LIMIT SETTING: A USEFUL STRATEGY IN REHABILITATION

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ABSTRACT

Limit setting is a concept familiar to most mental health clinicians, but much less familiar to staff not specifically trained in mental health care. This paper presents guidelines developed for rehabilitation staff on the strategy of limit setting. The aim of these guidelines was to provide a starting point for ongoing education on limit setting and behavioural management for staff working in a non-psychiatric rehabilitation environment. Limit setting is presented, not only as a response to challenging behaviour, but also as fundamental to all patient care within the rehabilitation context. The guidelines draw on the concepts of limit setting, acting out, therapeutic relationships and therapeutic milieu as described in the psychiatric literature. A humanistic framework for helping people underpins the guidelines. Principles for selecting and enforcing limits are described. Finally, a list of clarification prompts is provided for clinicians to use when faced with challenging patient behaviour.

INTRODUCTION

The purpose of this paper is to present guidelines developed for staff on the concept of limit setting in a rehabilitation environment. The guidelines evolved from a working party established to explore and improve the care of patients presenting with challenging behaviour. Limit setting is a concept familiar to most mental health clinicians but much less familiar to staff not specifically trained in mental health care. The aim of these guidelines was to provide a starting point for ongoing education on limit setting and behavioural management for staff working in a non-psychiatric rehabilitation environment. They were also used to support psychiatric consultations made to the rehabilitation centre in relation to the care of particular patients with challenging behaviour who had been referred to the psychiatric team. It is important to note that limit setting was identified by the working party as one of a number of strategies utilised when addressing challenging behaviour in a hospital environment. This paper does not seek to address the full range of strategies but is confined to limit setting.

BACKGROUND

The Royal Talbot Rehabilitation Centre (RTRC), a campus of the Austin and Repatriation Medical Centre in Melbourne, Australia, is a 100-bed inpatient rehabilitation facility. It provides inpatient and community services to people following brain injury, neurological, orthopaedic and spinal cord injuries.

The very nature of the medical diagnoses of patients undergoing rehabilitation, eg brain injury and neurological conditions, means that staff are expected to effectively manage patients with challenging behaviour. However, anecdotal evidence suggested that factors other than medical diagnoses influenced the likelihood of patients presenting with challenging behaviour and possibly being involved in a critical incident. Approximately every three to four months, a patient-related critical incident that affected staff work performance and/or safety occurred at RTRC. Patients with personality, substance abuse and psychiatric disorders were more likely to be involved in

critical incidents. The Challenging Behaviour Working Party was established in response to a series of critical incidents that staff found difficult to manage, particularly because of the co-morbid mental health issues and nature of the behaviour exhibited.

The Working Party, of which the authors were members, was multidisciplinary in nature and included personnel from a range of clinical backgrounds. Examples of challenging behaviour considered by the Working Party included verbal and physical aggression, manipulation, anti-social, loud and offensive language, self-harm, substance abuse, harassment and any activity that interfered with the safety and well being of others.

The aim of the working party was to develop a range of strategies to improve the management of patients with challenging behaviour and prevent critical incidents. In addition to the limit setting guidelines presented here, other initiatives included:

- Development of a patient drug and alcohol policy utilising a harm minimisation approach.
- Drug and alcohol education for staff.
- Exploration of a debriefing model ensuring 24-hour access for staff and patients following critical incidents.
- Further development of the relationship between RTRC and the Consultation-Liaison Psychiatry Service.
- Mental health and psychiatry education for staff.

LITERATURE REVIEW

To inform the working party in addressing the issue of challenging behaviour in the rehabilitation environment, the literature was consulted. There were no systemic reviews or clinical practice guidelines found in relation to limit setting. The majority of journal articles and texts available that addressed this concept were within psychiatric (eg Neale and Rosenheck 2000; Milton and Watt McMahon 1999; Schultz and Dark Videbeck 1998; Chatoor et al 1997; Rosenheck 1995; Stuart and Sundeen 1995; Lancee et al 1995; Love and Seaton 1991; DeLaune 1991) and psychotherapeutic (eg Gorney 1994; Pam 1994; Hawton et al 1989; Lerner 1987) literature. This literature was presented in language for an audience familiar with the concepts of psychiatry, not for staff not specifically trained in this area. For the purpose of this discussion, the theory of limit setting as understood in psychiatry will be briefly described.

The origins of limit setting are from psychoanalytical theory. According to Gorney '...limit is understood to be a boundary between self and others, established as an interactional dimension of experience' (1994, p.77). Drawing on Erikson's theory of development, Gorney (1994) explained that the core task of childhood and adolescence is the establishment and integration of personal limits and increasing an awareness of and respect for the limits of others. In other words, developing the ability to set one's own limits is part of the maturing process.

