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Contemporary issues: Resilience training alone is an incomplete intervention

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ABSTRACT

Resilience training focuses on the individual to improve self-care, self-efficacy, and work/life balance with an aim to reduce burnout. However, the concept of resilience is complex and contextual, affected by the interplay between an individual and their environment. As such, any intervention to promote resilience in healthcare workers must recognize and address structural and organizational factors, as well as individual influences. Resilience-based approaches are often grounded in a strength-based model, emphasizing factors that promote success, while often overlooking factors that contribute to failure (Cross, 2015). Without examining and addressing factors in the work environment contributing to burnout, resilience training alone is an incomplete intervention.

1. Introduction

Resilience is defined as "the ability of an individual to cope with and adapt positively to adversity" (Jackson et al., 2007, p. 1). In nursing research, the term resilience often relates to the professional challenges that nurses experience and is viewed as a personal capacity enabling them to cope with the workplace demands (Hart et al., 2014). It is recognized as an essential quality for healthcare professionals who experience stressful and potentially traumatic situations as part of their day-to-day work, experiences that may adversely affect their physical and mental health (Hart et al., 2014; Jackson et al., 2007). Once identified as a trait, resilience is now seen as something that can be developed or enhanced (Luthar et al., 2000; Turner, 2014). As such, and in response to the increasing demands of the current healthcare environment, it has been suggested that nurses need to further develop their personal resilience to prevent burnout (Turner, 2014). In preparation for practice, it is recommended that nursing programs incorporate resilience training into their curricula (Cross, 2015; Jackson et al., 2007).

Resilience training focuses on the individual to improve self-care, self-efficacy, and work/life balance with an aim to reduce burnout. The focus is almost entirely on personal responses and characteristics. However, the concept of resilience is recognized as complex and contextual, affected by the interplay between an individual and their environment. As such, any intervention to promote resilience in health care workers must recognize and address external, structural and organizational factors, as well as internal, individual influences. Resilience-based approaches are often grounded in a strength-based model, emphasizing factors that promote success, while often overlooking factors that contribute to failure (Cross, 2015). Without examining and addressing factors in the work environment contributing to burnout, resilience training alone is an incomplete intervention.

2. Background – resilience, support and empowerment

Early resilience research focused on children who thrived despite traumatic childhood circumstances, children who appeared "invulnerable" to adverse life situations (Earvolino-Ramirez, 2007). Researchers at the time concluded that resilience was a trait. However, ongoing research identified the single most common factor for these children was a supportive and stable relationship with at least one parent, caregiver, or another adult. Adaptive skill-building, and positive experiences were also identified as contributing to their resiliency. (Harvard University Center for the Developing Child, n.d.) Over time, the term "invulnerable" was replaced by the term "resilient" (Earvolino-Ramirez, 2007) and resilience is now seen as something that can be learned or modified (Luthar et al., 2000; Turner, 2014).

In an integrative review of the literature on resilience in nursing students, external factors affecting resilience included support (from family, friends and faculty) and empowerment (Thomas and Revell, 2016). If the findings from childhood resiliency studies and studies of nursing students identify support, adaptive skill-building, positive experiences, and empowerment as prerequisites, efforts to promote and enhance resiliency should include support, skill-building, positive experiences, and empowerment in the learning and working environments where stressors contributing to burnout are found.

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3. Expected stressors vs. modifiable stressors

In childhood resiliency research, the experience of trauma is a prerequisite and this experience is something that was overcome, whereas resiliency training offered to nurses and nursing students intends to prepare them to better cope with trauma they will encounter in their work. It is recognized that health care environments are inherently stressful. Nurses witness tragedy, suffering, and human distress, as part of their work, and nursing students are exposed to this early in their training. These traumas are intermittent and beyond control. Although these experiences may contribute to burnout, the literature points to excessive workloads, chronic staff shortages, lack of supplies, increasing administrative burdens, lack of autonomy, bullying and violence, and organizational issues as the primary sources of workplace stress (Jackson et al., 2007; Turner, 2014). Chronic, incremental and cumulative stress created by inefficient systems, overwork, understaffing, unsafe working conditions, and lack of resources must be differentiated from the acute temporary situations of high stress that are an expected part of nursing work. It is the persistence of unaddressed chronic stressors, many of them preventable or modifiable, that erode providers' mental and physical health (Card, 2018; Privitera et al., 2014). There is a need to investigate the causes of stress and a need to recognize that different interventions may need to be developed to address stress arising from the nature of the work (exposure to traumatic events and patient suffering) and that resulting from excessive workload, staff shortages and lack of support.

We currently have an overburdened nursing workforce. The work of nursing is intellectually challenging, as well as emotionally and physically demanding. Cognitive, emotional and physical overload are recognized problems in other industries, yet there is little attention paid to this in healthcare (Privitera et al., 2014). It has been suggested that physicians' working conditions, and by extension, all healthcare working conditions, "would be considered unsafe, unprofessional, and even illegal in other safety-critical industries" (Card, 2018, p. 268). Furthermore, it is suggested that these working conditions can only be seen as acceptable if the health and well-being of the providers are not a priority.

