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A communication approach to boundaries as an alternative training program for health care professionals

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A COMMUNICATION APPROACH TO BOUNDARIES AS AN ALTERNATIVE TRAINING PROGRAM FOR HEALTH CARE PROFESSIONALS

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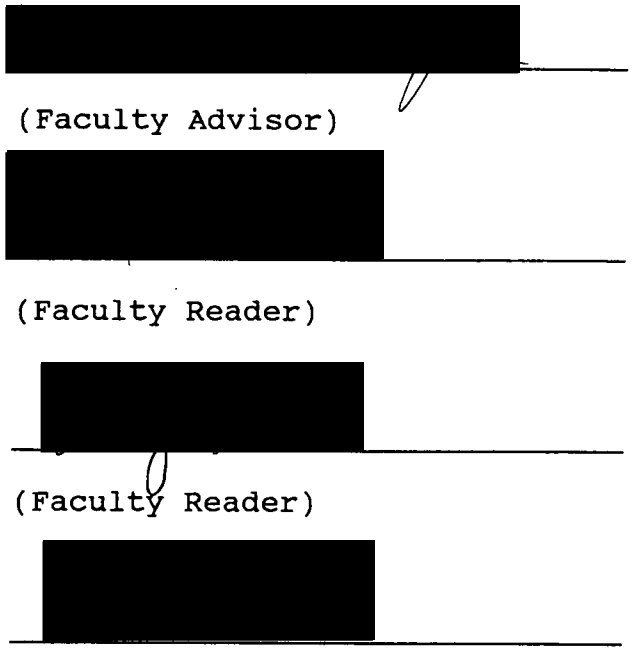

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ABSTRACT

A COMMUNICATION APPROACH TO BOUNDARIES AS AN ALTERNATIVE TRAINING PROGRAM FOR HEALTH CARE PROFESSIONALS

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Communication studies in the arena of health care report that the development of an empathic relationship between health care providers and patients is key to a more positive health outcome. Yet many health care providers suffering from burnout report this interpersonal relationship as the major cause. This study examined these areas and developed a training program that may offer health care providers a tool to maintain empathic links with patients while avoiding professional burnout. Applied with great success in the clinical setting by Drs. Henry Cloud and John Townsend, appropriate emotional boundaries is a tool that may allow health care providers to remain close to their patients yet emotionally separate. The training program developed for this study was pilot tested and then administered to an experimental group of care givers at a local pediatric hospital. The goal of the training program was to make care givers aware of the

boundaries tool. An Inventory of Interpersonal Concerns (IIP/C) was administered to the experimental group as well as a control group to measure the effectiveness of the training. Individual samples *t*-tests on pre- and post-experimental scores revealed a significant difference for only one variable - "authority." Individual samples *t*-tests for pre- and post-control scores showed no significant differences. Paired samples *t*-tests on experimental group change scores and control group change scores also showed no significant differences. These findings are not surprising, in that choosing to adopt and implement boundaries is based on individual choice. Further, implementation and growth of mature emotional boundaries is a process that happens over time and could not be expected to take place after one training session. A formal evaluation of the training conducted by the hospital indicated the program was successful in accomplishing its goal to make care givers aware of the boundaries tool.

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Chapter One

Introduction

Communication studies in the arena of health care tell us that the development of an empathic relationship between health care providers and patients is key to a more positive health outcome for the patient. These same studies also reveal that health care professionals are plagued by burnout, a problem that has reached national proportions. Health care providers suffering from burnout report the interpersonal relationship between themselves and their patients to be the major cause, thus linking burnout with the empathic relationship (Ray & Miller, 1990). Ray and Miller (1990) further state that the very organizations dedicated to healing individuals also contribute to the stresses experienced by health care professionals. Current training programs developed for health care providers address ways to improve communication and teach empathy but do not offer any solutions to the problem of burnout. This study proposes to explore these issues, develop and present a possible alternative that may help health care providers maintain empathic links with patients while

avoiding burnout.

That burnout and subsequent turnover in health care is a problem is indicated by a five-year national study of turnover rates for chief nursing officers at 100 hospitals, which reported an average rate of 21.6 percent with a trend toward rising rates, as illustrated by a 27.5 percent turnover rate in 1990 and 1991 (Kippenbrock & May, 1994). Researchers Fottler, Crawford, Quintana and White (1995) added that nurse turnover rates are not only high, but high relative to other female-dominated occupations. Fottler et al. note that one survey revealed that 94 percent of nurse respondents indicated they had considered leaving the profession altogether. At a local level, the pediatric hospital participating in this study's formal training program also stated that turnover rates among its care givers was high. A turnover rate of 14.7 percent was recorded for fiscal year 1993-94. The turnover rate rose to 16.6 percent for fiscal year 1994-95. Fottler et al. suggest that, unless the tide of high turnover rates among nurses is stemmed, the resulting shortage could jeopardize the quality of patient care. In light of this concern, examination of the suggested link

between burnout and the interpersonal relationship of care giver and patient may point to identifying a root cause of turnover rates among nurses. Exploration of a possible solution to professional burnout among care givers may also provide an answer that positively impacts the care giver, health organization and ultimately the patient.

Ray and Miller (1990) define burnout as a "wearing down from the chronic emotional pressures of human service work" (pg. 100). The "symptoms," physical, emotional and mental exhaustion, can result in a decreasing sense of personal accomplishment and a tendency to depersonalize care recipients (Ray & Miller, 1990).

Ray and Miller (1990) define empathy as a care giver's ability to listen to a patient's feelings and provide information as a means of reassurance. Morath (1989) states that empathy is "the ability to put oneself in another's shoes and respond with feeling - actually have the ability to experience and therefore, share the emotion of another person (pg. 60)." To practice empathy, care givers must be willing to expose themselves to feeling a possibly painful range of

emotions, a state that points to a unique aspect of the health profession.

Ray and Miller (1990) point out that provision of health care requires the establishment of an interpersonal relationship between health care provider and patient. They note that the stress arising from this social interaction between health care provider and patient is the major cause of burnout among health care professionals. Further, the profession is unusual from the standpoint that the health care provider must give but rarely receives - emotional replenishment from this interaction (Ray & Miller, 1990).

Ray and Miller (1990) suggest that health care providers can successfully expose themselves to the vulnerability of empathic relationships with patients without fear of burnout by maintaining emotional distance. Ray and Miller (1990) go on to state that that supervisors and co-workers can offer health care providers a healthy outlet for venting reactions about work and the stresses of the work environment.

While research supports these recommendations, advising health providers to link empathically with patients while maintaining high levels of emotional

distance appears to create a contradiction. Further, it can be argued that the literature leaves health care providers unsure as to how to carry out the above "prescription." Use of the words "emotional distance" suggests negative emotional connotations for the individual attempting to practice this "prescription." Finally, health care providers who do not have a supervisor or co-workers willing to act as buffers or outlets are seemingly left without positive alternatives for dealing with the stresses affecting them.

As stated, this study proposes attempting, through training, to make health care providers aware of a tool that may help them avoid burnout yet participate in empathic relationships with their patients. This tool permits closeness yet allows individuals to remain separate, a key to avoiding burnout. "Separate" refers to an individual's healthy and necessary need to perceive him or herself as distinct from other people (Cloud & Townsend, 1992). Practicing "separatness" in place of "emotional distance" may mean that health care providers can enjoy closeness without retaining toxic levels of emotional pain and stresses percipitated by

the crises and irritations of typical and not-so-typical work days. The tool is called "boundaries" -- a concept developed by Drs. Henry Cloud and John Townsend. According to Cloud and Townsend (1992), healthy emotional boundaries allow individuals to feel and appropriately deal with their emotions while maintaining the ability to practice separatness from the harmful, manipulative emotions and actions of others. They add that use of emotional distance at best is only a temporary boundary for people who have experienced such trauma as abuse and need a safe place to "thaw out" (Cloud & Townsend, 1992). Cloud and Townsend (1992) note that practice of emotional distance is "never a permanent way of living" (pg. 36). The concept of boundaries has been successfully applied in a clinical setting but has never been applied from a communication perspective to the problem of burnout in the health care field. Nor has the concept been tested quantitatively within the framework of communication.