When a person is unable to set personal limits, one response is to engage in *acting out* behaviour. Acting out behaviour can be a conscious or unconscious endeavour for limits to be set and may be aimed at testing out the authority of another. It can also be an attempt to communicate something that cannot be communicated in another way. Acting out behaviour can be destructive, disruptive, anti-social and problematic for those attempting to help that person (Pam 1994). If it is not addressed, such behaviour is often counterproductive to the patient's integration into a fulfilling life. If it is not contained in the rehabilitation environment it affects the person's rehabilitation and can also affect other patients.

In response to acting out, the therapist sets limits on behaviour and sets out the boundaries within which the person is expected to behave. The therapist acts as a '...firm but fair authority figure who sets standards and inculcates responsibility' (Pam 1994, p.433). The therapist also reaches '...out to the healthy ego of the patient, to whatever capacity he or she possesses to understand the underlying issue and to move toward autonomy' (Pam 1994, p.435). The client usually initially resists and resents the limits and may respond with anger because of the authoritative nature of the intervention. However, the goal is that with time and assistance from the therapist in addressing the underlying issues, more adaptive reactions, healthier expression of emotions and containment of disruptive behaviour is achieved (Pam 1994).

While limit setting as a concept arose from psychoanalytical theory, the development of different models of psychotherapy over the past decade has led to a degree of overlap in notions and techniques. For example, the term limit setting is not used in *behavioural therapy* but given that this type of therapy has a focus on learning (Bloch and Harari 2001), there are parallels. Behavioural therapy has expanded since the days of Pavlov's dogs and Skinner's pigeons and now forms a group of approaches that have a focus on assisting people to change behaviour through encouraging desirable behaviour and discouraging (and ultimately extinguishing) undesirable or negative behaviour. *Social learning theory* recognises the interdependence of cognition (thoughts and beliefs), environment and behaviour and incorporates this idea in understanding how learning within a social context occurs. Role modelling is a powerful phenomenon that is recognised within this theory (Bloch and Harari 2001), a process also utilised in limit setting. *Cognitive behaviour therapy* combines the work of the behaviourists with the cognitive model of understanding behaviour and emotion pioneered by Aaron Beck and Albert Ellis (Bloch and Singh 2001). This model of psychotherapy utilises a range of techniques aimed at reducing psychological distress and modifying emotional and behavioural responses (Hawton et al 1989). Understanding the cognition and emotion behind the behaviour is important in limit setting.

Pam (1994) identified a sparsity of literature on limit setting and suggests that mental health workers learn about the concept and develop the skill through peers in the

clinical setting. He further added that the theoretical framework for the concept of limit setting is not well documented in the literature and this omission needs redress. Given this, it is not surprising that few papers were found that discussed limit setting in the non-psychiatric context.

Grossman (1997) presented a case study of a 39-year-old man with quadriplegia, an intravenous drug user who was HIV positive. This patient's problems presented many challenges in the delivery of nursing care including endless complaints to staff, bursts of anger, abuse and blaming, avoidance of the patient by staff and multiple conflicts with and between staff. Limit setting was one of a number of strategies employed in the successful care of this patient. This strategy was set within a multidisciplinary care plan that was consistent and holistic. Staff support was provided in the form of education, team building, stress management and team meetings. The outcome was that the difficult behaviour was contained and the patient's care progressed to a positive end where he died as a 'loved member of the unit' (Grossman 1997 p107).

Gans (1983) presented four case scenarios within the rehabilitation environment. The common theme in each of these was hate: patient self-hatred, patient-staff hatred and staff hatred of patients and their families. He described problematic behaviour emanating from these clinical situations and again limit setting was suggested as a useful strategy. However, specific detail on the implementation of this strategy was not provided.

Smith (1978) discussed limit setting in a general hospital environment and she provided some practical guidance in the use of this strategy. She highlighted the importance of self-awareness, attitude, confidence, firmness, clarity, consistency, planning, staff communication and staff support in effective limit setting.

There were numerous articles relating to the care of specific problem behaviour and discussion of the concept of the *difficult* or *troublesome* patient (example Morrison et al 2000; Gatward 1999; Wolf et al 1997; Daum 1994; Procter 1992; Pelletier and Kane 1989; Antai-Otong 1989). Limit setting was referred to in many of these articles as a strategy when managing such behaviour. While this body of literature was useful in that it stimulated discussion and understanding of the issues related to challenging behaviour, it did not provide the detail on limit setting as a strategy that the working party was seeking.