The healthcare environment is more intense and complex than ever. In this environment, nurses are not being asked to simply move past traumatic events, but to endure working conditions hostile to their health and wellbeing, where demands routinely exceed resources. Today's healthcare workers are expected to "do more with less," caring for a greater number of patients with fewestaff and reduced resources, resulting in a phenomenon known as "work compression." Excessive workloads have not only been linked to nurse burnout but to poor patient outcomes as evidenced by failure to rescue, and in rationed and missed care. Short staffing, which is chronic in most environments, erodes resilience, yet is normalized (Urban, 2014).

Healthcare organizations have a responsibility to protect the safety and well-being of their employees, and it is in their best interest to do so. Even the most resilient nurse will be unable to survive, let alone thrive, without adequate resources and support. Relying on frontline workers to continuously make up for system failures and inefficiencies, not a lack of resilience, is at least partially to blame for burnout (Privitera et al., 2014).

4. Barriers – Focus on the individual and a selfless culture

While studies identify support and other external factors as positively affecting resilience, individual and internal factors remain the focus of many resilience-building interventions. Current approaches continue to individualize and decontextualize the concept of resilience, creating binary categories of "resilient" and "not-resilient." This "grit" narrative is both counterproductive and damaging. As those who care daily for the sick and injured, nurses are often perceived to be, and perceive themselves to be, immune to stress, injury or illness. They are not, yet many appear to have internalized the myth that "what doesn't kill you makes you stronger" (Steege and Rainbow, 2017). Without consideration for external factors affecting resiliency, resiliency training alone implies that vulnerability to workplace stressors is the result of the personal weakness and failure of the individual to cope. Ignoring current evidence implicating conditions of work as contributing to burnout and offering resilience training without addressing these conditions which undermine resilience is moral cowardice.

Nurses are the proximal source of patient care and their well-being affects the quality of care delivered (Privitera et al., 2014), but as long as care is provided, improving suboptimal processes and addressing extraneous demands on nursing time may not be a priority. Historically, nurses have taken it upon themselves to assure quality care for patients by coming in early, skipping meals, staying late to chart, and not taking breaks. Despite evidence indicating this adversely affects the care provided, in the "grit" narrative these actions are often seen as a badge of honor. Selflessness is an unwritten expectation of the profession (Urban, 2014). The nursing literature is filled with exemplars of good nursing work in the face of obstacles, profiles of hardy, heroic, and resilient nurses acting with grit and grace under fire (Cope et al., 2016). These profiles further perpetuate the perception that an inability to do it all is a personal failure, as evidenced by nurses who report unsafe working conditions being labeled as "complaining" or "lacking resilience." The tone of language in the nursing literature may also contribute to nurses' susceptibility to blame. Language about resilience is generally submissive, encouraging acceptance of the status quo by putting the onus on the individual to control their response to workplace adversity, suggesting nurses should with "roll with the punches" and that "you can't often choose what happens to you, but you can choose how you react" (Traynor, 2017, 2018). Intentions such as "helping the nurse to survive at the bedside longer" speak to the abusive work situations nurses are being asked to tolerate.

5. Mismatch with intention

Many nursing programs and facilities offer resiliency training to prepare nurses for the stress of the work environment despite the fact that the long-term effectiveness of resiliency training in reducing burnout has not been demonstrated. If the intent of such training is to reduce burnout, modifiable factors contributing to burnout must be addressed. These factors include ineffective leadership, resourcing problems, poor work organization, and ineffective human resources practices and strategies for the management of psychosocial hazards (Bentley et al., 2009).

Components of situational monitoring as described in the STEP tool in the patient safety initiative Team STEPPS recognize factors such as fatigue, workload, and stress as affecting individual and team performance and delivery of care. The "I'm Safe" checklist asks health care workers to self-identify when they are impaired by illness, medication, stress, alcohol and drugs, fatigue, or issues related to eating and elimination (Agency for Healthcare Research and Quality, 2013) (Figs. 1 and 2).

Team STEPPS identifies these concerns as risk factors in patient safety, yet there is no literature indicating how often nurses self-identify as impaired in this initiative. Anecdotally, nurses don't take meal or bathroom breaks and are expected to work through illness, stress, and fatigue. They may aware they are impaired but have little choice but to provide the best care possible given the possibility of being labeled "not-resilient" and the unknown consequences of self-reporting. Self-care is not possible when workplace culture and expectations prevent it (Steege and Rainbow, 2017).

