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Exploring the Boundaries of Pediatric Practice: Nurse Stories Related to Relationships

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# Abstract

Pediatric nurses struggle to find the right level of involvement withchildren and families. The purpose of this study was to illuminate nurses' struggles and insights as they learned to find the interpersonal boundaries of their own practice. The phenomenological method of Heideggerian hermeneutics was used to analyze data from audiotaped and transcribed single interviews of five pediatric nurses. The analysis of the transcriptions involved multiple stages of interpretation using a research team. The themes that emerged from the data were: (a) pediatric nurse as family caregiver: (b) finding the right level of care: over-involvement vs. crossing the line; (c) caring and the dying child; and (d) caring for the caregiver. Implications for pediatric nursing practice are explored.

Pediatric nurses struggle with finding the right level and kind of involvement regarding their relationships with children and families. Unfortunately, the stories that accompany a nurse's journey in this struggle are often kept secret (Larson, 1985, 1987; Totka, 1990). due to the personal nature of this aspect of care. Involvement, caring, and interpersonal connections form the basis from which nursing care is delivered and are important to pediatric nurses and the families for whom they care. Unhealthy. involvement can be destructive to the nurse and the family (Gemma, 1989; Barnsteiner & Gillis-Donovan, 1990; Benner & Wrubel 1989; Totka, 1990). The purpose of this study was to understand what unhealthy involvement, defined here as “crossing the line," meant to pediatric nurses.

There are innate differences in pediatric nursing that confound the setting of nurse/patient boundaries. Physical boundaries in the care of children are not the same as they are in adult nursing. Pediatric nurses hold, kiss, and nurture children. Many of the physical boundaries of care are taken away, yet it is expected that emotional boundaries remain clear. When children are ill, their parents are in crisis. This makes parents vulnerable to the nurses' words and actions. Parents make decisions related to their child's health care; however, those parents also receive care from pediatric nurses. In cases where parents are either physically or emotionally unavailable to their children. the struggle intensifies as the nurse tries to fill the gaps of care and advocacy.

# Review of Literature

In her practice as a pediatric psychiatric nurse clinician working with pediatric nurses regarding their emotional and social needs, Gemma (1989) found that over-involvement with pediatric patients and their families was a common theme. Barnsteiner and Gillis-Donovan (1990) stated that. "No doubt the situations [of pediatric nurse over-involvement) exist to some degree in all pediatric settings" (p. 227).

This investigator found no research and very little literature that explored the issues related to nurse and patient/family relationships as they related to interpersonal boundaries. Although the negotiation of interpersonal boundaries in pediatric nursing has been cited a:; problematic (Gemma, 1989; Barnsteiner & Gillis­Donovan, 1990), little was known regarding what this meant to pediatric nurses in their practices.

When mentioned in the literature, the term over-involvement had a negative connotation. Little was written or understood about levels of relation - ships or parameters that would suggest positive or negative patient or nurse outcomes. Barnsteiner and Gillis-Donovan (1990 I discussed the difficulty pediatric nurses have in being "meaningfully related to a patient and family yet separate enough to distinguish one's own feelings and needs" (p. 223). The authors outlined their hospital’s process in developing a policy and procedure related to therapeutic relationships. Benner (1984) stated that it was through experience that nurses learned the boundaries of their care. Benner and Wrubel (1989) discussed over-involvement as it was associated with over-identification (for example. feeling the patient's Jain) and over­involvement as helper (excessive need to control or dominate). They described the bound:1ries of professional practice as narrow paths traversed by nurses, or "what it is to place oneself in the situation without becoming enmeshed or inappropriately distanced from the situation" (p. 379). They stated that this path was "best negotiated through the support of others who understand the situation" (p. 375).

In studies that explored caregiver secrets, Larson (1985, 1987) found that nurses who thought about over-involvement, or putting limits on their care, tended to keep those thoughts secret. Maslach (1982) stated that over-involvement on a personal level was particularly stressful over the long run, and could cause burnout. Benner and Wrubel (1988) agreed about the stress of over-involvement, but felt that it was not the caring that caused burnout, but the loss of caring.