The practice of developing boundaries may prove to be particularly useful to the health care profession as its concept of "close yet separate" would also allow care-givers to empathically link with terminally ill

patients without retaining toxic levels of grief and/or anger. Before elaborating further on the concept of boundaries as a training program and the results of a pilot study and formal training session, the literature on existing training programs both from a communication and empathic perspective will be reviewed.

Literature Review

Training Programs From a Communication Perspective

Training programs by Lubbers and Roy (1990) and Martin and Barkin (1989) examined the importance of teaching nurses communication skills to enhance their role as patient educators. Although health communication research has typically targeted the patient-physician relationship, these researchers agreed that providing communication skills training to nurses was important in that the nurse often serves as a communication link between the doctor and the patient in the transfer of information.

Both training programs examined communication activities including listening, instructing, relationship building, giving feedback, motivating, exchanging information and use of nonverbal expressions. Lubbers and Roy's (1990) study identified

the above six activities as key communication skills best suited to enhancing nurses' skills in health care delivery and improved quality care. The study also identified the need for health care facilities to provide nurses with continuing communication skills education. Martin and Barkin (1989) also identified certain patterns of nonverbal and verbal strategies used by nurses to facilitate patient education, but indicated that the effectiveness of multiple strategies in improving communication with various types of patients requires more study.

Studies link and show a direct relationship between between an increasing breakdown in doctor-patient communication and widespread patient dissatisfaction (Korsch, 1989). Several studies have discussed the need to address patient satisfaction through communication skills training. Evans, Stanley and Burrows (1992) describe patient satisfaction as the patients' positive perception of the amount and clarity of communication with the provider and their perception of the amount of warmth, caring, and concern exhibited by the provider. In broad terms, each of the studies alluded to the consumeristic shift in patients'

attitudes towards their physicians. This shift has contributed to patients' growing awareness of their dissatisfaction with physicians' loss of an emphasis on interpersonal variables.

Each of the studies targeted to some degree the amount and clarity of information given to patients as well as doctors' expressions of caring and respect as areas needing improvement. The studies agreed that training programs designed to help physicians improve these areas would positively impact patient satisfaction. The studies also revealed that doctors find determining patients' reasons for making medical appointments and persuading patients to modify health behaviors their two most difficult tasks. This factor appears to precipitate a doctor-centered rather than a patient-centered interaction thus contributing to deficiencies in the areas cited by patients experiencing dissatisfaction. Engel (1978) points to the prevailing biomedical model, which is disease-oriented rather than patient-oriented, as another contributor to the tendency of doctors to approach patients from a more mechanical perspective. Engel proposes combining the medical, psychological and

social needs of patients in a biopsychosocial model to be taught at the general competency level. Kline and Ceropski (1985) expanded this thought with the idea that, depending on the patient, one communication style may be more effective than another. They coded their patient-centered training program into three categories of (1) regulative appeals, (2) interpersonal appeals, and (3) informational appeals both at the level of denying individual perspectives and recognizing individual perspectives.

While these studies provide general thoughts about the interconnectedness of such communication variables as empathy, listening and information exchange and their positive impact on patient satisfaction and health outcome, Gerteis, Edgman-Levitan, Daley and Delbanco (1993) provide a specific example. Gerteis et al (1993) report the results one doctor achieved after incorporating the communication variables of empathy, listening and increased information exchange.

Concentrating on patients with chronic illnesses, the doctor spent additional time talking with each individual on the day of discharge. The doctor discussed in detail what each patient could or could

not do at home and listened to the patient's understanding of the instructions. Although incorporating the above activities caused the doctor to spend more time on hospital wards, the doctor reported seeing decreased morbidity in several of his patients and feels his actions may have prevented early readmission for others. The doctor also reported receiving fewer phone calls from patients seeking clarification once they were home. The most dramatic example involved a patient hospitalized three times in six months due to renal failure and electrolyte imbalance. The doctor spent extended time with the patient on the day of discharge. Using the above communication variables the doctor revealed misconceptions the patient had about diet and medicines. At the time of the report the patient had done well at home for more than eight months (Gerteis et al, 1993). Overall, Gerteis et al. found that more time was saved than was required to develop the more empathic relationship.

Evans, Stanley and Burrows (1992) added that physicians' ability to raise patient satisfaction in the areas discussed can lead to the elicitation of

more accurate information from patients thus aiding diagnoses. Each of the studies concluded that communication skills training programs addressing the issue of patient satisfaction were necessary. Training programs also appeared to be more successful if administered to medical students as opposed to practicing physicians. Practicing physicians were found to be more resistant to change and less willing, due to time constraints, to participate in training. Medical students on the other hand, already working in a learning environment, were found to respond to communication skills training programs and showed dramatic improvements in interpersonal skills (Evans, Stanley & Burrows, 1992).

Two studies examined communicaton between patient and physician from a meta-analysis perspective. Roter, Hall and Katz (1988) identified over 200 unique patient and provider variables and grouped them in six categories of communication process variables: information-giving, information-seeking, partnership-building, social conversation, positive talk and negative talk. While the researchers admit they used few formally recognized meta-analytic techniques, their

goal was to present descriptive data for studies of the communication process itself. Like some of the previous programs we have already looked at, this study also states that the patient-provider relationship is undergoing revolutionary changes toward a more consumerist orientation. These researchers feel their study may support intervention programs targeted at changing physicians' communication behaviors towards a more partnership-oriented perspective.

Roter and Hall (1991) also looked at the dynamics of patient-physician behavior within the context of the medical visit. Using meta-analysis, Rotor and Hall looked at the communication variables listed above but examined them within the framework of a model loosely derived from social exchange and reciprocity theory. The researchers suggest that provider behaviors within the technical and socioemotional domains can generate parallel patient behaviors and attitudes. While their study provided some evidence to support this hypothesis, they felt the reciprocity principle in the medical exchange also contributes to the field of health education and the consumerist perspective which lifts the patient from a role of passivity to one of

activity and partnership.

The last two studies, Omololu (1984) and Farsad et al. (1977) focused upon improving the interviewing techniques of medical students. Both studies agreed there is enough communication research in the area of health care to begin to identify appropriate and inappropriate communication behaviors. Most learning was found to take place in the outpatient rotation. In short-course programs, interns were found to be able to improve their interviewing skills.

From An Empathic Perspective

Morath (1989) approaches empathy training from the perspective of developing sensitivity and caring in hospitals. Morath (1989) asserts that people come to the hospital to be cured and cared for and that sensitive and responsive interactions are fundamental to the creation of a "healing environment." She further adds that hospitalization is stressful for patients and care-givers working within the hospital environment must deal with these stresses. She states that use of empathy is most effective in this environment (Morath, 1989).

Working on the assumpation that empathy can be

learned, Morath (1989) advocates administering a process-oriented small group training program over a period of weeks that focuses on increasing perspective-taking and role-taking skills. Role-taking permits care-givers to explore verbal and non-verbal communication as a means of addressing patient's fears, irritations and demands. Morath (1989) concludes that by working in small groups, care-givers can be trained to become aware and sensitive.

Hughes (1995) addressed the high anxiety student nurses often experience during their first interactions with critical care patients. Desiring to strengthen and legitimize the philosophy of nursing caring, Hughes (1995) discussed a training program that would assist students in focusing on the patient from a caring perspective rather than feeling paralyzed by the equipment and paraphenalia surrounding critical care patients. Hughes (1995) stated that to teach caring behaviors to nursing students, the trainer must consider how both nurses and patients perceive "caring." Hughes (1995) promoted the use of 10 carative factors: (1) formation of a humanistic-altruistic system of values; (2) installation of faith

and hope; (3) cultivation of sensitivity to one's self and to others; (4) development of a helping-trust relationship; (5) promotion and acceptance of the expression of positive and negative feelings; (6) systematic use of the scientific problem-solving method for decision making; (7) promotion of interpersonal teaching-learning; (8) provision for a supportive, protective or corrective mental, physical, sociocultural, and spiritual environment, (9) assistance with gratifcation of human needs; and (10) allowance for existential-phenomenological forces. According to Hughes (1995), assisting students to identify and practice carative factors in a clinical setting helped them "unveil" the patient from the tubes and equipment to see the real person.