The need to recognize contextual factors affecting clinician well-being is now the focus of a number of initiatives, including the Action Collaboration on Clinician Well-Being and Resilience by the National Academy of Medicine. The American Association of Colleges of Nursing, American Association of Critical-Care Nurses, American

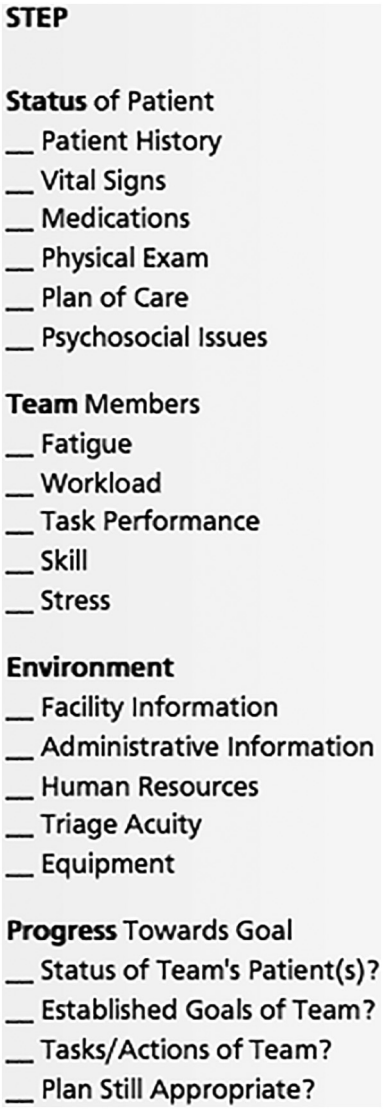

Fig. 1. STEP tool – components of situational monitoring.

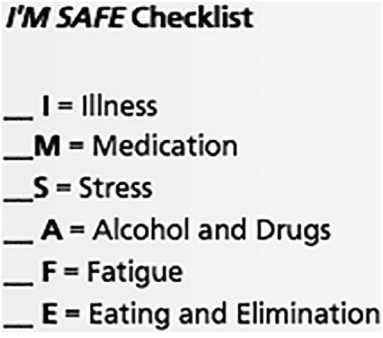

Fig. 2. I'M SAFE Checklist.

Psychiatric Nurses Association, National League for Nursing, and the American Nurses Association are among the active contributors to this collaborative. This collaboration, as well as the introduction of the Quadruple Aim, recognizes and intends to increase awareness of the conditions of work as a factor in clinician health. (Academy of Medicine, n.d.; Bodenheimer and Sinsky, 2014) Progress is being made, as evidenced by a recent publication in the *Journal of Nursing Administration* which suggests shortcomings of the current care environment undermine personal resilience and the focus on individual resilience be replaced with initiatives to "repair the cracks in the foundation of the healthcare environment" (Virkstis et al., 2018).

6. Implications for action and nursing practice

The ICN Code of Ethics (2012) underscores our responsibility as nurses to contribute to and maintain an environment conducive to staff safety. "The nurse, acting through the professional organization, participates in creating a positive practice environment and maintaining safe equitable social and economic working conditions in nursing" (ICN, 2012, p. 3). This requires that nurses advocate for the resources to do their job without sacrificing their own safety and well-being.

For resiliency training to be effective, interventions should include critical investigation of the conditions of learning and work that undermine resilience and empowering nurses to resist the status quo, rejecting the idea that this is the way things have to be (Traynor, 2017, 2018; Virkstis et al., 2018). Programs of nursing already include reflection and quality improvement in their curricula. Interventions to promote resilience should provide opportunities for nurses to use these skills in reflective practice and training in quality improvement to address modifiable processes and conditions endangering patient and nurse health and to promote positive practice environments. This focus on nurse well-being does not detract from the primacy of the patient; rather the primacy of the patient requires us to address conditions in our broken health care system that affect their safety and the quality of care provided.

7. Conclusion

Supporting nurses to engage in wellness, self-care and enhance coping through resilience training is only part of the solution. The ICN Code of Ethics and health care's current focus on patient safety and quality improvement compel us to address processes and conditions of learning and working environments that are substandard. Strategies are needed to support students and health professionals to cultivate resiliency and wellbeing in their personal and professional lives, while addressing system issues that contribute to unhealthy learning and work environments and erode individual resiliency (Kreitzer and Klatt, 2017).

Nursing programs and healthcare organizations can support resiliency through focused primary, secondary, and tertiary interventions. Primary level interventions would aim to enhance resilience, strengthening individual self-awareness, coping, and communication skills. Health professional education needs to support students to enact and embody the self-care required to allow them to deliver high quality patient care (Kreitzer and Klatt, 2017), not prepare them to tolerate abuse. In addition, nurses' concerns must be heard. Nurses must have a seat at the table where decisions affecting their practices are made and the culture of the clinical environment must allow for nurse empowerment and self-care to take place.

Secondary level interventions would include screening and early recognition of individuals, or entire units, at risk for burnout, and providing support and the resources needed to provide safe, effective care. System inefficiencies would be proactively addressed through ongoing quality improvement initiatives, led by frontline providers, reducing unnecessary stressors and contributing to efficient use of resources. Tertiary interventions would include supporting individuals whose resilience threshold has been breached and supporting them in return to work. In order to move forward, the stigma healthcare workers associate with needing and asking for help must also be addressed. We cannot simply train nurses and future nurses to be more resilient. A multifaceted approach to improving nurses' working and learning environments and to support and empower nurses to create positive practice environments is required.

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