# Method

The method of Heideggerian hermeneutic phenomenology was chosen as the approach for this study becauseof the nature of the study question. This form of research explores the meanings and shared practices embedded in a situation through language. Meaning is seen to be shared by human beings through language, skills, and practices (Allen, Benner, & Diekelmann, 1986). Packer (1985) stated that this was the most appropriate method to study human action because, "any act, looked at in isolation from its situation, is likely to be ambiguous to the point of opacity or obscurity" (p. 1081). Therefore, using this method, the feelings, thoughts, and meanings of a concept to a participant are sought in the context of that participant's own account or story. The words themselves are studied to glean the meanings behind them through clustered meanings or themes.

## Sample

Pediatric nurses at a children's hospital in the midwestern United States with at least three years experience were the targeted population for inclusion in the study. It was thought that at or beyond the competent level, based on Benner's novice to expert model (1984), participants would be most able to reflect upon and integrate the experiences of their practice at the level needed for this data analysis method. An expert in this method of investigation (who was also part of the research team) determined that a target sample of five interviewswere needed to produce adequate data for analysis (Nancy Diekelmann, personal communication, May 1990). More interviews would have been obtained in the event that the first five interviews produced insufficient or inadequate data. Participants ranged in experience from three to eleven years, and represented diverse pediatric nursing specialties and acute care, intermediate care, and intensive care. The final participants consisted of five nurses, four females and one male.

## Datacollection

Individual interviews were conducted with each participant in private conference rooms at the hospital where they worked. The participants chose the preferred time and site of the interview. The interviewswere open ended and unstructured. The participants responded to the question, "What does it mean to you, as a pediatric nurse, to be overinvolved or cross the line with a patient and/or family?" Each interview was audiotaped and transcribed verbatim by the investigator. All references to specific names and gender were changed to ensure confidentiality. The average interview was one hour. No interview lasted longer than one and a half hours. The stories related were from each nurse's experience, either their own personal struggles or their perceptions of the struggles of their colleagues. There were times during the interviews that the same story was told in first person by the nurse who lived it, and in third person by a peer who was affected by it, to illustrate the same point (although none of the participants were currently working on the same unit or knew the identity of the other participants).

## Data analysis

Data analysis began after all five interviews were transcribed. This transcription was a 75-paged single-spaced document in which all references to name and gender were changed. The data was analyzed using a research team consisting of (a) the principal investigator, (b) a professor who is an expert in the method of Heideggerian hermeneutical analysis, (c) two Ph.D. prepared instructors, (d) two graduate students, and (e) an undergraduate student. All members of the team were currently involved in interpretive research. The team met weekly to analyze the data in seven stages (adapted from Diekelmann, Allen, & Tanner, 1989). These stages were:

1. Examination of the entire set of transcripts as a whole by the research team;
2. in-depth study of each interview in weekly sessions by all research team members to identify themes with the goal of group consensus;
3. Re-analysis of each interview with respect to the identified themes by the investigator with any discrepancies brought back to the research team using the original text for clarification;
4. Identification of themes that cut across all interviews (relational themes) using extensive documentation from the text identified to support these themes;
5. Exploration of the possibility of a pattern of meaning that cuts across all themes and expresses a relationship between themes (constitutive pattern)-the highest level of hermeneutical analysis. but not identified in this study;
6. Review of the entire analysis by a participant from the study, another pediatric nurse not involved with the study, and the research team. to provide validation and consensus related to the identified themes for the final report**;** and
7. Development of a final report.

This multi-staged design for the interpretation of the data was identified by Benner (1985) as a means for the control of bias. As the transcripts of the interviews were continually revisited, it was hoped that any unsupported interpretations were exposed and rectified. Extensive excerpts from the transcripts were included in the final report so that each reader would be involved in the validation process. For this same reason, excerpts from the transcripts were included in the results and discussion section of this report. It was hoped that each reader could be part of the validation process.

# Results and Discussion

Four themes emerged from the analysis of the data. These themes were: (a) Pediatric nurse as family caregiver; (b) Finding the right level of care: over-involvement versus crossing the line; (c) Car:ng and the dying child; and (d) Caring for the caregiver.