Feighny, Monaco, and Arnold (1995) examined empathy training as a means of improving physician-patient communication skills. Feighny, Monaco and Arnold (1995) conceptualized empathy as a physician's cognitive capacity to understand a patient's needs, affect sensitivity to a patient's feelings, and convey empathy through behavior. The training goal of these researchers was to determine whether or not educational

intervention could raise medical students' empathy levels for patients (Feighny et al., 1995). A second objective was to determine whether increased empathy would facilitate physician-patient communication skills.

Using first-year medical students as participants, a three-stage educational model was created utilizing simulated scenarios of illness from the patient's perspective as well as role playing corrective feedback (Feighny et al., 1995). While the model is to undergo further testing, researchers reported that the pilot test revealed significant positive correlations (Feighny et al., 1995).

Presswalla, Rose, and Cornett (1995) conducted a pretest-posttest experimental study to look at the effect of a teaching strategy called "The Circle of Life" on nursing students' knowledge, attitudes and caring for individuals with AIDS. According to Presswalla, Rose and Cornett (1995) research revealed that nurses' attitudes towards patients with AIDS or HIV were negative. Negativity was classified as either AIDS-related stigma or homophobia.

According to Presswalla, Rose, and Cornett (1995),

"The Circle of Life" is a simulation design based on the empathy learning model. In effect, "The Circle of Life" through simulation, places the care giver in the shoes of the HIV or AIDS patient. This exercise is expected to increase the empathy and sensitivity of the care-giver. Presswalla, Rose, and Cornett (1995) concluded that all participating students showed a marked increase in knowledge about AIDS and some improvement in attitude towards AIDS patients. The researchers also commended the training as a timely tool that could help providers develop a concerned, caring relationship with AIDS patients as opposed to relationships complicated by criticism and condemnation (Preswalla, Rose, & Cornett, 1995).

The Boundaries Training Program

The aforementioned studies discussed teaching empathy and identifying communication variables for the purpose of examining and facilitating interaction between physicians and patients. The studies also presented ways to improve various aspects of physician communication skills and raise patient satisfaction levels.

However, none of the training programs reviewed

addressed the overall problem of how care-givers can link empathically with patients yet remain separate and avoid burnout. Further, these programs appeared to discuss training in general terms rather than offering specific guidelines for teaching empathy in tandem with the proper emotional tools to process stresses that could lead to burnout - two important objectives that affect both patient satisfaction levels and improved health outcomes.

Developing a training program that applies the concept of boundaries to the special problems experienced by health care professionals may offer a solution. A boundary is an emotional "property line" that helps individuals understand what they are responsible for in terms of feelings, attitudes, behaviors, limits and choices (Cloud & Townsend, 1992). A boundary defines who the individual is and who the individual is not. More importantly, boundaries show individuals where they end and others begin. Cloud and Townsend's (1992) "boundaries" make it possible for people to be as close as they wish yet remain emotionally separate. Boundaries also make it possible for individuals to disengage from the harmful

manipulations of others. It is suggested that boundaries can also assist care givers in appropriately owning and letting go of the powerful emotions associated with patient suffering and the loss of a patient. This idea is also key to the boundaries concept of "close but separate."

Based upon this rationale, a training program has been developed that presents the basic concepts of boundaries from a communication perspective. The goal of the training program is to acquaint care givers with the boundaries tool as an aid to maintaining empathic links with patients while learning to remain emotionally separate and thus avoid burnout. Unlike the training programs reviewed which offered general information, this training program will include examples detailing how care givers might implement boundaries. Examples will extend to include details on how to implement boundaries in situations involving overwork and critical co-workers, thus helping care givers effectively deal with the stresses of their environment as well. It is important at this point to mention that the training concludes by making individuals aware of the cost they may incur if they

choose to use boundaries. According to Drs. Cloud and Townsend (1992) initial attempts to establish appropriate boundaries typically result in higher levels of anxiety and greater internal and external resistance (Cloud & Townsend, 1992). Cloud and Townsend (1992) go on to state, however, that this initial "emotional upheaval" is a welcome sign that the individual is establishing appropriate boundaries. Weathering the "storm" these new boundaries may percipitate will result in new emotional growth and maturity (Cloud & Townsend, 1992).

Care givers receiving the training will be asked to complete an Inventory of Interpersonal Concerns (IIP/C) as a pre-test and post-test. A control group comprised of care givers will also be asked to complete the pre and post-tests but will not receive the training. It is hypothesized that individuals receiving the boundaries training will show more improvement on their post-test scores than will participants of the control group who do not receive the training. Based on Cloud and Townsend's rationale that individuals initially experience higher levels of anxiety and difficulty when first establishing boundaries, post-

test experimental scores should show improvement by being higher than pre-test experimental scores or control group scores.

Chapter Two

Methods

Participants

Participants for the pilot test, formal training and control group were health care professionals from a local nursing home facility, pediatric hospital and doctor's office. Selection of participants for the pilot test were based on a convenience sample. A volunteer sample was used for both the experimental training and control groups.

Instrumentation

An Inventory of Interpersonal Concerns (IIP/C), modified from Leonard Horowitz' (1988) Inventory of Interpersonal Problems, was selected as an appropriate measurement tool to administer as a pre and post-test to care givers in the pilot, training and control groups. The title of the inventory was slightly modified to appear less threatening to participants and relay the message that care givers have "concerns" rather than "problems." Modification also occurred in terms of the inventory itself. The original inventory contained 127 questions. Due to a one-hour time

constraint for training, the inventory was reduced to 30 questions that specifically dealt with issues of confrontation, authority, ability to say no, ability to set limits on others, ability to reveal feelings and people pleasing. This self-report inventory was selected to assess the effectiveness of the boundaries training program due to its ability to identify interpersonal problems discussed most often in psychotherapy. In summary, the inventory was also determined to meet content validity for the present study because it identified enmeshment and detachment issues pertinent to an individual's need for boundaries, individuation and separation. These variables, and those stated above, are key to measuring health care providers' grasp of boundaries concepts an whether or not they are attempting to use boundaries to develop empathic relationships with their patients, remain separate and thus avoid burnout. Research cited below shows that the IIP/C also meets the need for an easily administered self-report inventory by describing the types of interpersonal problems people experience and the level of distress associated with them (Horowitz et al., 1988).

Research presented by Horowitz, Rosenberg, Baer, Ureno, and Villasenor (1988) details psychometric data for 103 patients who were tested at the beginning and end of a waiting period before beginning brief dynamic psychotherapy. During both periods, a factor analysis provided the same six subscales - (1) assertive; (2) sociable; (3) submissive; (4) intimate; (5) responsible and (6) controlling (Horowitz et al., 1988). These scales showed high internal consistency and high test-retest reliability (Horowitz et al., 1988). Following administration, values of alpha ranged from .82 to .94, and the test-retest correlation coefficients across the 10-week waiting period ranged from .80 to .90 (Horowitz et al., 1988). The Inventory of Interpersonal Problems was deemed a promising new instrument that specifically measured distress due to interpersonal problems (Horowitz et al., 1988). The IIP/C's subscales also apply directly to the measurement of boundaries.

Procedure

In order to develop a boundaries training program for pilot-testing and formal administration, it was important to build the program to fit the time contraints faced by health care providers. Attendance

function of emotional boundaries to provide health professionals with a concrete example from their field of expertise. Like emotional boundaries, the skin acts as a physical boundary to keep good things in (food) and let bad things out (perspiration and waste). After attempting to provide care givers with a basic foundation, the program moved to specific examples of situations care givers may encounter with patients, family members, co-workers and supervisors. The program addressed these situations by presenting actual steps (as outlined by Drs. Cloud and Townsend) care givers might wish to follow in order to begin establishing boundaries. The program is provided in full detail in Appendix A.

Pilot Testing

After the initial development of the training program, it was pilot tested at local nursing home. In the case of the nursing home, optimum training availability was determined to be after the completion of the work day.

Two social workers and two dieticians entered a classroom-like setting and sat facing the trainer. The training was administered in a lecture-style format

was determined to be a key factor in successfully accomplishing the program's goal. Based on feedback received from administration and education personnel at the local health facilities targeted for pilot testing and formal training, the program was designed to be administered within a one-hour time frame. To comply with the one-hour time frame and still provide health care professionals with enough information to begin using boundaries, the content of the program focused on six key areas - boundary identification, what items fall within individual boundaries, identification of boundary weaknesses, using boundaries to cope with overwork, difficult co-workers and patients, critical attitudes and future implications should individuals decide to use boundaries.