THE GUIDELINES

In light of the lack of literature that provided clear and specific guidance in the implementation of limit setting as a strategy framed in language that was understandable to non-psychiatric clinicians, the following guidelines were developed. These guidelines provided the starting point for further education on limit setting and behavioural management for staff. It is not proposed that the guidelines are applied rigidly but summarise a set of principles and viewpoints that can contribute to patient care planning.

Within the guidelines, limit setting is presented, not only as a response to challenging behaviour, but also as fundamental to all patient care within the rehabilitation context. The guidelines draw on the concept of limit setting as described previously. In addition, notions of the therapeutic relationship and therapeutic milieu have influenced these guidelines. A therapeutic relationship is between a professional and client that is time limited, goal orientated and focussed on positive health outcomes for the client (Queensland Nursing Council 1997). A therapeutic milieu is an environment that is structured and maintained with the aim of maximising the opportunity for patients to achieve health orientated goals, both physically and psychologically (Schultz et al 1998).

A humanistic framework for helping people underpins the guidelines. This view or set of values is based on the work of Maslow (1968), Rogers (1961), Bugental (1963), Yalom (1981) and May (Corsini and Wedding 1981) and has contributed to the body of knowledge utilised within the social sciences in understanding and interacting with human beings and assisting individuals to change and grow. The humanistic view of human beings is hopeful and includes a belief that there is an inherent drive within each individual toward a strong sense of self, self-awareness, self-determination, responsibility, trustworthiness and creativeness. Given an environment of trust, positive regard, genuine communication and understanding (empathy) then individuals can move toward healthier and more productive lifestyles (Rogers 1961). The importance of the trusting, confiding or therapeutic relationship now underpins psychotherapy (Bloch and Harari 2001).

The principles for selecting and enforcing limits are described. A list of clarification prompts is provided for clinicians to use when faced with challenging patient behaviour.

GUIDELINES FOR LIMIT SETTING

The establishment and maintenance of limits are essential to the operation of a hospital and the wards and units within it. Limits provide a framework from within which patients, staff and visitors can function. Although limit setting is often raised in response to situations where a person's behaviour is creating some disturbance, it should be remembered that limits are part of everyday life. We all feel more secure when we receive clear and unambiguous messages, when we know what the rules are and what is expected of us and that these expectations are consistent. We are able to function more productively when the goal posts do not keep shifting.

Limit setting is also used to describe a therapeutic strategy utilised in the care of patients that have difficulty setting limits on their own behaviour, eg patients with cognitive impairment or personality disorder. In the context of a hospital it is the communication of boundaries and expectations within the relationship between patient and staff. The establishment of boundaries provides a structure, a sense of caring, and can provide a sense of relief and a greater sense of control for the patient. They are essential to the maintenance of a therapeutic professional relationship or alliance between the patient and the staff and minimise manipulation by and secondary gains for the patient. Limit setting does not ensure behavioural change but it does set parameters for acceptable behaviour and gives the patient the best chance to change reactions and behaviour if s/he has the skills and is willing to do so.

Principles to remember when selecting limits

- Limits must be consistent with policy and reflect the philosophy of the hospital and the unit.

- Staff must be aware that they are role models for the limits they set. Their behaviour must be consistent with what is expected of the patient and visitors.

- Patient information and orientation processes must reflect these limits consistently and clearly and yet be flexible enough so that individualised care planning can be provided.

- Limits should be clear and simple with a clear rationale, ie have some therapeutic and/or practical aim. Do not set unnecessary or controlling rules without clear reasoning.

- Teamwork and consistency are essential. Where possible, the limits selected are understood and supported by the majority of staff involved in the care of the patient.

- Limits must be selected so that the staff have the best chance to maintain the limits consistently on all shifts, remembering that staff are not robots and unexpected contingencies will always arise.

- Some actions have natural consequences and these can provide a basis for the selection of limits and add strength to their rationale, eg - if a patient stays in bed in one position all the time then s/he will develop pressure sores and is at risk of developing other complications.

- Individualised consequences of breaking limits can be selected but these need to be considered very carefully, be realistic and enforceable.

- Some limits can be renegotiated, others cannot especially those that are beyond the control of the staff.

- Limits are documented in the management plan.

- Limits can be documented in a formal written agreement that is signed by both patient and staff. An agreement should not be an isolated intervention but embedded within the broader principles. It is important to remember that this is not a legally binding contract but reinforces the commitment on behalf of the patient and the staff toward health outcomes for the patient.

Principles to remember when enforcing limits

- Limits are *clearly* and *simply* stated in a non-punitive/non-condemning manner. Explain clearly what behaviour is inappropriate and what is expected of the person.

