients in the opinions of the therapists (N=88)

Manipulation method	N	%
Lying / concealing information	34	23
Compliments / coaxing	24	16
Puns	17	11
Inspiring pity	15	10
Simulation of symptoms of illness	13	9
Actor's behaviour	13	8
Breaking / bending rules / setting	11	7
Promising improvement	8	5
Intimidation, aggression	7	5
Blackmail / guilt induction	7	5

An important problem revealed by the study is manipulation used by patients who wish to obtain certificates, disability allowances and sick notes of various types. Answers to the question concerning the aims of manipulation revealed that in the view of the participants the common motive is the wish to obtain certificates of various types (25%) or passes and sick notes (16%). One of the participants answered the question about the type of patients who are particularly prone to manipulation by saying: "Patients referred by the court or the Social Insurance Institution (ZUS)".

RESULTS AND CONCLUSIONS

Results of the presented research showed that in the BDP patients group the overall level of psychological masculinity was significantly lower than in the control group. Most patients had the feminine psychological gender and none of the patients had the masculine psychological gender. This result may be linked to the features of the feminine psychological gender, such as: weakness, dependence, helplessness. The features linked with masculinity, such as instrumentality, activity, resourcefulness, may be more rarely found in BPD patients, especially those who are currently staying in psychiatric hospitals [32, 33, 34]. In the literature of the subject, it is accepted that people with BPD are characterised by a distorted sense of identity, instability of relationships with others, emotional instability, distorted image of own goals and preferences, and even frequent and chaotic perverse behaviour [35]. The above is confirmed by the differences between both groups revealed in the study: in the patient group there were more people with undifferentiated psychological gender. In such people the feminine and masculine features are developed to a small extent, irrespective of their biological sex.

The results of the study showed a statistically significant correlation between the use of manipulation in everyday life and its use in therapy in BPD patients. This confirms of the tendency of manipulation of their behaviour. Patients with BPD obtained significantly higher scores with regard to the use of manipulation tactics in everyday life than the control group; this refers to the following tactics: taking offence, begging, threatening and threatening to break up the relationship. Patients are less tendency to use the tactic of seduction than people from the control group. The use of numerous manipulation tactics confirms the data suggesting that people with BPD have difficulties in controlling their emotions, are incapable of establishing more profound emotional bonds and prone to enter into unstable and intensive relationships with others [36]. The manipulation tactics they use are at the same time offensive (e.g. taking offence, threatening) and defensive (e.g. begging). This shows the great determination of patients in achieving their interests. BPD patients are less prone to use the tactic of seduction than people from the control group, because the groups of patients and therapists were composed mostly of people of the same sex (women). Seduction is a tactic of manipulation used in contacts with the other sex [37].

In the course of the study it was also noted that among the patients the tendency to use the tactic of self-inflicted injuries decreased with age. This may be explained by the fact that older people care more about their health and life than younger ones and probably believe that this type of manipulative behaviour is not socially acceptable.

A comparison of the scores obtained by the patients and therapists suggests that there are differences between the assessment of the behaviour of patients in the eyes of the therapists and the self-assessment of the patients. The therapists believe that patients use manipulation tactics more often than declared by the patients. This may mean that patients do not realise they use manipulation tactics in everyday life and during therapy or are not ready to admit it. The participants may also want to conceal their use of manipulation tactics in order to present themselves in a better light, i.e. in order to deliberately lower the scores or hold back their own proneness to manipulation. Almost all the therapists participating in the study viewed their interpersonal contacts with BDP patients as particularly difficult, inspiring negative emotions and constituting a big challenge from the therapeutic point of view.

The research revealed that most of the therapists participating in the study admitted having

experienced manipulation attempts from their patients. In the view of the therapists, the most common reason for manipulation among patients was: striving to obtain benefits or avoid negative consequences, and more rarely – fear. The most frequent methods of manipulation were: lying, concealing information and coaxing. These results demonstrate that manipulation is a frequent phenomenon in the therapeutic process of BPD patients. The results concerning the frequency of manipulation in BPD patients may also be connected to knowledge on BPD and approach to this disorder among the therapists [38]. It is possible that some therapists treat certain types of behaviour as manipulation although they are only symptoms of the illness; such behaviour may also be linked to the difficult economic situation of the patients.

The problem of manipulation used by patients with BPD in therapeutic contact may be viewed from the perspective of the phenomena of transference and countertransference. In psychotherapy, transference consists in the redirection of emotional reactions and past experiences of the patient onto the therapist during the therapeutic process. The patient repeats their experiences from early childhood in the relationship with a new object [38, 39, 40]. Manipulation attempts used by a patient may be explained in the context of transference: The patient is capable of only those behaviours which they have learned in the relationship with an important object. The therapists' views regarding manipulation attempts used by patients may be seen in the context of countertransference. According to the classical definition of Freud, countertransference is an influence of the transferential reactions of a patient on the unconscious internal conflicts of the psychotherapist [38, 41]. In this context, the therapist's perception of some situations as manipulation may be a result of the therapist's projection of their own unworked-through conflicts and problems onto the relationship with the patient.

In the patient–therapist relationship, the methods of communication may also be of significance, e.g. asking too complex questions, ambiguous comments, misunderstandings and difficulties in detecting the so-called communication traps, such as confabulation, distortion of content, silence. As a result, manipulative intentions may be ascribed to patients [38].

The present study demonstrates the importance of manipulation in therapeutic contact and the need to deepen the knowledge of the subject in order to improve the broadly understood contact between the patient and the therapist.

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