To maximize the time alloted for training, the program began by helping care givers understand what a boundary looks like and how it operates. The training program attempted to facilitate care giver understanding by relating boundaries and their functions to concrete objects. One general example included a fence with a gate. The trainer also compared the functions of the human skin to the

and concluded with a short question and answer period. Before releasing the participants, an evaluation form was administered for the purpose of gaining feedback to make improvements to the training program. All four participants felt the material was pertinent to their professions. The participants seemed to find the portions dealing with critical attitudes and conflicts the most helpful. Three of the participants also suggested that more concrete examples of how boundaries can be applied to specific patient/provider interactions be provided. Participants agreed that visual aids would also be beneficial.

In response to the feedback provided, the sections dealing with critical attitudes and conflicts were retained. After interviewing a nurse from a critical care unit at a local hospital, a training administrator for a local pediatric hospital, and a local psychologist, the following sections were added. Entitled "Dealing With Suffering and Death," the first section addressed care-givers work with patients experiencing long-term or terminal illnesses. This group included infants and children. The section pointed to the use of internal boundaries and walked

care-givers through suggested steps for implementing internal boundaries. The second section, called "Parents and Family Members" suggested a mix of internal and external boundaries and provided suggested steps for implementation. Eight transparencies were developed to support the ideas presented in the training materials. The transparencies reinforced boundary concepts using simple cartoons. To complete the pilot test, the IIP/C was readministered a month later through the mail. Three out of four of the self-reports were returned. Pre-test and post-test scores were compared to determine the significance of the pilot test. The results indicated some improvement over time.

Formal Training

Upon completion of the pilot study and modification of the training program, it was presented to and approved by the nursing and research boards of a local pediatric hospital for formal administration. Feedback from the nursing board and the education coordinator at the hospital revealed the lunch hour as the optimum time for training availability. Employees were made aware of the training through standard

advertising channels within the hospital. These included the hospital newsletter, flyers and internal e-mail announcements. Motivation to attend was further increased with the offer of continuing education credits. Twenty-two employees (the capacity of the training room) signed up to attend the training. Training slots were filled the same day promotion materials were released.

The training was administered on April 9, 1996 from 11:00 a.m to 12:00 p.m. to care givers dealing primarily with infants and children suffering from cancer and other long-term illnesses. Twenty employees actually attended the training, a number considered by the training coordinator to be unusually high. The coordinator indicated that due to a varity of environmental factors such as emergencies and time constraints, employee attendance of scheduled training was consistently poor.

Upon entering the room, participants were asked to sit at tables set in a U-shape classroom style. The training program was administered in a lecture-type format. The trainer provided a brief introduction about the training program and the IIP/C. The trainer

noted the credentials of the IIP/C. Copies of the IIP/C were passed to participants. Participants were asked to complete the pre-test prior to receiving the training program. Once participants completed the IIP/C, the education coordinator collected the self-reports. The trainer administered the training program utilizing the transparencies at the appropriate intervals. Training concluded with a short question and answer session. Following the question and answer session, the trainer passed out hand-outs which included the boundary concepts covered in the training as well as a 1-800 phone number should participants wish to obtain the boundary materials written by Drs. Cloud and Townsend. Finally, participants were given a second IIP/C with a stamped, addressed envelope and instructions to complete and mail the second IIP/C two weeks after the initial training date.

A control group comprised of care givers from the pediatric hospital and a local doctor's office also received the IIP/C pre and post-tests and were instructed when to complete and return the tests to the trainer. Control group scores were used to determine whether or not the simple act of completing the IIP/C

influences differences between control group scores and experimental scores.

Data Analysis

T-tests on individual and group scores were conducted to determine if the post-test scores of trained participants show significant increase when compared with pre-test scores and the scores of the control group.

Chapter Three

Results

Independent samples t-tests comparing experimental and control groups were run on the individual variables of the IIP/C and its subscales. Means for pre- and post-experimental scores showed no significant differences except for on one variable. The variable "authority" (Question 9. It is hard for me to get along with people who have authority over me.) , as listed in Table 1 (see Table 2 for key to labels), showed that the pre-experimental score was significantly different from the post-experimental score ($t=2.37$, $df=34$, $p=.0298$). The post-test mean score was higher than the pre-test mean score, indicating greater anxiety and difficulty with the item. Pre- and post-test control scores showed no significant differences. Pre- and post-experimental scores for the five subscales (assertive, sociable, submissive, intimate and responsible) also demonstrated no significant differences. The same was the case with pre- and post-control scores. A series of t-tests for paired samples comparing change scores for the experimental group with the change scores for the

Table 1

Means For Items And Subscales

	Pre-Experimental	Post-Experimental	Change Experimental
Angry	2.4737	2.3529	.1207
Argue	2.9474	2.7059	.2415
Assertive	2.5789	2.6471	-.0681
Authority	1.4211	2.1176	-.6966
Blame	2.1579	2.4706	-.3127
Confront	2.7368	2.7647	-.0279
Demand	2.4211	2.7059	-.2848
Dependent	2.0526	2.5294	-.4768
Disagree	2.5263	2.5294	-.0031
Disappoint	3.3684	3.0588	.3096
Distance	2.2105	2.4706	-.2601
Feel	2.6842	2.5882	.0960
Firm	2.3684	2.5882	-.2198
Limits	2.5789	3.0588	-.4799
Loss	3.3158	3.1176	.1981
Misery	2.8421	2.4706	.3715
Moods	2.8421	2.5882	.2539

Table 1 (Cont.)

	Pre-Control	Post-Control	Change Control
Angry	2.2000	2.3333	-.1333
Argue	2.4667	2.3750	.0917
Assertive	2.6667	2.5333	.1333
Authority	1.2000	1.3750	-.1750
Blame	1.8000	1.6875	.1125
Confront	2.8000	2.5333	.2667
Demand	1.8667	1.8750	-.0083
Dependent	1.6667	1.7333	-.0667
Disagree	2.3333	2.0667	.2667
Disappoint	3.0667	2.8125	.2542
Distance	2.0000	2.0000	.0000
Feel	2.0000	2.0625	-.0625
Firm	1.5333	1.9375	-.4042
Limits	2.6000	2.3750	.2250
Loss	2.8000	2.8750	-.0750
Misery	2.4667	2.1250	.3417
Moods	2.4667	2.3750	.0917

Table 1 (Cont.)

	Pre-Experimental	Post-Experimental	Change Experimental
No	3.0526	2.7647	.2879
Don't Like	2.4737	2.5294	-.0557
Open Up	2.6842	2.5294	.1548
Persuaded	2.5263	2.2941	.2322
Please	3.2105	3.1765	.0341
Reactions	3.2632	3.0588	.2043
Solving	3.1053	2.8235	.2817
Stop	3.1053	2.7059	.3994
Advantage	2.7895	2.8235	-.0341
View	2.3158	2.4706	-.1548
Want	2.9474	2.7647	.1827
Welfare	3.1579	2.7059	.4520
Worry	3.3158	3.4118	-.0960
<u>Subscales</u>			
Assertive	43.3158	43.0588	.2570
Sociable	4.8947	5.0000	-.1053
Submissive	3.8947	4.6471	-.7523
Intimate	5.3684	5.6471	-.2786
Responsible	23.8421	22.3529	1.4892

Table 1 (Cont.)

	Pre-Control	Post-Control	Change Control
No	3.0667	2.8750	.1917
Don't Like	2.0667	2.5000	-.4333
Open Up	2.7333	2.5000	.2333
Persuaded	2.0667	2.0000	.0667
Please	3.0000	2.9375	.0625
Reactions	2.8667	2.5000	.3667
Solving	2.5333	2.5625	-.0292
Stop	2.4667	2.4667	.0000
Advantage	2.7895	2.8235	-.0341
View	1.9333	1.8750	.0583
Want	2.0667	2.5333	-.4667
Welfare	3.3333	2.8125	.5208
Worry	3.2000	2.6875	.5125
Subscales			
Assertive	37.4000	35.1250	2.2750
Sociable	4.7333	4.5000	.2333
Submissive	3.2667	3.8750	-.6083
Intimate	4.4667	4.6875	-.2208
Responsible	21.5333	19.8125	1.7208

Table 2

Key To Variable Names and Subscales

It Is Hard For Me To:

Angry = 8. let other people know when I am angry.