- They should include a brief *rationale* without entering into extensive debate, agreement or rationalisation.

- *Negotiate* only those limits that are negotiable.

- Explain the *natural* consequences of actions. Example: 'if you...then...will happen'.

- If *consequences* are used they should be enforced as soon as possible after breaking the limit.

- Do not make *threats* or set consequences that cannot be followed through.

- Offer *alternative* actions/options/behaviour. Example: 'I don't like it when you....I would prefer if you.....'

- Be *mindful of the feelings* of loss of control people often experience in hospital.

- If you *anticipate* that there is likely to be testing of limits by a patient, *plan* your responses in advance.

- Be *clear* in your own mind what the limit is and why it is necessary.

- Do not give mixed messages by making exceptions by wanting to be the 'only', 'special' or 'favourite' one. Be *aware* of your own motivations and reactions to the person's behaviour and situation. Provide support to each other by giving the team an opportunity to discuss interactions with patients and visitors. This helps the team maintain clarity and cohesiveness, particularly in difficult situations.

Limit setting within the broader context

Effective limit setting can only occur within the context of a supportive and collaborative relationship with the patient, in a caring environment that respects the rights of the individual.

- Every patient is viewed as a whole person who must be cared for with consideration given to his/her social/cultural/spiritual context.

- Physical, psychological and social health are interrelated.

- Each patient is accepted as an individual and treated with respect, honesty and a genuine sense of caring for that patient as a person. Accepting the person does not mean that all behaviour is accepted.

- Each patient has ultimate responsibility for their health (except in patients with clearly diminished capacity). Generally patients opt toward healthier and more productive lifestyles whenever they are able. All behaviour has motivating factors that may not always be obvious to or easily understood by the observer.

Some behaviour is directed at satisfying an immediate need yet is damaging in the long term. You can only facilitate awareness of the need for change but cannot force it.

- Care is provided for patients when they are dependent and the goal is to work toward the greatest level of independence possible. Staff do for patients what patients cannot do for themselves. Staff work toward independence by working *with* the patients, not doing things *to* them.

- Health care is collaboration between the patient and the staff working toward negotiated health orientated goals. This can be viewed as a therapeutic professional alliance/relationship. A therapeutic relationship is a relationship between a professional and client (either patient or family/significant other) that is time limited, goal orientated and focused on positive health outcomes for the client. Trust is fundamental to this relationship.

- The ward environment is structured and maintained with the aim of maximising the opportunity for patients and staff to work together to achieve health orientated (both physical and psychological) goals for the patient. Clear communication processes, both verbal and written, are in place. Physical and psychological safety is maintained.

- It is acknowledged that hospitalisation is a stressful event and that living within the artificial environment that operates within a structured framework can be challenging for many patients.

- Confidentiality is maintained but confidentiality is always qualified as each staff member works within a team.

- Supporting patients' self esteem and self-image during a time when it may be under threat is essential. This is done through having realistic expectations, giving positive feedback and being supportive of attempts at healthy behaviour, no matter how small. It is considered important to respond to the behaviour and not the person.

- A multidisciplinary team approach to patient care utilises a mix of skills to assist the patient.

When faced with behaviour that is a problem the following areas should be considered:

1. Define the behaviour.
2. Identify the problem/risk associated with the behaviour (to patients, others, staff).
3. Identify the relationship between the behaviour and the clinical condition(s).
4. Identify related policy and legislation.
5. Identify the philosophical and ethical questions raised.
6. Identify what the preferred/required behaviour is.
7. Identify precipitants to and reinforcers of the behaviour.
8. Consider what else (eg emotions, conflicts) might be contributing to the behaviour.
9. Establish if there is patient-motivation to change the behaviour.
10. Identify the strategies that can be utilised.
11. Identify potential difficulties in utilising strategies.
12. Identify who should be clear about the limits.

CONCLUSION

This paper presents limit setting as a useful strategy in the management of challenging behaviour within a rehabilitation environment. The intention is that the guidelines provide a practical framework within which clinicians can effectively care for all patients and in particular, those presenting with challenging behaviour. Preliminary utilisation of these guidelines has occurred in clinical and educational forums. This work has demonstrated that developing skills in effective limit setting is of benefit to staff working in a rehabilitation environment. However, it has also highlighted that these are complex interpersonal skills that require time to learn, commitment from the team, support from management and input from mental health experts so that staff can develop and utilise these skills appropriately and effectively. Finally, the lack of literature describing limit setting, particularly in the non-psychiatric environment, is of concern. It is intended that this paper will stimulate discussion and debate about the utilisation of this strategy in a range of environments as well as contribute to the body of knowledge in this area.

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