Limit-Setting as Treatment

Andrew J. McLean, MD, MPH
Clinical Professor and Chair
Department of Psychiatry and Behavioral Science
Associate Dean for Wellness
University of North Dakota School of Medicine & Health Sciences
1919 Elm St. N., Fargo, ND 58102
Phone: (701) 293-4113
Fax: (701) 293-4109
E-mail: andrew.mclean@und.edu

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OBJECTIVES:

Upon completion of this program, the learner will be able to:

1) Identify 3 types of Treatment Decision-Making Models

2) Describe the rationale for limit setting in the context of treatment.

3) Identify factors which facilitate or interfere with effective limit setting

Limit Setting

…in this presentation pertains to:

- An agreed upon Treatment Plan
- Adult clients/patients, particularly those who struggle with relationships, self-regulation, and adhering to treatment
- A review meant as a general guideline only

Definitions in this presentation

- Therapist, therapy are meant to be general terms.
- Also refers to clinician, treatment, etc..
- The term “patient” can be used interchangeably with “client.”

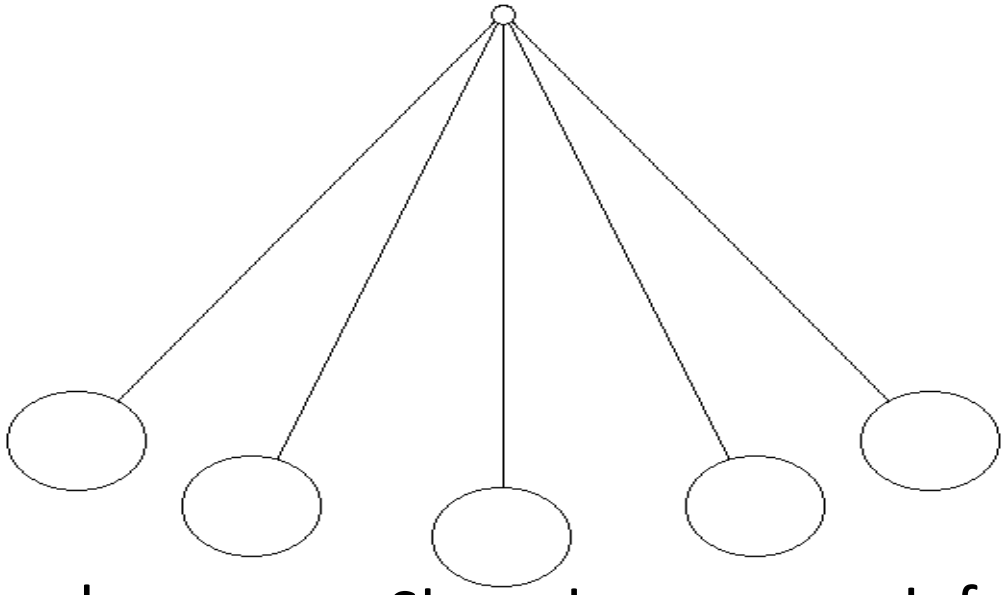
Limit Setting

- Doesn't this sound unilateral?
- How does this fit with person-centered care/patient autonomy?
  - Always treatment, (needs based) never punishment
  - Trauma Informed
- Limit setting implies a relationship, and relationships are about communication.

Treatment Decision-Making Models

Model	Paternalistic (Traditional Medical Model)	Shared Decision-Making	Informed
Role of the clinician	Active: Reports only selected information to the patient. Chooses the therapy he/she considers best for the patient.	Active: Reports all information and treatment possibilities to the patient. Can recommend an option. Decides on therapy together with the patient.	Passive: Reports all information and treatment possibilities to the patient. Withholds his/her recommendations. Makes no decision.
Role of the patient	Passive: Accepts the proposal of the clinician. Is obliged to cooperate in his/her recovery.	Active: Receives all information. Forms his/her own judgment on harms and benefits of treatment options. Discusses preferences with the clinician. Decides on the therapy together with the clinician.	Active: Receives all information. Forms own judgment. Is free to choose between all options unbiased by the clinician's own opinion. Decides on the therapy alone.
Information	One way (mainly): Clinician → Patient	Two way: Clinician ↔ Patient	One way (mainly): Clinician ← Patient
Deliberation	Clinician alone or with other clinicians	Clinician and patient (plus potential others)	Patient (plus potential others)
Who Decides?	Clinician	Clinician and patient	Patient

Case by case, instance by instance



Traditional Shared Informed

Rationale-

- Provide a safe (holding) environment
- Model: Consistency, responsibility, self-care, etc...
- Teach: Behavior has consequences, both positive and negative.

