

“I’LL BREATHE WITH IT AND I’LL NOTICE”: THE ART OF SELF CARE

Shayna Hornstein
shayna@shaw.ca

“I got sick partly because of an infectious disease, but partly because I was over-functioning...some of us...want to fix everything, and we can never have done enough...I had to work on boundaries.”

These words from a female physician, Regina (not her real name), when she was looking back on her early years as a doctor. During several hours of interviews,¹ Regina and I explored practitioner self care and her experiences of relating to patients² (Hornstein 2008). She recounted her journey through debilitating bowel disease and colitis, to being able to do the work she loves, to create and maintain therapeutic connections with patients and stay healthy and enthusiastic about her work. Excerpts of this interview follow.

The boundaries referred to in this article are the limits or borders that allow individuals to connect with each other while remaining separate beings. In a healthy state, our boundaries are flexible as they respond, on a moment-by-moment basis, not only to our environment, but also to our inner signals. Healthy boundaries range from being open and receptive to outside input, to being closed and protective. They enable us to decide what stimuli to guard against, and what is okay to take in and integrate. With healthy boundaries we can assess the circumstances and fully say, “Yes,” or “No,” and all the variations in between. Boundaries are naturally fluid and do three things; they protect, screen and contain. Containment allows us to hold on to our own feelings and thoughts as well as impulses. With this latter function intact, we are able to accept and appreciate differences, rather than feeling either threatened or absorbed by them (Ogden 2007).

Regina talked about how her work overseas affected her:

“When you are working in conditions [of extreme poverty] you can never have done enough...I had some patients who loved me but were completely dependent on me, so my job had never ended. There are some people whose personality and whose upbringing [mean] they can’t bear other people’s pain, so they have to fix it. And so the work that I had to do was to be able to tolerate my own pain, and tolerate their pain without getting compelled to fix it and burning out...Another way [professionals try to cope] is that you withdraw and become non-feeling. So some physicians will...cut off, and then they appear not to have any empathy. Neither way is useful.”

These common practitioner behaviours in the face of situations they find difficult: attempting to fix everything or disconnecting, can be understood in terms of boundary functions and styles. Regina described that in her first years of practice, with boundaries too open, she absorbed others’ distress as her own. In her words, she “took it on.” With intact self-awareness and boundaries, she would have been able to notice her urge to fix everything, without feeling compelled to act on each impulse. Curing some diseases is not possible nor is solving the larger problems that often underlie the suffering. She mentions her upbringing as the template for her response to others. We develop our boundary styles as children in our families. The quality of these early experiences influences our ability to set and maintain healthy boundaries (Ogden 2007).

The other behaviour Regina observed, that of withdrawal, may be the setting of a rigid boundary that disconnects the practitioner from the patient. Inflexible boundaries – perhaps described as “not letting people affect us” – attempt to inhibit connection, and often result in our abandoning patients when they most need us (Kuhl, 2002, p.56). We *do* affect each

other. The issue is whether or not we are aware of *how* we are influenced by one another. Stein (1985) wrote extensively about the unconscious factors in practitioners that dictate patient care. He explains that the “best way for us to keep from either fostering in our patients too great a reliance on us or rejecting patients entirely is to become more aware of our own vulnerabilities and limitations” (Stein, 1985, p.4).

Linking her absence of boundaries to her ensuing illness, Regina spoke about her own patterns of behaviour:

“I got an infectious disease that developed into something else and became progressively worse and I had to stop work for a year. It was that serious. I ignored the illness and kept persisting...I got really ill. I came back [to Canada] and was working...and not getting better and ignoring it...When I was off, I started exploring, “Why I am not getting better?” I realized that...I had no inner mechanism for self care. I was constantly pushing the boundaries, using caffeine to keep going and working. So it was stress related, and the stress was imposed by not having done enough and not having good enough boundaries.”

Turning these self-destructive patterns around took a long time. Unable to work, she began meditation and psychotherapy.

