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Guest Editorial

'Playing the Manic Game' revisited

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Summary

In this editorial, we argue that revisiting 'Playing the Manic Game', a paper whose clinical observations remain recognisable more than 50 years later, may help clarify a problem clinicians still face: when disruptive behaviour occurs during acute mania, how much reflects the episode itself and how much reflects a more enduring personality pattern? That distinction matters for treatment, team responses, families and stigma.

Keywords

Bipolar type I or II disorders; diagnosis and classification; history of psychiatry; general adult psychiatry; personality disorders.

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Knowing where psychiatry has been can help us appreciate where we are now and perhaps better manage patients at times of uncertainty. We consider the clinical challenges of acute mania from the perspective described by Janowsky et al[1] in 1970 in their paper 'Playing the Manic Game' by comparing interpretations from a half century ago with those used today. The following vignette shows why that shift matters at the bedside.

Vignette: one patient's restlessness had the in-patient unit on its feet at 02.13 h. She had made it her business to put in an appearance with every patient and was not shy about her opinions: one nurse was 'the only truly intelligent person on this floor'; another was accused of being cold and punitive; and a psychiatry resident was asked whether he was 'always this anxious' or only around pretty women. Minutes later, she was on the phone with her husband in tears, insisting everyone was overreacting and that she was simply 'feeling alive again'. By morning rounds, the staff were divided. One clinician viewed her as manipulative and provocative; another saw a woman who was gravely ill and could no longer control herself. Her husband, worn out from weeks of impulsive spending, public scenes and little sleep, vacillated between anger, guilt, protectiveness and thoughts of walking away.

Late-20th-century view: Janowsky, Leff and Epstein would have recognised the scene. More than half a century ago, they framed such a predicament as 'playing the manic game'.[1] They described five recurring patterns: manipulating others' self-esteem, sensitivity to conflict, projecting responsibility, progressive limit-testing and alienating family and therapists. We still recognise those observations but now interpret them through different explanatory models.

The Manic Game captures something real: acute mania can quickly unseat an interpersonal system. Janowsky and colleagues described patients who left staff feeling outmanoeuvred and drove families into self-doubt.[1] The persuasive, charming patient with poor judgement and grandiosity continues to challenge clinicians, particularly when apparent moments of lucidity obscure the severity of the episode.

Psychiatry's explanatory frame has changed. Mania is now defined as a discrete episode involving changes in mood, energy, sleep and cognition.[2,3] It is not a 'way of being'. A patient may appear calculating or oppositional while having little appreciation of the consequences. Janowsky et al captured the impact on others but were less able to distinguish an acute state from enduring personality.

The paper predates DSM-III (1980) and the formal introduction of borderline personality disorder as a diagnosis, a construct that emerged from efforts to classify patients who fell between neurosis and psychosis.[4] The diagnosis was not available to Janowsky and colleagues, whose observations were necessarily interpreted through the diagnostic concepts of their era.

Their patients had severe symptoms, including insomnia, agitation and at times the need for seclusion. Yet flattery and blame-shifting were read as 'manic character' rather than the disruptive conduct of an acute episode. When the authors described patients 'using' or 'dividing' others, the implication was an enduring character structure. A modern reader, informed by comorbid pathology and trauma, may interpret these behaviours differently.[4–6]

What is experienced as manipulation may be better understood through neurobiology, but still must be managed within the limits of available pharmacological and psychosocial interventions. Provocative limit-testing, treatment refusal and apparent exploitation described by Janowsky et al reflect documented impairments in executive function, reward regulation and illness insight, summarised in Table 1.[3,7] The patient who insists there is no problem may genuinely believe it; clinicians and families can cope with that reality rather than assuming deliberate opposition.

That said, those interpersonal patterns still warrant attention. Staff splitting, polarised attitudes toward caregivers and volatile attachment can overlap with personality pathology. Kernberg and Yeomans noted the difficulty distinguishing borderline or narcissistic presentations from bipolar disorder when clinicians focus too narrowly on surface symptoms.[5] Whether the 1970 patterns reflected comorbid personality pathology, diagnostic limitations of the era or features of some manic presentations remains an open question.

The two diagnoses remain conflated in research and practice.[6] Their overlap is real: impulsivity, anger, suicidality and conflict. The key distinction is temporal: bipolar disorder is episodic; borderline personality disorder is enduring.[2,4,5] When both are present, complexity increases, and neither diagnosis alone fully explains the clinical picture. The limitations of our nosology and treatments prompt humility, particularly when clinicians must make rapid decisions from behaviour observed during the most activated phase of an illness.

A modern reframing of the Manic Game would emphasise the interaction of environment, psychology and neurobiology rather than character. Current models implicate circadian disruption, executive dysfunction, altered salience attribution and reward dysregulation.[3,7] These mechanisms do not eliminate questions of agency or responsibility, but they change how clinicians understand the behaviour and how quickly they infer intent. The patient who

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Table 1 Reframing the 'Manic Game': observed behaviours, current evidence and clinical implications

Observed behaviour	1970 interpretation	Current interpretation	Key evidence	Clinical implication
Flattery, blame-shifting; staff splitting	Deliberate manipulation of self-esteem	Impaired social cognition; theory of mind deficits present across illness phases, most pronounced in acute mania	Moderate-to-large effect sizes for Theory of Mind deficits in bipolar disorder[3]	Maintain staff cohesion; avoid attributing intent
Limit-testing; provocative behaviour	Calculated provocation	Reward-seeking with impaired inhibitory control; disrupted prefrontal–mesolimbic circuitry	Elevated impulsivity scores and aberrant striatal reward-circuit activation vs healthy controls[7]	Set firm limits; avoid punitive framing
Denying illness; refusing treatment	Wilful denial; non-compliance	Clinically significant unawareness of illness (anosognosia)	~40–60% of patients in acute mania show impaired illness insight on structured measures[3]	Defer confrontation; target psychoeducation at euthymia
Impulsive spending; major relationship decisions	Character flaw; poor judgement	Impaired executive function; altered salience attribution	Executive dysfunction present across illness phases; most severe during acute episodes[3]	Defer high-stakes decisions until euthymia
Splitting, externalisation, volatile attachment	Fixed character structure	Acute episode feature, or comorbid borderline personality disorder	BPD present in ~20% of patients with bipolar disorder; comorbidity predicts greater illness severity and hospitalisation rates[6]	Screen for BPD; adjust treatment plan accordingly

BPD, borderline personality disorder.

tests limits may have impaired inhibitory control; the one who rejects treatment may genuinely believe it is unnecessary; the one who appears exploitative may be acting from grandiosity rather than guile. Regardless of explanation, interpersonal harm remains: families feel betrayed, and staff become polarised.

The original paper also offers advice that endures. Firm boundaries, clear limit-setting and communication within the treatment team remain essential, not because the patient is 'up to something', but because a severe mood episode can destabilise everyone involved. Good care emphasises longitudinal planning rather than reacting to disruptions during an acute manic state. The goal is to recognise the realities of mania without mistaking a transient illness for the patient's character.

More than five decades later, the Manic Game still names something real: acute mania can sabotage relationships. Our interpretation, however, has changed. We distinguish episodic states from traits and neurocognitive dysfunction from manipulation. The task is not to debate whether mania is character or illness but to recognise how a severe mood state can temporarily appear to be the patient's character. Staff who understand these behaviours as acute, time-limited and not necessarily purposeful are better positioned to hold the clinical frame, reduce ward hazards and limit harm to family members and social supports.

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Declaration of interest

None.

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