“When doctors can't say 'no‘”
CNN.com, July 16, 2009

Safe Environment

Protect the therapy by:

- Reducing boundary violations by both parties
- Reducing acting out by both parties
- Physically protect the safety of the patient, therapist, and others

Emotional Currency

- Currency: “That which is in circulation, or is given and taken as having or representing value”

Examples?

Protecting the Therapy

Patient “Acting Out”:

Overt: Threats, gestures, actions

“para-communication”

Covert: Missing appointments, late payments, “distractions”

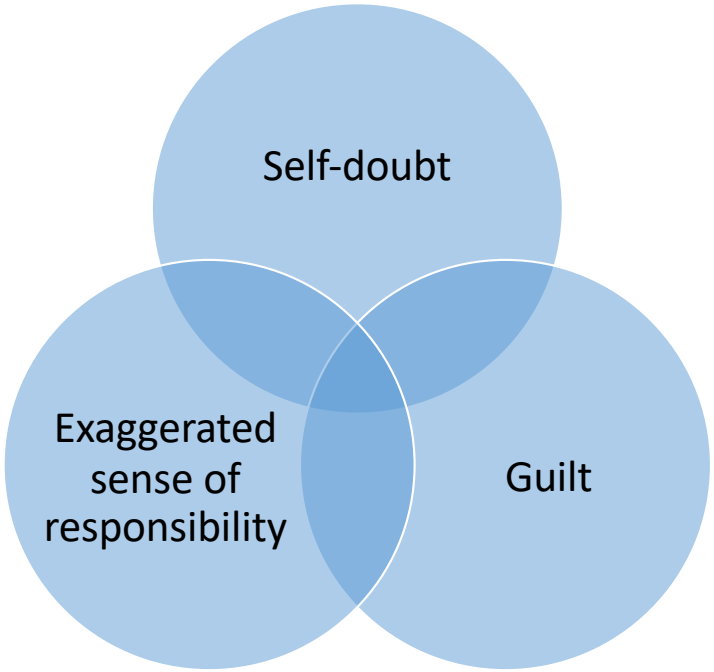
Protecting the Therapy

Therapist/Clinician acting out:

Countertransference: Broad definition-

Unconscious and conscious emotional reaction to the patient.

The Compulsive Triad (of the typical provider)



Gabbard

Countertransference, continued…

- Over-identification
- Fear
- Anger
- Romantic feelings

Countertransference/Sexual Boundary Violations

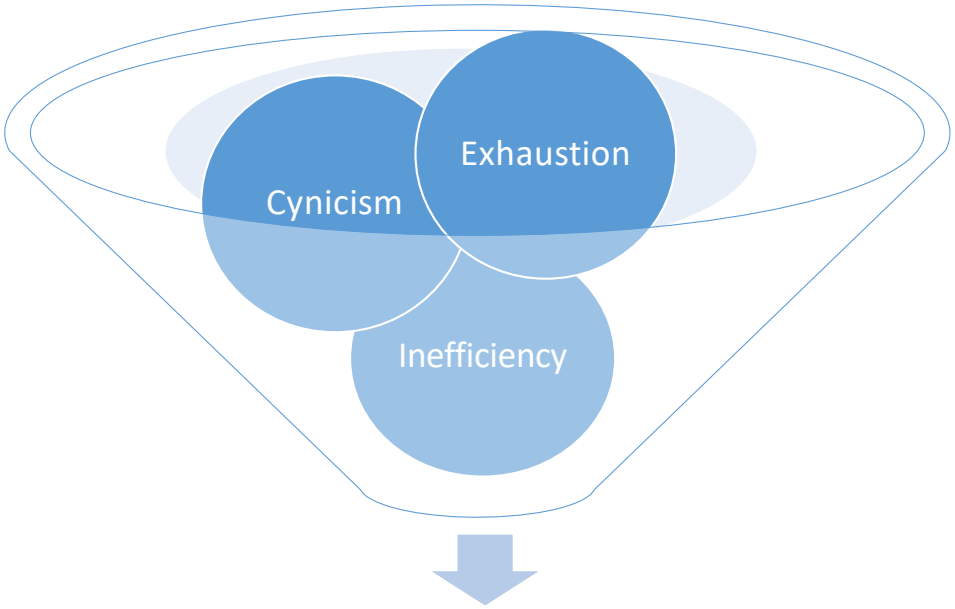
- Predatory Psychopathy and Paraphilias
- Lovesickness
- Masochistic Surrender
- Psychotic Disorders

(Gabbard, 1994)