## Pediatric nurse as family caregiver

In these stories, nurses described the times in their practice when they needed to be family and child advocates. Sometimes there were language barriers or a lack of language skills (as in the case of a baby). As one nurse stated:

*An infant can't communicate with you verbally and communicate what he or she needs. I think that puts them in a special area of vulnerability. And* *you need to know how to read their cues. And as somebody who's always there you've learned to do that. And you've learned how to stand up for what they're saying, even though they can't do it verbally....*

Sometimes the stories described times in the nurses' practices when they or a colleague needed to take over roles normally held by family members or friends. There was a sense that when this went well, the nurses would temporarily take over these roles. When the parent, family, or friend was able to take over again, the nurses were able to change their role and level of involvement. To illustrate this, a nurse described an example of the sub-theme "nurse-as-parent:"

*...If the parents aren't going to be there I feel somebody*'*s* *got to do it...And* so *I bought her sleepers and stuff.... And you make a schedule for them, and you do all those parenting things that a parent would do.../and when the baby was sent to a foster home] I knew she was going to a good home and that she would be well taken care of, but there is still that loss...and you miss her.*

This story contrasts another "nurse-as-parent" story that was used to illustrate crossing the line by a colleague of the nurse who lived it:

*So she became a foster Mom for this child. And was very negative about the parents, which I did not like at all...She would talk very scathingly about the parents [in front of the child]...this is one case where it is clearly pointed out about how she crossed over more for her need than for anything. And once her need for this child stopped. she didn't see what the child needed anymore....I think the most uncomfortable part of the whole thing is when crossing over becomes a rejection of the child's parents...then there's not doubt in my mind that objectivity is lost.*

The nurse as family or friend was a role that often walked a fine line, and was clearly on the margin of the nurse's practice. In some cases, stories relating to friendships with families were seen as empowering to both nurse and family. In other cases, relationships taken to extremes (such as romantic relationships with parents) were seen as destructive and impaired the nurse's ability to function in his or her role.

There was a strong sense in pediatric nursing that it is the family, not just the child, that is (or should be) the focus of the nurse's care. Pediatric nurses felt responsible for the needs of all family members. However, there also seemed to be a strong sense of the limits that relationship imposes. In pediatric nursing, the parents were seen to be as vulnerable as their children in many ways. To impose oneself romantically, or allow oneself to get involved romantically, was a break in professional ethics. This was true for pediatric nurses whether the parent was married or single.

Finding the right level of care: over-involvement versus crossing the line. The core of this theme was that caring came first. This process of finding the boundaries of care was far from automatic. As with any other skill, time and experience taught nurses the margins of their practice. Gemma (1989) stated that a common theme that emerged from her practice (working with pediatric nurses related to their social and emotional problems) was that nurses needed to set limits on their care. She stated, "Losing hold of the boundaries that protect them-and allow them to do effective work-they have entered into the family systems of others" (p. 743). To avoid crossing the boundaries of one's practice, one first had to find out where the boundaries were.

Nurses interviewed stated that much of the learning related to interpersonal boundaries stemmed from times that they felt that they had made mistakes. Another sub-theme that illustrated this point was "first you get it wrong." Many of the nurses felt that during the experience they were confused and unclear about where their boundaries were, or how to negotiate them. There seemed to be a pervading sense of discomfort, however vague, throughout the experience. That she had crossed the line seemed clearer to the nurse upon reflection:

*...well you can't always stop and sort it all out at the time; you just have to keep going. I just kept on going to work and kept up the relationship and... I’m not sure...I don't think I talked about it much at work. 'Cause I didn't want to get on people's bad side.*

Many times this confusion brought about conflict with peers and supervisors. Supervisors who had no direct patient care responsibility were seen as unhelpful. They were seen as "too far from nursing" to understand the interpersonal struggles at the bedside. For example:

*And my nurse manager talked to me about Betsy, my very first baby. She said...she was worried that I was becoming too attached. And I just blew her off. I mean I had to live through that before I knew what she meant.*

One nurse described an incident when a shift supervisor with patient care responsibilities helped him sort out his issues related to a parent interaction that he was uncomfortable about. He described this as very helpful.