“There were several things I had to fix for myself. One was really having a sense of where my body ends and another person begins. So there’s both the autonomy...and the interconnectedness. There’s the truth that it’s a universal pain. That’s true. But when I take it personally, then it becomes that I have to fix it somehow. So if I can’t bear it, then I have to fix it.”

With meditation came mindfulness and heightened body awareness. When she is with patients, Regina tracks her body

sensations for clues, notices what emotions come up and watches her own responses carefully. Having learned to tolerate her own discomfort, Regina explained that she is now able to be fully present with patients who are suffering.

These strategies guide her daily interactions.

"So now if I'm with somebody, I will know that...I have an uncomfortable feeling in my belly and I'll pay attention to that. I'll breathe with it and I'll notice, "Oh I just took that on." Or, "Oh, I am upset because I don't have an answer for this."

Mindfulness. Patient, non-judgmental witnessing of her own patterns helped her change them. She does not force a breath. She breathes "with it." Mindfulness gently breathes air into the tightness, creating space. In that space, Regina then has options.

These interviews took place many years after recovering from bowel disease:

"Probably 90% of the time now, I do not get symptoms of irritable bowel. Very very rarely does that happen. I can feel that contraction [in my belly], and I can work with it, and can recognize, "Oh, this is what's happening. Oh, I am taking this on."

While attending to her physical sensations, Regina talks gently to herself as she engages with the patient. These subtle strategies were difficult for her to articulate:

"Caring...There's a caring for myself: "Oh, I care about this pain. This is hard to hear." Or having compassion: "Oh, I can't fix this"...There's some self-talk. Even if the words aren't there, the attitude is there. It's like...a holding of myself...And I guess a self-reminder that there can be caring without [pauses]. Sometimes caring is, gosh, I don't know how to have words for that [pauses]. Well, all I know is that when I do that, it has an impact. I

relax...There's an openness, and there's a softness. And there's an embracing...So it's like in that openness and softness and embracing, there might be space for transformation."

Regina's awareness of and clarity about why she acts as she does continues to grow. While she agreed with my observation that developing this attentiveness was hard work, she explained other benefits:

"I also find it exciting and inspiring because it's possible. I can close the door and know, "I wouldn't have been able to do that five years ago." I was just with that person and we just worked that out. I wouldn't have been able to sit there and have a good boundary...and at the same time not shut them out. So it's being able to connect with someone's heart and at the same time have a boundary."

Since our work focuses on assisting others, I asked her how she thought not always jumping in to "fix things" affected the patient.

"It's way more helpful for the patient in the long run, because it's more empowering. In that space, creativity can come up from them too. They're not just dependent on [me] the wonderful person who does everything for them, which increases their need...You know, I've become the universal mother who takes care of everyone, which is not a useful role for me or for them. And also there's an element of seductiveness in it, because everyone loves me...It's way more useful for me if what's happening is coming from both of us. And I am more set back. It's not about me."

¹ I designed and conducted in-depth interviews with seven health practitioners as part of a nationally funded qualitative research inquiry. I explored their experiences about the challenge of power dynamics in the patient-professional relationship. I was particularly interested in the practitioner's internal experience and the subsequent impact on their own

health as they tended to the health of others. To read my full account of this study, contact me at shayna@shaw.ca.

² I am consciously taking back the word "patient," defined as a person under treatment for a disease or injury, because the contemporary term "client" rings business and hollow to me. When visiting my doctor, I don't want her to think of me as a client!

References:

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*Shayna Hornstein is an experienced facilitator and registered physiotherapist based in Vancouver. Her professional development workshop series entitled, **Beyond the Bubble Bath**, addresses our inner mechanisms for self care using creative activities and reflective dialogue. Simple exercises, grounded in mindful learning principles, enable participants to experience a felt sense of their own boundaries under different conditions. These workshops are designed to strengthen our abilities to comfortably set healthy limits and to reduce the impact of cumulative stress on the body.*



"I took a deep breath and listened to the old bray of my heart: I am, I am, I am."

Sylvia Plath