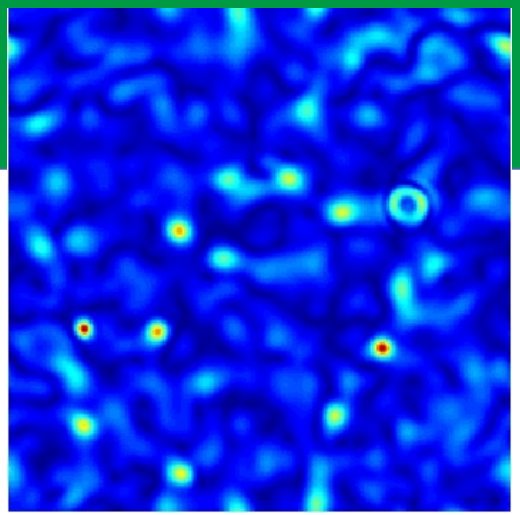
Failure by the provider to adhere to the agreed upon treatment plan or set limits implies:

- Therapist doesn't care
- Therapist does not understand the treatment plan
- Therapist is incompetent

Burnout (per Maslach); 3 Dimensions



Entropy



The measure of a system's energy that is unavailable for work. Since work is obtained from order, the amount of entropy is also a measure of the disorder, or randomness of a system.

(Encyclopaedia Britannica)

Considerations:

- “Reasonable Care”
- Collaboration
- Individual Treatment Plan

Considerations:

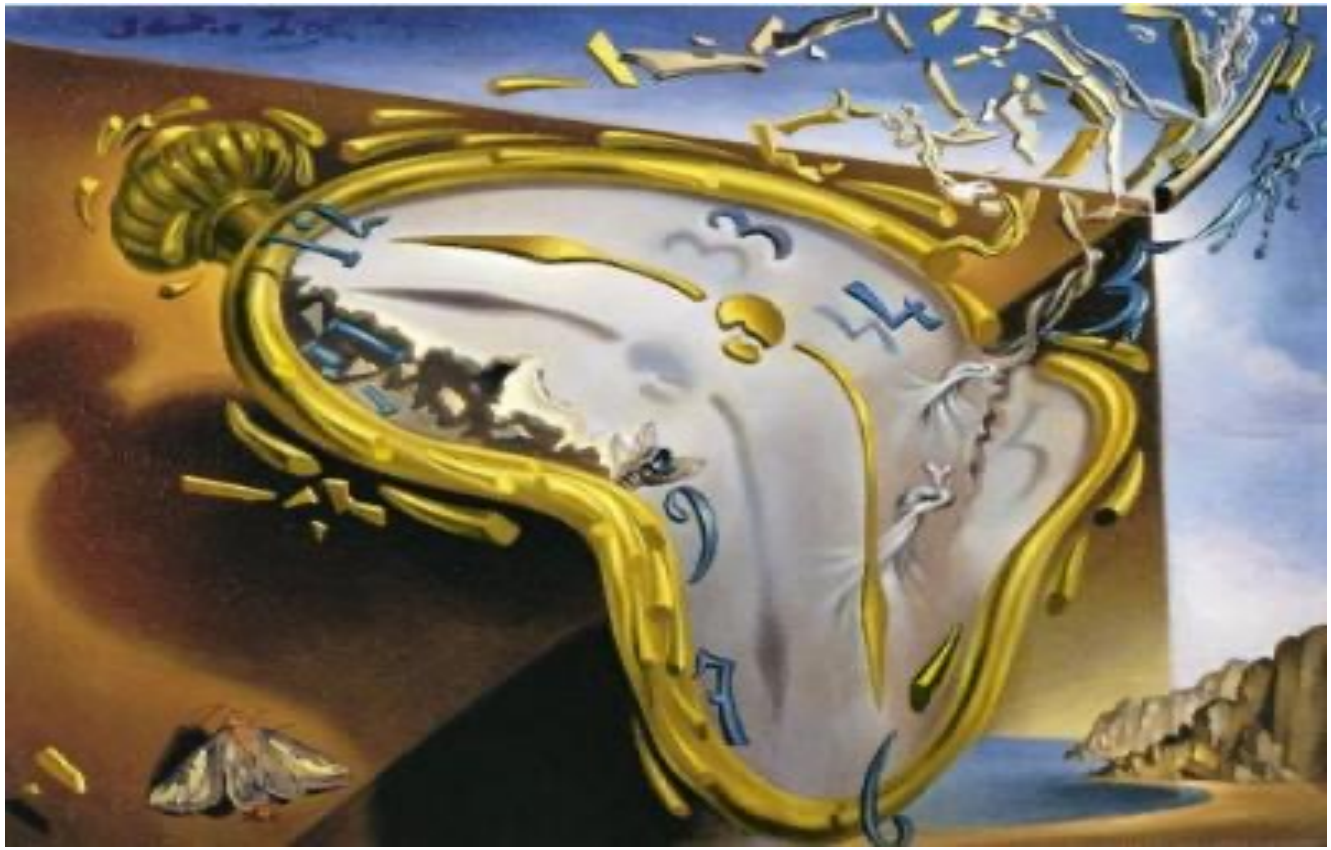
- Discuss Issues/Set limits at the appropriate time: sooner in therapy vs. later*