Confusion related to feelings associated with crossing the line appeared to be more common early in practice. Time and experience taught most of the nurses where their "line" was and showed them how to stay safely on their "comfortable" side.

There was also a sense that one nurse's boundary was not necessarily equal to another's. For some nurses, maintaining a professional identity separate from their personal identity was of paramount importance. One nurse stated, "I guess, professionally parents know me on one level and personally I'd rather they don't know me." Other nurses, with experience and knowledge of their own personal boundaries, found the t those relationships developed in the margins of their practice were some of their most satisfying. Nurses needed to continue to re-evaluate their relationships over lime using self-reflection. Developing close relationships with children and families could bring great joy to a nurse, but taken past the margins of care could cause harm to both the nurse and the family.

All members of the data analysis team struggled with the terms over­involvement and crossing the line. Members sensed that there were times when nurses became more involved with families to the benefit of each. There was a sense of reciprocity in an invested, caring relationship between a nurse and family. It was this intense, engaged, authentic care that marked the times in pediatric nurses' practice when they did so much more than just their job. Those were the times that kept nurses in nursing. This was not to discount the real, caring. synchronous relationships that nurses attempted to have with all patients; it wasan acknowledgment that some nurse-patient interactions were more powerful than others. This positive relationship was called "over-involvement" in the final report only because no one could think of a better term.

Highly synchronous relationships usually occurred in relationships that had developed over time, either through repeated or long-term patient contact. It appeared to occur more frequently, but certainly not exclusively, with chronically ill or terminal patients. Nurses found it impossible to discuss negative behaviors that they saw ascrossing the line without telling stories about over-involvement that they saw as highly positive for comparison.

Heidegger (1927/1962) described two kinds of concern or solicitude: leaping ahead and leaping in. Leaping ahead was care that freed both the caregiver and the recipient to understand new possibilities for being. It was authentic, invested, and by its very nature situated and contextual. Because of this, it was always transforming and changing w.th changing situations. Benner and Wrubel (1989) described this kind of solicitude (or caring) as "a form of advocacy and facilitation. It empowers the other (person) to be what he or she wants to be, and this is the ultimate goal in nursing care relationships" (p. 49). It was the dynamic nature of highly synchronous relationships that made them successful; as the patient/family needs changed, the relationship changed. It was when relationships transcended or defined the child or families' needs, with little or no input from the child or family, that they were thought of as crossing the line.

Crossing the line was when the care itself became destructive to the patients and families or to the nurses themselves. Pediatric nurses had an embodied sense of when this occurred, although they did not always see the boundaries until they had crossed them. Heidegger (1927/1962) described the kind of concern that dominates or controls another human being as "leaping in." This was when the needs of the caregiver superseded the needs of those receiving the care. Benner and Wrubel (1989) described this kind of care as "overinvolvement," when "the boundaries between the self and others become blurred, and the one caring may take on the role of omnipotent rescuer, overlooking the responsibility, integrity, and resources of the person and the situation" (p. 374). One nurse described a time when she crossed the line of her practice and the margins of her practice became blurred:

*I was dating the father (divorced) of* a *patient who was dying. And in supporting him (the father) when [the patient/died we got really close, and I think that it wasn't appropriate...it was really hard to draw the line...to where my professionalism was and the relationship with the person and his family...I had to be there for them But in my mind It was confusing* also. *Was I doing this as* a *nurse? Or was I doing this as* a *person?...I think that maybe it took away from my objectivity of my looking at the relationship...because there was* a *crisis, I was filling in in* a *place where I really shouldn't have been.*

Intimacies developed in times of crisis were problematic. Nurses as human beings were confronted with situations where powerful emotions were evoked and shared. This could be beautiful and seductive. At the same time, it was the nurse, not the child or family, who had to keep the boundaries of practice clear. The nurse was the one who was ethically responsible for negotiating these margins.