Argue = 14. argue with another person.

Assertive = 5. be assertive with another person.

Authority = 9. get along with people who have authority over me.

Things You Do Too Much:

Blame = 27. I blame myself too much for causing other people's problems.

It Is Hard For Me To:

Confront = 4. confront people with problems that come up.

Demand = 11. make reasonable demands of others.

Dependent = 6. have someone dependent on me.

Disagree = 7. disagree with other people.

Things You Do Too Much:

Disappoint = 26. I worry too much about disappointing other people.

Distance = 28. I keep other people at a distance too much.

Table 2 (Cont.)

It Is Hard For Me To:	
Feel =	17. feel angry at other people.
Firm =	12. be firm when I need to be.
Limits =	13. set limits on other people.
Things You Do Too Much:	
Misery =	30. I am affected by another person's misery too much.
Moods =	24. I am affected by another person's moods too much.
It Is Hard For Me To:	
No =	1. say "no" to other people.
Don't Like =	15. maintain a working relationship with people I don't like.
Open Up =	18. open up and tell my feelings to another person.
Things You Do Too Much:	
Persuaded =	22. I am too easily persuaded by others.
Please =	23. I try to please other people too much.
Reactions =	25. I worry too much about other people's reactions to me.

Table 2 (Cont.)

Solving = 21. I feel too responsible for solving other people's problems.

It Is Hard For Me To:

Stop = 3. tell a person to stop bothering me.

Advantage = 29. I let others take advantage of me too much.

It Is Hard For Me To:

View = 10. stick to my own point of view and not be swayed by other people.

Want = 2. let other people know what I want.

Welfare = 19. attend to my own welfare when somebody else is needy.

Worry = 20. be assertive without worrying about hurting the other person's feelings.

Subscales:

Assertive = (I1, I2, I3, I4, I5, I7, I8, I10, I11, I12, I13, I14, I17, I20, I22, I29)

Sociable = (I18, I28)

Submissive = (I9, I15)

Intimate = (I6, I16)

Responsible = (I19, I21, I26, I27, I30, I23, I25, I24)

control group showed no significant differences.

Cronbach's alpha values were computed on each of the subscales to determine reliability coefficients. The assertive subscale had a reliability coefficient of .89. The sociable subscale scored .55. The submissive subscale scored .52. The intimate subscale scored .77. The responsible subscale scored .85. The sociable and submissive subscales were the only scales failing to show acceptable reliability. These subscales contained only two items each.

Chapter Four

Discussion

Exploration of appropriate emotional boundries as a potential tool to aid care-givers in maintaining empathic relationships with their patients while avoiding burnout has included the development, pilot testing and administration of a formal training program. The IIP/C was selected as a measurement tool and administered to both the experimental and control groups to determine whether or not the experimental group showed any improvement following the training. Individual samples and paired samples t-tests showed no significant differences except for on one variable - the "authority" item. The lack of statistical findings will be noted along with the results of a formal evaluation of the training program conducted by the pediatric hospital that participated in this study. It is suggested that the hospital evaluation may offer insight into the true value of the training concepts. Limitations of the study and suggestions for future research will follow.

Interpretation

As previously stated, *t*-tests showed no significant findings except for on the authority variable. It is, of course, possible that the significant difference of this variable could be the result of experiment wise error and, thus, a random result. In the event that it is not, it could indicate that care givers at the pediatric hospital are highly ego-involved with issues surrounding the dyadic relationship between themselves and people who are in authority over them. High scores on this inventory item for both the pre- and post-experimental tests could indicate that care givers recognize that it is difficult for them to get along with people in authority over them. Further, the fact that the post-test experimental mean was higher than the pre-test experimental mean could suggest that care givers were attempting to apply boundary skills to this particular dyadic relationship. If this is the case, the higher post-test experimental mean could point to earlier discussions in this study about the high anxiety and difficulty attached to individuals' initial attempts to use boundaries. Drs. Cloud and Townsend (1992) agree

that people face a risk in setting boundaries and taking control of their lives. However, they add that "running into resistance is a good sign that you are doing what you need to do (pg. 268)." Cloud and Townsend (1992) conclude that it is not uncommon for individuals applying newly acquired boundary skills to initially experience increased anxiety and feel that the situation is worse instead of better.

While the noted finding may be a random result, hospital educators might find it useful to investigate this issue as a possible area of stress for care givers. Training programs that include ways to improve communication between care givers and supervisors might enhance understanding. Team-building skills that emphasize partnering might also be appropriate. Training programs teaching supervisors how appropriate communication can reduce stress levels for care givers could also tie into increased understanding and team building skills.

As previously mentioned, *t*-tests for paired samples comparing change scores for experimental groups with change scores for control groups also showed no significant differences. Based on the short amount of

time allotted by the hospital for the initial training program and the amount of time it takes to implement boundaries, these results are not surprising. Individuals thinking about establishing appropriate emotional boundaries must first assess and evaluate areas of emotional damage. Repair of such damage, implementation, and mature growth of boundaries is a process that can only occur over time (Cloud & Townsend, 1992). It is realistic to assume that one training program may make care givers aware of the boundaries tool and motivate individuals to think about the tool. It would not be realistic to assume that individuals could implement and nurture boundaries to a mature growth level with only one training session.

Additionally, the small sample size of the present study leads to low power. It is possible that a larger sample would yield more significant differences. Examination of the means in Table 1 does indicate that more change in the hypothesized direction occured in the experimental group than in the control group.

The true value of the training program may, however, be found in the results of a formal evaluation of experimental group members by the pediatric

hospital's corporate education department. According to the director of the hospital's education department, the results of the evaluation are particularly significant due to the fact that care givers at this hospital are traditionally non-compliant in regard to training and scores for previous training programs have been consistently rated as poor.

All twenty participants from the experimental group completed the hospital's evaluation form. Fifty percent of participants rated the presentation of the boundaries training program as high. Forty percent of participants also gave high ratings for the usefulness of the handouts and the audio visual materials. One hundred percent of participants indicated they could explain the concept of boundaries while 95 percent stated they could recognize the feelings, attitudes and behaviors that fall within an individual's boundary responsibilities. Ninety percent felt they could identify possible boundary behavior weaknesses and apply boundary knowledge to improve interpersonal relationships. Fifty percent of participants rated the value of the information to their work as high and 90 percent of participants indicated they would like to

attend additional training sessions on boundaries.

The results of the course evaluation combined with the established historical information about this group of care givers' resistance towards training and non-compliance regarding attendance, may suggest these training concepts have value for the health care field. Written comments included by a portion of the care givers who evaluated the training also appears to support this idea. Care givers wrote they were interested in the trainer returning to administer additional sessions and asked that the sessions be longer. High interest in additional training combined with 90 percent of care givers who reported they could identify possible boundary behavior weaknesses and apply boundary knowledge to improve interpersonal relationships, are key elements necessary to successful implementation of boundaries. The individual benefits gained from the use of boundaries appears to complement the trend driving hospitals toward a more team-oriented approach to health care. The information contained both in this study and the hospital's evaluation of the training could also aid this pediatric hospital in strengthening its internal structure while taking steps

to reduce the stresses experienced by its care givers.

Limitations

In examining the limitations of this study it is important to begin by discussing the limitations of the training program itself. Due to the hospital's initial resistance to the training and the time constraints faced by care givers participating in the training, only one hour was allotted for administering the pre-experimental IIP/C, training concepts and continuing education credits. The time constraint did not permit the training program to do much more than make care givers aware of the boundaries tool. More time was spent explaining the concept and giving examples of applications within the health care setting than was spent discussing ways to weather the initial emotional "storm" should individuals choose to use the tool. Although information was provided to care givers on how to obtain in-depth information about the boundaries concepts, the lack of information about what to expect could prove a limitation to individuals attempting to use the tool.

As mentioned, the lack of significant differences among scores tested may be partially due to the small

sample size. The small training room offered by the hospital also limited the size of participants. Although the sociable and submissive subscales showed low reliability, it is necessary to point out that these subscales contained only two items each and were not considered key to the boundary issues presented in the training program. The pertinent variables identifying key boundary issues were contained in the subscales which tested as reliable.

