

Resilience: part of the problem or part of the solution?

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Wherever I go I see posters and leaflets promoting resilience. It seems that politicians, employers, managers and some well-meaning therapists have acknowledged that life today is hard but there is a solution ready to hand. And it's the best type of solution because nothing needs to change.

As a nurse you would make the ideal customer for the resilience industry because everybody knows how difficult your work is. Yet you are probably ambivalent about the topic. On the one hand you may encourage your patients and clients to develop resilience to help them cope with the difficulties that life has dealt them. On the other hand you sense something fishy in the way that your manager keeps telling you about another resilience course being offered to your NHS trust's staff by volunteering therapists.

To try to explain this, I want to write about where notions of resilience in health first came from, how discussion of resilience has proliferated across widely different sectors, how it has been taken up by individualising tendencies in culture and finally how it is the perfect neoliberal tool. I want to also argue that if you understand something of the political and policy context of today's healthcare it can allow you to avoid taking on personal responsibility for situations that have been brought about by others – by politicians and policy makers for example. This awareness can give you and your colleagues what I will call 'critical resilience'.

Where resilience came from

The work of the so-called father of psychoanalysis Sigmund Freud (1856 – 1939) and his colleagues provided a ground for psychological studies of childhood that we take for granted today. John Bowlby's (1907-1990) attachment theory emerged from Freud's ideas. Bowlby, whose own childhood involved distant and interrupted relationships with his parents, focussed his work on the child's early environmental experiences and found that separation from a primary care giver was often associated with trauma and sometimes problems in later life.

James Anthony (1916-2014) was one of the first child psychiatrists to write at length about resilience and vulnerability. He collaborated with Bowlby as well as Anna Freud (daughter of Sigmund Freud) in his early career. Anthony and others focussed on child development in conditions of social disadvantage. They were fascinated by the apparent ability of some children to survive adversity. For Anthony and others, the most efficient protective system took the form of the infant's caregiver and their actions.

One of the continuing debates among resilience researchers concerned two related questions: Is resilience essentially a personal characteristic—a character trait—or a dynamic developmental process? and if it is a

developmental process, can it be taught or improved by external intervention?’

Researchers focused their work on identifying sources of vulnerability and protective factors that could modify the harmful impact of adverse circumstances. It is important to remember that the flavour of this research is largely a result of its focus on children and young people growing up with disadvantage. Many researchers were at pains to point out that protective factors are contextual as well as individual (Johnson & Wiechelt, 2004) and that resilience is not a personal characteristic of the individual but a term we can apply to developmental trajectories. Both vulnerabilities and protective factors can be operating at the community, family or individual level (Luthar & Cicchetti, 2000). But already we find different ideas about the role of resilience. Consider these two contrasting statements by researchers about the importance of resilience research relative to broader social programmes—actually changing something:

Some sources of adversity are preventable such as child maltreatment and it is far more effective to try to prevent these in the first place (Masten & Obradović, 2006).

The primary concern of those working with children and adolescents at risk is the prevention of maltreatment and abuse, but given that this is not always possible, the promotion of resilience is even more valuable (Williams and Hazell, 2011) cited in (Winders, 2014 page 7).

Resilience began to be understood, investigated and promoted by psychologists, popular and otherwise, as an almost entirely individual ‘inner’ characteristic. The environmental aspect that was emphasised as integral by the early researchers was ignored by many. Researchers developed questionnaires claiming to measure resilience, opening the possibility of ‘targeting’ those individuals—perhaps ourselves or our colleagues—labelled as being ‘at risk’ with resilience-enhancing inputs. Many websites promote simplified and individualised versions of resilience along with quizzes for visitors to ‘test’ how well they ‘bounce back’. The introductions to these sites tell us repeatedly that ‘while we can’t always chose what happens to us, we can chose how we respond’. I will return to this formula later when I talk about how nurse researchers have taken up resilience among nurses.

Resilience in other sectors

Meanwhile, and more positively, progressive workers in other sectors took up the concept of resilience to understand and act in complex social and ecological systems. The definition of the term from the Stockholm Resilience Centre, to take one example, features none of the passivity that we read just above: ‘It is about how humans and nature can use shocks and disturbances like a financial crisis or climate change to spur renewal and innovative thinking’ (Stockholm Resilience Centre, 2012).

Resilience in nursing

Resilience is a popular topic in nursing publications both in the form of exhortations to be better at it and research papers. The research papers, where we might hope to see critical and progressive thinking, show an approach to resilience that I believe leaves a number of problems.