All of the nurses interviewed viewed experiences of crossing the line in their practice as milestones, either positive or negative. Accompanying the stories were often such statements as, "That experience taught me never to get involved in that way again," or "That was the only time that ever happened to me." Crossing the line was a powerful teacher. The lesson could be empowering or destructive. Some nurses saw their experiences as spring­boards to healthier relationships; others learned lessons of mistrust and disillusionment Nurses who learned negative messages often went to great lengths to protect themselves from future emotional involvement They felt they had "used up" or "lost” their ability to care.

Much of this loss of care could be traced back to the nurses' mistaken belief that to protect themselves from pain, they must distance themselves from interpersonal relationships and the feelings of loss that may be evoked by those relationships changing or ending. This was often accomplished by objectifying patients and shielding oneself from all but the most superficial of relationships. The danger of objectifying human beings was that although it might protect a nurse from the pain that accompanied personal involvement in the short run, it altered the nurse's ability to care. This was illustrated by stories of nurses who described themselves or colleagues as "robots" just getting through their shifts or assignments.

One subject stated that she learned not to get too involved with patients in nursing school. The result of this belief was costly to her and to nursing. This nurse felt that care was a finite resource that had to be rationed over time. Benner and Wrubel (1988) stated that it was not care, but the loss of care, that caused burnout, and that the cure was the return to care. That same nurse felt that the loss of care was just a matter of time, "I think you just don't have any more to give after a while." This nurse found no joy or meaning in her practice; this nurse left nursing.

## Caring and the dying child

This theme represented some of the most significant stories in pediatric nurses' practices. Caring for children through their deaths and for family members during and after their child's death were times in the practice of pediatric nurses that would forever resonate. The death of a child affected not only that nurse's heart, but transformed that nurse's practice. Most of the pediatric nurses interviewed saw the importance of self care during those times. Nurses described their need to attend funerals, maintain contact with families, and experience their own grief. One nurse described bringing balloons to the funeral of a child she had taken care of for 6 years:

*I didn't know if I should, I had never done that before...Mom was so happy. And that make me feel good...and then she let them go...outside...which was kind of neat.*

The symbols und rituals attached to death were important to the understandings and acceptance of death as part of the life cycle. Particularly for children, who should have a life of possibilities ahead of them, nurses grieved. From that grief could come new hope and understanding, and that could be the child and families' gift to the nurse. If, however, nurses saw death as an unnatural event and did not allow the time or rituals needed for coping, they would forever dose off their own possibilities. They also shut themselves off from future care.

At times in practice, nurses encountered the challenge of helping the family let the life of their child complete its cycle. One nurse spoke of when it was time to let go: "Dying is sad, and it hurts...but sometimes it's the living that's even harder to deal with." A nurse's practice became more difficult at times when life and death could be controlled by a flick of a switch; when technology obscured humanity in health care. Diekelmann (personal communication, September 24, 1990) wrote:

"Medical care presents a dilemma to parents of dying children. Heroic measures to preserve life sometimes fail. Yet we can sustain life; death becomes a symptom. It is in these circumstances that parents are asked to consider discontinuing heroic measures and to allow a life to complete its cycle. Death then becomes a life event."

Pediatric nurses cared for children and families as they faced death, but they also acknowledged their experiences of care and renewal. Pediatric nurses needed to understand their own experiences and accept them. Often this entailed seeking and accepting care, or reciprocity of care, and that was difficult for them.

Caring for the caregiver. The final theme described that reciprocity of care. Because of the intimacy and complexity of the, work of nursing, communities of support must be built in the work place. Benner and Wrubel (1989) stated:

"The traditionaI view of work as competitive demands and home as the sole source of comfort does not suit any occupation, but it is untenable in nursing, where care is central to the work. This is why health promotion and social support belong in the work place as well as in the home (p. 393)."

Nurses must care for each other. Perhaps the struggles that the nurses described in maintaining and negotiating interpersonal boundaries were areas that were most neglected in conversations of nurses as a whole. A pattern that emerged in all the stories was that nurses rarely shared these stories with each other. If the issue was discussed at all it was often brought up by supervisors in a way that the nurses involved did not find helpful.