The fact that the pre- and post-control group scores did not show significant differences could suggest internal validity, in that the process of taking the inventory itself appears not to have sensitized control group members. In discussing the results of the IIP/C it is also important to point out the limitations of a pencil and paper self-report. Responses are dependent on each individual's willingness to respond honestly and could be influenced by social desirability, by outside factors such as how the person is feeling the day they fill out the self-report, or in this case, by how in touch they are with their emotions. Despite its limitations, the self-report is still considered one of the best ways to

measure "black box" concepts. Based on the high test-retest reliability of the IIP/C in the clinical setting, this particular self-report was considered an appropriate measurement tool for this study.

As previously stated, experimental and control group members were selected based on a volunteer sample. The limitation of this type of sample is that it may not be representative of the population. However, as the success of the training program is dependent on the interest and motivation of individuals to implement the concepts it is suggested that a volunteer sample in this case was not inappropriate.

Difficulty in gathering the post-experimental data was a serious limitation to this study. It is suggested that in broad terms history, maturation and mortality played a part. Initially, only nine responses out of 20 were returned within the allotted time. Three mailings of blank IIP/Cs with stamped, self-addressed envelopes and a series of follow-up phone calls by the education coordinator over a period of a month and a half were required to elicit eight more responses for a total of 17 post experimental IIP/Cs. Prior to the study, the hospital's education

coordinator discussed the established history of care givers' non-compliance as a caution. Mortality may have been an issue from the standpoint that once care givers received their continuing education credits they lost interest in completing the study. Maturation could have influenced post-experimental responses from the standpoint that a portion of the individuals trained may have completed the study out of resentment over the pressure exerted by the researcher and the education coordinator to return post-experimental data. Due to the length of time that elapsed between completion of the pre and post experimental data, history could also have influenced the final responses. However, in light of the fact that authority seems to have become more of a concern for these participants, there may have been a purpose behind these responses rather than mere coincidence based on the influences of history, mortality or maturation.

External validity also presents a limitation from the standpoint of generalizability of the training program itself to other audiences. Use of continuing education credits to motivate care givers to attend the training session affects generalizability from the

standpoint that other audiences could not expect a tangible reward in exchange for adopting the boundaries concepts.

Secondly, although the boundaries concepts have been clinically demonstrated to be both successful and life-changing, generalizability hinges on the individual's willingness to accept the personal costs associated with using boundaries. Accepting the "costs" means each individual must initially face the fear of the unknown, exhibit willingness to step out in faith and weather the initial storms to live a healthier life. While the concepts can be presented, the true success of their implementation requires the individual to chose for themselves and not because they have been persuaded by outside sources.

Future Research

It is necessary to note suggestions for overcoming the limitations mentioned in this study but more emphasis will be placed on how future training sessions should be conducted. It is suggested that proper administration of the training could enhance implementation of the concepts and provide data that would more clearly define the progress of care givers

attending additional training sessions.

Care givers' requests for additional and longer training sessions does seem to indicate that individuals would be receptive to a series of training sessions, thus aiding future researchers in overcoming the limitation of a short, one-time-only training program. The waiting list of potential attendees compiled by the hospital's education director also indicates that it would be possible to gather a larger sample group. The hospital would also need to provide a larger facility for future sessions, as the original training program was limited to the small capacity of the training room.

A longitudinal study combined with multiple training sessions might also provide a more appropriate environment for gathering more definitive data showing a pattern of boundaries implementation, growth and maturation over time. It is possible that such a study could identify initially high scores related to implementation of boundaries followed by progressively lower scores related to boundary growth and maturation.

Other outcomes measures should also be utilized in future research. Meta-analysis studies of exit

interviews to determine root causes for nursing turnover rates has been applied to the health care field (Fottler et al., 1995). Use of this approach to determine levels of professional burnout and its tie to turnover rates might not only build on existing research but contribute new information about the role of boundaries and boundary training in health care. Identifying and coding the outcomes of using boundaries during a study of multiple training sessions might also offer more definitive data. Additionally, other dependent variables that might be affected by burnout, such as interactional factors or absenteeism, should be investigated.

Compliance in returning the post-experimental data might be improved if the continuing education credits were withheld until the post-experimental data were collected. Compliance might also be improved if the researcher arranged to meet with the trainees and collect the data in person. Once the researcher collected the data, the education coordinator would pass out certificates for the continuing education credits.

How future training sessions are conducted may not

only provide improved compliance rates and more definitive data but also encourage greater implementation and thus generalizability of the boundaries concepts. As mentioned, 90 percent of the care givers who participated in the original training program indicated they were interested in both additional and longer training sessions about boundaries. Multiple training sessions would permit repetition of boundaries concepts and thus improve recall. Longer sessions would allow more in-depth presentation of the material to include such enhancements as role-playing and discussion of ways to appropriately cope with the emotional upheaval associated with initial attempts to use boundaries. Incorporation of role playing to illustrate the use of boundaries in specific situations care givers would typically encounter might serve to reinforce the principles and again, allow for greater recall. Preplanned role playing between the researcher and the education coordinator could serve to prepare trainees for the exercise. Impromptu role playing between the researcher and trainees selected randomly might also prove useful by providing individuals with a way to

"practice" boundaries in a safe environment. The exercise, followed by a critique and suggestions for improvement, might clarify use of boundaries to the group and stimulate additional discussion. Repetition of training sessions throughout the year showcasing the boundaries concepts within the framework of new examples that blend patient, supervisor and co-worker interactions might also serve to entrench the concepts.

Aiding the hospital in establishing a support group for care givers participating in boundaries training might also prove valuable to successful implementation of the concepts. Multiple training sessions and role playing exercises would serve the purpose of helping individuals replace old, unhealthy behavorial tools for boundaries. A support group would provide care givers with an additional "safe" environment within which to practice their new tools and discuss problems they might encounter. It is suggested that a psychotherapist trained in the boundaries concepts might be the most appropriate individual to lead a support group.

Conclusion

Based on the results of the hospital's evaluation,

it appears that the training program met its established goal to make care givers aware of a training tool that could help them establish and maintain empathic relationships with their patients while avoiding professional burnout.

Future trends for care givers seem to point towards continued pressure from insurance companies to contain costs, a consumeristic approach by patients to improve individual health care and internal organizational directives to become more team-oriented. These pressures suggest that communication and the interpersonal relationship may become a care giver's most important diagnostic tool. As communication and the interpersonal relationship continue to become more prominent in health care, it is suggested that burnout may also continue to rise. Within this broad framework, future research in the field of health care communication targeting the dynamics of the dyadic relationship and boundaries as a safety valve could contribute valuable information to this field of study.

For care givers seeking to meet their patients on an emotional level without draining their own reserves, use of boundaries may bring a plethora of benefits from

reduced rates of professional burnout to improved health outcomes for patients. On a personal level, health care providers who choose to use boundaries might also find they have mined an even greater treasure - true personal freedom and emotional maturity - characteristics that can only underscore the valuable contributions health care providers bring to today's society.

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APPENDIX A

How to Love Your Patients, Like Your Job and Keep Your Sanity:

A Training Program For Health Care Providers

Communication studies in the arena of health care tell us that the development of an empathic relationship between health care providers and patients is key to a more positive health outcome for the patient. Yet many health care providers experiencing burnout report this interpersonal relationship as a major contributor.

Research also tells us that the very organizations dedicated to healing individuals, also contribute to the stresses experienced by health care professionals.

Researchers Eileen Ray and Katherine Miller define burnout as a "wearing down from the chronic emotional pressures of human service work." The "symptoms," physical, emotional, and mental exhaustion, can result in a decreasing sense of personal accomplishment and a tendency to depersonalize care recipients.

To do your jobs, each of you must establish an interpersonal relationship of some sort with each of your patients. What makes the health care profession unusual is the stress this interaction can produce for the provider. The relationship is also unique in that the health care provider constantly gives - but rarely receives - emotional resources from this interaction.