1 Intrinsic and extrinsic adversity in nursing are conflated

Researchers list contemporary features of nursing work that make it stressful and therefore comparable to the 'adversity' that classic resilience studies deal with. These stressful factors have two origins: those that are intrinsic to the work itself and those that are a result of contemporary demographic, economic and political forces. The first include exposure to patient suffering and death and the close relationships that may develop with these patients (Dolan, Strodl, & Hamernik, 2012). The second group, which is referred to more often and at greater length, includes global nursing shortages and high turnover e.g. (Larrabee et al., 2010 page 82), political change and under-resourcing of public healthcare (Koen, van Eeden, & Wissing, 2011), casualization, staff shortages, bullying, abuse and violence e.g. (Jackson, Fau - Firtko, & Edenborough, 2007).

2 Leaving the profession suggests a lack of resilience

There is an assumption across this writing that for a nurse to remain in the nursing workforce is a free choice that can point to resilience and that some of those who remain even apparently 'thrive' on the adversity they experience. There is also an assumption that a decision to leave nursing amounts to succumbing to adversity. None of the work I read discusses the possibility that nurses might remain in nursing because of lack of alternatives nor that leaving the profession could be seen as a sign of strength.

3 **Parochial**

There is a tendency to take understandings and definitions of resilience either entirely (Cameron & Brownie, 2010) from other nursing literature or to rely heavily on it (Matos, Neushotz, Griffin, & Fitzpatrick, 2010) so that key debates and nuances in the field, some of which I mentioned earlier, are ignored and subsequent authors who rely on nursing literature heavily seem unaware of them. The nursing literature tends to draw on an 'internal' understanding of resilience as 'a positive personality characteristic' (Matos et al., 2010 page 309).

4 **Few attempts to measure organizational 'adversity'**

Following on from the above, while 'adversity' is understood in organisational and workforce terms there is little attempt to measure this. The focus is almost entirely on individual personal response and characteristics. Most studies are carried out in single sites so there is no opportunity to investigate whether any differences in resilience are associated with different ways of working (rather than differences in individuals). The one author who compared resilience scores across two sectors, the for-profit and the highly stretched public sector in South Africa, found apparently higher resilience among private sector nurses (Koen et al., 2011) suggesting paradoxically that less adversity is associated with apparently higher resilience.

5 **Interventions are individual/individualistic**

Studies that describe initiatives aimed at fostering resilience among nurses are individual-based. This focus on the individual differs from the community-based programmes described in the child psychology literature. There is no conception or consideration of resilient systems in the nursing literature. The evidence from resilience research suggests that it is important that those planning

interventions recognise the mutual interactions between the individual and different aspects of their environments, as attempts to improve particular protective factors are likely to be ineffective on their own (Luther & Cicchetti, 2007) cited in (Winders, 2014).

6 **Powerlessness and pessimism**

Finally, and most disappointing, there is a tacit acknowledgement and a sense of powerlessness from the authors that the workplace experienced by nurses is so dysfunctional that it is better to invest energy in devising personal approaches to coping than investigating or challenging the causes of dysfunction. This is on the basis that 'nurses' occupational settings will always contain elements of stressful, traumatic or difficult situations, and episodes of hardship'. (Jackson et al., 2007 page 7) or 'it is important to acknowledge that work stress and crises are inevitable and even necessary for the growth and maturity of the individual and to allow them to reach their full potential' (Manzano García & Carlos, 2012 page 105). Promoting resilience among nurses is a way, according to many of these authors, of reducing turnover in the nursing workforce, with the promise that 'nurses can thrive at the bedside for 'extended periods of time' (Mealer et al., 2012 page 297).

It is hard to resist the conclusion that the approach to resilience that we find in nursing writing—with the intention of protecting nurses—promotes the status quo by trying to avoid a crisis in healthcare systems or organisations that might bring about action. It colludes with a neoliberal tendency to atomise society so that individuals can be encouraged to take responsibility for situations that are the responsibility of others instead of acting together to change.

Critical Resilience

My conclusion is that nurses need another type of resilience entirely and that the conventional view of resilience is part of an ideology that operates to our disadvantage. I'd like to suggest something we could call 'critical resilience'. Critical resilience is about applying analytical energy, in groups of colleagues or fellow students to ask what might be behind our day-to-day experiences of

so called adversity—and to do this in detail, searching out specific information when necessary. Critique is not just another name for debilitating and unproductive complaint. Developing critical resilience in groups can release nurses from the sometimes crushing sense of individual responsibility for an inability to work properly in an obstructive setting, or blaming other individuals instead of understanding system problems. It can provide a basis for survival *at the very least* and, ultimately, resistance and change.

For more information see my book, *Critical Resilience for Nurses* at <https://www.routledge.com/Critical-Resilience-for-Nurses-An-Evidence-Based-Guide-to-Survival-and/Traynor/p/book/9781138194236>

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