An interesting aspect of the silence that nurses maintained when they felt that they had crossed the line was that their peers were often aware of the situation, just as those nurses were aware of the situations that their peers faced. In fact, peers often recognized unhealthy situations before the nurse involved, but they did not know how to talk about it either. One nurse illustrated this point in a story:

*I mean we could all* see *it..I don't think she saw it. No. And I don't think that when you're in the situation that you always see things clearly. And did any of us address it? No. We probably should have...She was a very new nurse at the time...lt's hard...Because that's you that someone's saying something about, not a skill you're doing, it's you.*

Because issues of interpersonal boundaries were so personal, talking about them was difficult. The trouble with avoiding these conversations was that while some nurses found their way on their own, others withdrew and floundered.

# Implications for Nursing

All pediatric nurses have experienced the struggle themselves, or have seen their colleagues struggle with interpersonal boundaries. The meanings associated with connecting or having synchronous relationships with children and families--as opposed to crossing the line into a negative plane of behaviors that are not helpful to the child, family, or nurse-can only be illuminated by the stories of the nurses themselves.

These stories and struggles must not remain secret. Nurses' stories related to connections and interpersonal boundaries must be shared with new students and new nurses to help them understand the dilemmas they will face. Krejci (1995) describes synchronous connections nurses make with patients, which she defines as holistic and healing:

"These connections make powerful contributions to the person's overall health but are almost never charted, discussed or valued, although they are always remembered by nurses and patients. Connections have often been discussed by nurses and patients as something that happens between the nurse and patient whereby healing is optimized and access to knowing is maximized (p. 25)."

Tanner and colleagues (1993) described nurses need to know the patient as central to skilled clinical judgment. They stated, "Knowing the patient means both knowing a patient's typical pattern of responses and knowing the patient as a person ...(it] requires involvement, and sets up the possibility for patient advocacy and for learning about patient populations (p. 273)."

If involvement and connections are central to nursing practice, yet are rarely charted or discussed, it is not surprising that the issues of unhealthy involvement orcrossing the line are so problematic. If nurses do not share the positive connections made with patients and families, how can they feel comfortable sharing the negative? The pediatric nurses interviewed could not describe crossing the line without telling a story of positive connections as a comparison. A behavior cannot be judged out of the context of the situation in which it has occurred; neither can a story be told out of context of the culture of meanings.

For example, stories of crossing the line related to a nurse's romantic relationship with a parent of a child in that nurse's care were confusing to certain members of the research team who were nurses, but not pediatric nurses. They could not understand what was wrong with a relationship between two single adults. It was only when these stories were compared to the connections between nurses and families that illuminated a parent's vulnerability and a pediatric nurse as a family caregiver, not just a child's caregiver, that these members of the research team began to understand the culture of pediatric nursing and why such relationships were considered crossing the line.

Behaviors, even clusters of behaviors, examined out of context, cannot define a nurse who is in trouble. Protocols developed related to relationships between nurses and families such as those described by Barnsteiner and Gillis-Donovan (1990) are not the answer, but at least they are a beginning to the discussion. Although some nurses and nurse managers find the idea of a concrete list of do's and don'ts comforting, even helpful, it does nothing to promote that nurse's professional development or promote self-reflection or introspection as only their stories can do. In the same article, Barnsteiner & Gillis-Donovan described the incorporation of Advanced Practice Nurses (APNs) specializing in mental health being available to support nurses; this intervention was positive and empowering.

Linda Armstrong (1993) stated that an institution has a responsibility to its nurses to provide resources to eliminate behaviors that the institution felt were inappropriate, but nurses felt were important. For example, institutions can provide facilities for families or nurses to wash children's clothes, have a slush fund to provide patients with a present on their birthday, and have volunteers organized to provide clothing for children who were hospitalized long term. She also felt it was the institution's responsibility to provide support for and acknowledge a nurse's grief when there was a loss of a long-term relationship either through death, transfer, or discharge.