Let's take a minute to define what we mean by an empathic relationship. Empathy is the emotional response we feel towards another's suffering. It is the ability to put oneself in the place of another and relate to that individual's feelings. (Slide 1) A care provider might express empathy toward a patient through a reassuring touch, smile or other gesture. Empathy might also be expressed in practical terms such as offering to assist a patient with personal hygiene, incorporate relaxation techniques or breathing exercises to help a patient through a difficult medical exam, or employ communication techniques sensitive to a patient's socioeconomic status, cultural differences or educational level.

Researchers Lief and Fox suggest that health care professionals can open themselves to the vulnerability of emotional attachment with patients yet avoid burnout by maintaining emotional distance. Researchers also suggest that the relationship between a health care provider and his or her supervisor can provide an outlet for the health care provider to vent reactions about work. Co-workers too can act as important buffers against workplace stresses.

Research supports these assessments but recommended training programs tend to leave healthcare providers confused as to how one links up emotionally with a patient while remaining distant. Nor does the training address the needs of health care providers who need to take control of their stresses but do not have the necessary support from supervisors or co-workers.

We're going to talk about a tool that can help each of you take control of your stresses while developing more effective empathic relationships with your patients. The tool is called a "boundary."

Boundaries can help you cope effectively with difficult patients and family members as well as irritating bosses and frustrating co-workers. Boundaries allow you to grieve over a patient with whom you have empathically linked and yet let go of the grief in the event of the patient's death. Boundaries permit you to care for a patient through long-term suffering, empathize with family members and let go.

Drs. Henry Cloud and John Townsend have developed a set of explanations that describe how healthy emotional boundaries allow us to feel and appropriately deal with our emotions while maintaining the ability to

disengage from the harmful, manipulative emotions and actions of others. Whether we possess healthy boundaries or are boundryless, the learning process actually begins when we are infants. If we find as adults, that our boundaries are damaged or nonexistent, we can choose to retrain ourselves and begin to build and practice solid, healthy boundaries.

WHAT DOES A BOUNDARY LOOK LIKE?

The first step to practicing healthy boundaries is to begin recognizing what they look like. We can all relate to things like fences, property lines or walls. These are physical boundaries that border properties owned by individuals. We also recognize and understand the meaning of signs that may accompany these property divisions such as "Keep Off The Grass," "No Trespassing" or "Welcome."

We can't see them, like we can the fence that may border our yard, but our emotional boundaries are similar to our property boundaries because they define US. They define what we are and what we are not. Emotional boundaries show us where we end and someone else begins. Such awareness helps us begin taking steps towards ownership. When we know what we own and are responsible for - we are free to choose what we will do with it. Taking ownership of our life gives us many options. Lack of ownership limits us. Boundaries not only help us define our "property" so we can take care of it - but helps us guard it as well. In a nutshell - boundaries help us keep the good things in and the bad things out. Boundaries also come equipped

with gates so that we can let the bad that is sometimes inside out and the good things that we need in.

EXAMPLES

Our skin is the most basic boundary that defines us. As health care providers you understand instantly how the skin as a boundary works to keep the good, like food- in and the bad - like waste or perspiration - out.

The most basic boundary-setting word is "no." The word "no" communicates to those around you that you are a person apart from them and that you are in control of you. The ability to be clear about your no and your yes is key to healthy boundaries. It is a word that allows us to establish boundaries with those with whom we interact on a daily basis in a firm yet kind manner. People with poor boundaries struggle with saying no to the controls, pressures, demands and sometimes real needs of others.

Fear of losing or damaging a relationship can also make it difficult for people to say no. Inside pressures of what we feel we "should" do also make it difficult to say that one syllable word. If we find

that we cannot say no to this internal or external presure - then we have lost control of our property.

Aside from the word "no," communicating feelings, dislikes, and intentions to other people helps them to see the parameters of our property.

WHAT IS WITHIN OUR BOUNDARIES

Before we can begin using boundaries, we need to know what things fall within our "property lines." As health care providers, knowing what you are specifically responsible for and what things fall outside your property lines is the key that allows you to connect emotionally with patients and yet maintain a healthy distance. This understanding helps you make safe emotional links and yet deal effectively with dying and death. It allows you to acknowledge that you feel frustrated with a patient who is not compliant and yet make the emotional choice to let it go because you understand that their choices do not fall within your property lines. It allows you to cope effectively with difficult patients, co-workers or bosses without allowing resentment to take a foothold and develop into stresses that lead to physical illnesses. In short, the power you may have unknowingly been giving to

others is restored to you. Lets look at those things for which each of us is directly responsible. (Slide 2)

FEELINGS - Feelings should never be ignored or placed in charge. They are internal signals that alert us to the state of our relationships - whether it's with a patient, co-worker or boss. They act as a barometer to tell us if things are going well or not. If we feel irritation or resentment, these types of negative feelings are usually an early warning signal that one of our boundaries is being violated in some way. Our feelings are our responsibility. We must own them and see them as our problem, so that we can find answers to the issues to which they point.

ATTITUDES - Attitudes are the stance we take toward others, our work and our relationships. They belong to us.

BEHAVIOR - Behavior has consequences. We need to own our choices and accept the consequences. How many of us have been tempted or followed through with rescuing someone else from the natural consequences of their

behavior? Not only does such action fall outside our property lines, it renders that person powerless and lessens their chances to learn through correction.

CHOICES - Like behavior, our choices also belong to us. A common boundary problem is disowning our choices and mistakenly laying the responsibility for them at someone elses' feet. How many of us can recall using phrases like "I had to" or "She (he) made me" when explaining why we did or did not do something. We are in control of our choices, no matter how we may feel. We have to live with the consequences of our choices and we may be keeping ourelves from making choices that would ultimately make us happy.

LIMITS - There are two aspects to limits. While we can't put limits on others, we can limit our exposure to people who behave poorly. We can also set internal limits on ourselves. This gives us the space inside that we need to have a feeling, impulse or desire without acting it out. Internal limits give us self-control without repression or denial.

IDENTIFYING OUR WEAKNESSES

To develop boundaries we need to identify possible weaknesses and understand what boundaries are not. (Slide 3 and 4) Boundaries are not a tool to control the unpleasant behaviors of others. (Slide 5) They are not a weapon we can use to hurt others - although our boundary setting will at times cause others emotional pain. (Slide 6) Boundaries are not permanent walls we can use to lock ourselves away from others. (Slide 7) As we mentioned, boundaries have gates that swing both ways. We can not begin to develop or set boundaries apart from loving supportive relationships with people who will love us no matter what. We can not develop or set boundaries within a vacuum.

Secondly, we can begin to develop and set boundaries more easily if we can identify our boundary weaknesses.

COMPLIANTS - Compliant people have fuzzy boundaries because they tend to melt beneath the demands and needs of others. Chameleon-like, their inability to say no keeps them from recognizing the harmful things they should be keeping outside their gates. A key question

to ask oneself might be - "Do you find yourself realizing that someone took advantage or treated you wrongly only after the fact or in hindsight?"

AVOIDANCE - Avoidance is a tendency that keeps people from asking for legitimate help. They do not recognize their own needs and tend to withdraw from others when they are in need. They feel guilty if they accept support or are forced by circumstances to accept help.

CONTROLLERS - Controllers hate the word "no." They see another person's "no" as a challenge to change his or her mind. They resist taking responsibility for their own lives so they need to control the lives of others. People who can't hear "no" usually are projecting the responsibility for their own lives onto others.

Whether we realize it or not - our deepest need is to belong - to be in relationship. I feel this statement tells us most clearly why the empathic relationship between health care provider and patient is key to the patient's health outcome. In effect, hospital care cuts patients off from their normal relationships, thus placing new importance on their

relationships with their health care providers. A health care provider also holds significance for the patient because he or she has information the patient can not receive from family members or friends.

(Go back to Slide 7) Defining your "property" and identifying potential weaknesses are keys to how well you will be able to empathize with your patients and yet avoid overloading your emotional circuitry. Lets talk now about how boundaries can help you own feelings of grief or saddness without turning those experiences into millstones that sap your strength. We will also discuss how boundaries can help you resolve conflict with patients, their family members, bosses or co-workers. Finally, you'll understand how you can achieve a state of greater fulfillment, a condition which will also positively impact your patients.