- Know your own limits: what **should** you tolerate, what **can** you tolerate--(not only you, but what is necessary for the integrity of the system as well)

Considerations:

- Don’t set limits you aren’t willing or able to adhere to

Everything/Always in Context

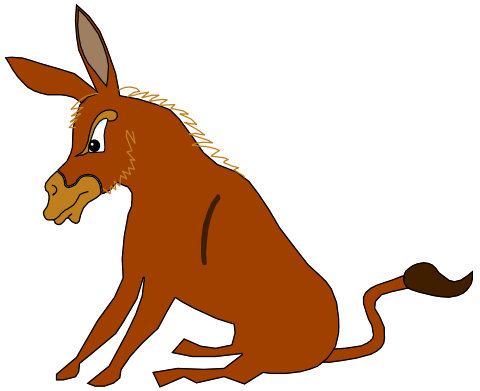


Stages of Change

Stage	Characteristics	Strategies
Pre-contemplation	Not even on the person's radar; or may feel change is futile	Education (risks/benefits, etc…)
Contemplation	Individual is ambivalent, weighing risks/benefits…	Identify barriers, misconceptions. Discuss concerns, supports.
Preparation	Person is prepared to experiment with small changes	Develop realistic goals/timeframe Provide positive reinforcement
Action	Definitive changes in health related behavior	Provide positive reinforcement
Maintenance	Committed to healthy behavior long-term	Encouragement/support

Defense or Deficit
(admittedly, not “strength-based” language)

Is the person choosing not to follow the plan?



or are they not capable of doing so?

How does this change your approach?

Caution!

- Always be careful when “rules” change.
- Discuss, plan
- It is dangerous if only one party is aware of “rule” change…

Potential problems with treatment plans

Inconsistent	Poorly defined	Out of proportion
Out of context	Poorly timed	Non-Collaborative

Also, it is difficult to formulate a plan when you are constantly putting out fires…

Potential Problems

- Lack of clear formulation of the case.
- Lack of clinical experience
- Lack of instruction
- Lack of collegial feedback

- **When stuck, expand the field!**

The Paradox:

Be fair and consistent, and willing to change.
Limits/Plans should be changed when:

- They obviously aren't working
- The patient's/client's needs have changed
- The therapist made a mistake

- "When in doubt, be human" (Menninger)

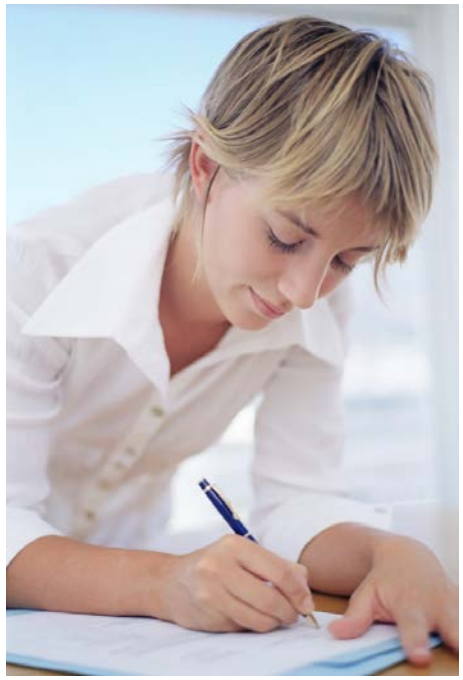
Behavior D.I.F.

- Duration
- Intensity
- Frequency

- (“Manner and Degree”)

Documentation-history/context

- What has helped?
- What has not helped?



Documentation

- What is your thought process?
- Why have you chosen this action?
- Do you have objective information to support this?

Negligence:

- Omission of Fact
- Omission of Judgment

Document

- As if:
- The client
- The client's advocate/attorney
- Another clinician

- Were reading over your shoulder…

When not to treat:

- We are not obligated to treat everyone who comes to us… (Exceptions*, particularly emergencies)
- Not everyone can benefit from your treatment ("fit subject for treatment")
- Not everyone needs your treatment

In Closing

- "Reasonable Care"
  (Sound formulation of case)
- Collaboration
- Individual Treatment Plan
- Expand the field

Self-care

- Take care of yourself personally and professionally!!!

References/Resources

How to Set Limits: https://www.crisisprevention.com/Blog/How-to-Set-Limits

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A non-PHI case from the field

Q+A