This kind of support could come from peers through formal support groups or informal dialogue. It could come from APNs in mental health as described above. Direct intervention by evaluative staff v.as usually not thought to be helpful by the nurses in this study, but that may be unit or institution specific (or that the intervention was seen as punitive not therapeutic. Time and resources spent on the support of nurses in trouble could have long range benefits. Figley (1995) uses the phrase "compassion fatigue" to describe a reaction to the stress of caregiving. He stated that compassion fatigue is an acute, treatable, precursor to burnout. Perhaps proper intervention would keep nurses from quitting or changing jobs when the stress of the care becomes too much.

Another implication is that pediatric nurses need to assess their comfort level related to patient/family involvement to choose their career paths realistically. Pediatric nurses who work with chronically ill and/or dying children need a strong sense oftheir own boundaries (or the support to find them). Some units and roles are more demanding in this respect than others. Nurses have to learn andknow their own triggers: times when they are more at risk. For example, many nurses are uncomfortable working with a child too dose in age to their own children, especially if thechild is severely or critically ill.

The themes identified through the interviews suggested that nurses need to develop caring communities work, where open communication anddialogue can take place. It is, in fact the silence that is dangerous, not the struggle. Confusion related to interpersonal boundaries is a normal phenomenon in a profession that is by its very function an intimate act. Pediatric nurses need to search for meanings and guidance related to their level of personal involvement with children and families.

# References

Allen, D., Benner, P., & Diekelmann, N.L. (1986). Three paradigms for nursing research: Methodological implications. In P.L Chinn (Ed.), *Nursing research methodology: Issues and implications.* Rockville, MD: Aspen Publishers.

Armstrong, L. (1993, April). *Establishing and maintaining boundaries in the nurse/family relationship: Challenges and controversies.* Presented at the Society of Pediatric Nurses' Conference, San Francisco, CA.

Barnsteiner, J.H., & Gillis-Donovan, J. (1990). Being related and separate: Astandard for therapeutic relationships**.** *American Journal of Maternal Child Nursing, 15,* 223-228.

Benner, P. (1984). *From novice to expert.* Reading, MA: Addison-Wesley.

Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction and understanding in nursing science. *Advances in Nursing Science,* 8(1), 1-14.

Benner, P., & Wrubel, J. (1988). Caring comes first. *American* *Journal of Nursing, 88*, (8), 1073-1075.

Benner, P., & Wrubel, J. (1989). *The primacy of caring: Stress and coping in health and illness.* Menlo Park**,** CA: Addison-Wesley.

Diekelmann, N.L., & Allen, 0., & Tanner, C. (1989) *The NLN Criteria for appraisal of baccalaureate programs: A**critical hermeneutic analysis.* (Pub. No. 15- 2253). New York: National League for Nursing.

Figley, C.R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* Now York: Brunner/Mazel, Inc.

Gemma. P.B. (1989). Can nurses care too much? *American Journal of Nursing,* 89(5), 743-744.

Heidegger, M**.** (1962) *Being in time.* (J. Macquarrie & Robinson, Trans.) New York: Harper & Flow (Original work published in 1927).

Krejci, J. W. (1995). Synchronous connections: Nursing's little secret. *Journal of Nursing Care Quality,* 9(4), 24-30.

Larson, D.G. (1985) Helper secrets: Invisible stressors in hospice work:Recommendations for antidotes. *American Journal of Hospice Care,* 2(12), 35-40.

Larson, D.G. (1987) Helper secrets. *Journal of Psychological Nursing, 25* (4), 20-27.

Maslach, C. (1982). *Burnout-The cost of caring.* New York: Prentice-Hall.

Packer, M.J. (1985). Hermeneutic inquiry in the study of human conduct. *American Psychologist, 40,* 1081-1093.

Tanner, C.A, Benner, P., Chesia, C., & Gordon, D.R. (1993). The phenomenology of knowing the patient. Image: *Journal of Nursing Scholarship,* 2514), 273-280.

Totka, J.P. (1990) *Exploring the boundaries in pediatric nursing practice—over-involvement and crossing the line: A Heideggerian hermeneutical analy*sis. Unpublished Master's Thesis, University of Wisconsin, Madison.