DEALING WITH SUFFERING AND DEATH

Forming an empathic link with a patient whose suffering extends over a long period of time or whose hospital stay ends in death can create special problems for the health care provider. When the patient is a child or infant, difficulties become more complex. In

these cases empathy comes easy but how do you process the range of emotions you may be experiencing? Internal boundaries allow us to be as close as we want without becoming emeshed. In other words, we can be close yet separate. We can own our feelings of grief, sorrow, loss or anger without retaining toxic levels that continue to build with each new patient.

THE STEPS . . .

Define your purpose for serving in the health care field until it becomes firmly fixed at a conscious level. This will help you define your emotional responsibilities by reframing your role from that of a healer to one who provides comfort, care and medical skills.

As an example you might say "I do not have control over death or disease but I can use the skills I have learned to contribute to this patient's care.

Take ownership of your feelings. "I feel sad that this patient died." "I am angry that children and babies have to become ill and suffer." "I feel frustrated that the medical field is not able to do more for

patients suffering from diseases." Recognize that as a health care provider you are a very important link in the patient's health care process.

Establish and cultivate loving supportive relationships with people at work and outside the work environment. Once you own your feelings, these relationships will help you decide where it is appropriate to for you to vent.

This self-talk enables you to relate appropriately by helping you place the proper perspective on what you can accomplish for the patient and what is beyond your control.

PARENTS AND FAMILY MEMBERS

Part of patient health care, particularly in the case of children, involves dealing with parents and family members. Again, it is important for care-givers to define their role in relation to parents and family members. They will look to you for information and support because of your special link with their child. Their need may be legitimate but you as a care-giver must acknowledge that your emotional resources are not without limits.

THE STEPS . . .

Decide ahead of time what you are able to give and what resources you may be able to use as alternative sources of help for family members.

Realizing that parents or family members may react in a variety of ways due to anxiety over their child or relative - internal boundaries help you to know your position and lay appropriate external boundaries regardless of parents' reactions.

In the face of unreasonable demands, anger or a desire to keep in touch after a child has died, boundaries give you the freedom to calmly, lovingly but firmly respond and relate appropriately with parents and family members.

WHEN GIVING BECOMES ENABLING

Have you ever felt saddled with someone else's work? In answering this question it is important to acknowledge that it perfectly legitimate to bail out a responsible co-worker or sacrifice some of your time to aid a colleague who needs some extra help. But when

one party begins taking advantage of such help - giving can quickly become enabling.

THE STEPS . . .

Health care professionals who relate to this, whether on the job or in some other aspect of their life, must first take responsibility for themselves and their feelings of resentment or irritation.

Then act responsibly towards the problem person by talking with them about the situation.

Say no to things that are not your work responsibility.

Empathize with the person's anger while being firm in your no. Don't fight anger with anger.

Keep your emotional distance by saying something like "I'm sorry if this upsets you - but that is not my responsibility."

Don't fall into the trap of justifying why you can't do the task.

If the person continues to argue, tell him or her you are finished talking about it but are available when they are ready to come back and discuss something else.

DEALING WITH DIFFICULT CO-WORKERS, PATIENTS OR FAMILY MEMBERS

Drs. Cloud and Townsend report that personnel counselors often send individuals to their clinic because of stress at work. When the cases are finally unraveled, the "stress at work" usually turns out to be someone at the office who is driving the stressed-out person crazy. Using boundaries in this area is especially effective but involves a thought process that isn't always easy to receive.

THE STEPS . . .

The Law of Power in the boundaries concepts tell us that we only have the power to change ourselves - we cannot change anyone else.

We must see ourself as the problem - not the other person.

To see the other person as the problem to be fixed is to give that person power over us and our well-being and because we cannot change the other person - we are out of control.

Recognize that the real problem is how we are relating to that person. We are the one in pain - and only we

have the power to fix that.

The doctors report that many people have found immense relief in the thought that they cannot control anyone else.

Instead they must focus on changing their reactions to that person. Refuse to allow that person to affect you. This idea is life changing and the beginning of true self-control.

CRITICAL ATTITUDES

Stress is also caused by working with or for a supercritical person. It can also be caused by providing a service to a supercritical patient or client or having to cope with a supercritical member of the patient's family. Without boundaries - we are tempted to either win the person over (usually impossible) or we allow them to provoke us to anger - again a no-win situation. Some people even internalize the criticism and get down on themselves.

THE STEPS . . .

Allow the critical person to be who they are.

Keep yourself separate from them and do not internalize their opinion of you.

Make sure you have a more accurate appraisal of yourself and then internally disagree with the critical person's view.

You may want confront the person and talk to them about how you feel about their actions and the ways it affects you. If they do not listen - you may need to say that you do not wish to speak with the person until they get their attitude under control.

You can't control the critical person, but you can limit your emotional and physical exposure to the person by absenting yourself or distancing yourself emotionally.

Don't try to win this person's approval - you can't.

Don't get drawn into discussions or disagreements - you won't win.

Stay separate - keep your boundaries. Remember - when you take a stand emotionally - you don't have to move from that spot no matter how scary the other's response.

AS YOU BEGIN TO IMPLEMENT BOUNDARIES

As you begin to practice boundaries, it is important to prepare yourself for the external and internal resistance you will experience. People with whom you need to set boundaries will probably not react positively at first. You yourself may experience feelings of guilt, selfishness, or fear.

Remember that resentment or irritation is your early warning signal. One of the first signs that you are beginning to develop boundaries will be a sense of resentment, frustration or irritation at the subtle and not-so-subtle violations in your life.

You may begin to experience a change in tastes regarding friends as you begin to become attracted to people who can hear your no without being critical or withholding their love.

If you are interested in pursuing more information about boundaries, you may order Dr. Cloud's and Dr. Townsend's books and workbooks by calling 1-800-266-5745.

"Boundaries: Gaining Control of Your Life"

"Boundaries Workbook"

"Safe People"

APPENDIX B

INVENTORY OF INTERPERSONAL CONCERNS

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that problem has been a problem for you with respect to *any* significant person in your life. Then select the number that describes how distressing that problem has been, and circle that number.

EXAMPLE					
It is hard for me to:	Not at all	A little bit	Moder-ately	Quite a bit	Extremely
...get along with my relatives	1	2	3	4	5

Part I. The following are things you find hard to do with other people.

It is hard for me to:

1. say "no" to other people.	1	2	3	4	5
2. let other people know what I want.	1	2	3	4	5
3. tell a person to stop bothering me.	1	2	3	4	5
4. confront people with problems that come up.	1	2	3	4	5
5. be assertive with another person	1	2	3	4	5
6. have someone dependent on me.	1	2	3	4	5
7. disagree with other people.	1	2	3	4	5
8. let other people know when I am angry.	1	2	3	4	5
9. get along with people who have authority over me.	1	2	3	4	5
10. stick to my own point of view and not be swayed by other people.	1	2	3	4	5
11. make reasonable demands of others.	1	2	3	4	5
12. be firm when I need to be.	1	2	3	4	5
13. set limits on other people.	1	2	3	4	5
14. argue with another person.	1	2	3	4	5
15. maintain a working relationship with people I don't like.	1	2	3	4	5

EXAMPLE					
It is hard for me to:	Not at all	A little bit	Moder-ately	Quite a bit	Extremely
...get along with my relatives	1	2	3	4	5

It is hard for me to:

16. get over the feeling of loss after a relationship has ended.	1	2	3	4	5
17. feel angry at other people	1	2	3	4	5
18. open up and tell my feelings to another person.	1	2	3	4	5
19. attend to my own welfare when somebody else is needy.	1	2	3	4	5
20. be assertive without worrying about hurting the other person's feelings.	1	2	3	4	5

PART II. The following are things that you do too much.

21. I feel too responsible for solving other people's problems.	1	2	3	4	5
22. I am too easily persuaded by others.	1	2	3	4	5
23. I try to please other people too much.	1	2	3	4	5
24. I am affected by another person's moods too much.	1	2	3	4	5
25. I worry too much about other people's reactions too me.	1	2	3	4	5
26. I worry too much about disappointing other people.	1	2	3	4	5
27. I blame myself too much for causing other people's problems.	1	2	3	4	5
28. I keep other people at a distance too much.	1	2	3	4	5
29. I let others take advantage of me too much.	1	2	3	4	5
30. I am affected by another person's misery too much.	1	2	3	4	5

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