Resilience and Nursing

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The first section of this document covers resilience as an abstract concept versus resilience as a life habit. Generalizations about the nature of resilience, its mechanisms, and factors which contribute to its development are provided. The second half of this document focuses on the role of nurses with children who have suffered from abuse, neglect or abandonment as well as with individuals who have been seriously affected by adversity in their lives.

Working with patients who have suffered adversity

Throughout their careers, nurses must work with people who have experienced tragedies. They must develop suitable methods to intervene with these individuals. Helping relationship training is an invaluable asset for nurses.[1] The guiding principles of helping relationship and the skills which nurses subsequently develop lead them to adopt positive attitudes and behaviours, to build further upon them, and to evolve.[2]

The full strength of reaction and adaptation may be inhibited by a traumatic event. The presence of a nurse may allow it to resurface. Respecting an individual and his pain is essential to reach out to him in his suffering. Yet the individual may prefer to remain silent for some time. His choice must be respected. Welcoming the individual and providing him with warmth, compassion and caring, if he allows it, remain the only options available at that point in time.

Welcome, presence and patience

Welcoming an individual who is experiencing trauma goes well beyond our normal social customs. Welcoming is a professional act which requires thought, which can be learned, and which can be perfected. Welcoming is the moment to demonstrate openness and to develop a meaningful bond, with the patient (Monique Formarier).[3] The patient-caregiver relationship is built upon the nurse's welcome and the warmth that she provides, even if they are not accepted by the patient. An individual whose pride is wounded can be quite irritable. He may

[1] Margot Phaneuf (2002) Communication, entretien, relation d'aide et validation. Montréal, Chenelière et McGraw-Hill.
[2] The current trend in Rogerian helpful relations focuses on the internal strength possessed by all humans as a tool for personal growth.
[3] Monique Formarier. «Approche du concept d'accueil, entre banalité et complexité. From: l'Association de la recherche en soins infirmiers (ARSI) », déc. 2003.
http://www.infiressources.ca/fer/depotdocuments/Arsi%20concept%20d_accueil15.pdf

be negative, suspicious or doubt the sincerity of those who are offering a helping hand. This is especially true of individuals who have survived prolonged periods of violence and deprivation (i.e. a battered child or wife). One must understand the individual's resistance and be aware of the defence mechanisms that he deploys. Denial, avoidance, lying, manipulation, splitting, and aggressiveness are but a few of the mechanisms which might have helped the individual survive. Yet they are also obstacles for the untrained or unsuspecting caregiver.

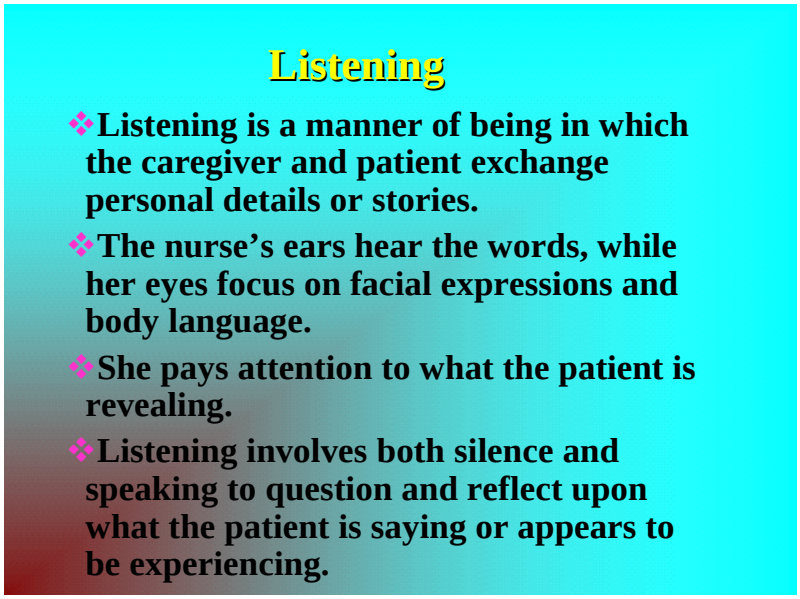
On the other hand, an individual who has been brutally assaulted or who has survived a natural disaster may be suffering from ***post-traumatic reaction*** and be using rigid defence mechanisms such as ***negation*** or ***avoidance***. These can be expressed by showing indifference or refusing help or assistance.

These expressions might be off-putting for a caregiver; however, she should neither become discouraged nor impose dialogue. The caregiver should remain open and available to the needs of the victim. Over time, his fear and anxiety will abate and leave room for interaction. Nurses must be ready to help the individual once he opens up.

The value of listening

Speaking softly in a comforting tone is essential if we are to show the individual or child that we are there to help him. In a way, caregivers resort to the **Terpnos Logos** of Antiquity, which was considered to have therapeutic value.

Yet the most important tool at our disposal is ***listening***, a skill which allows us to show respect for others and to interact with them.



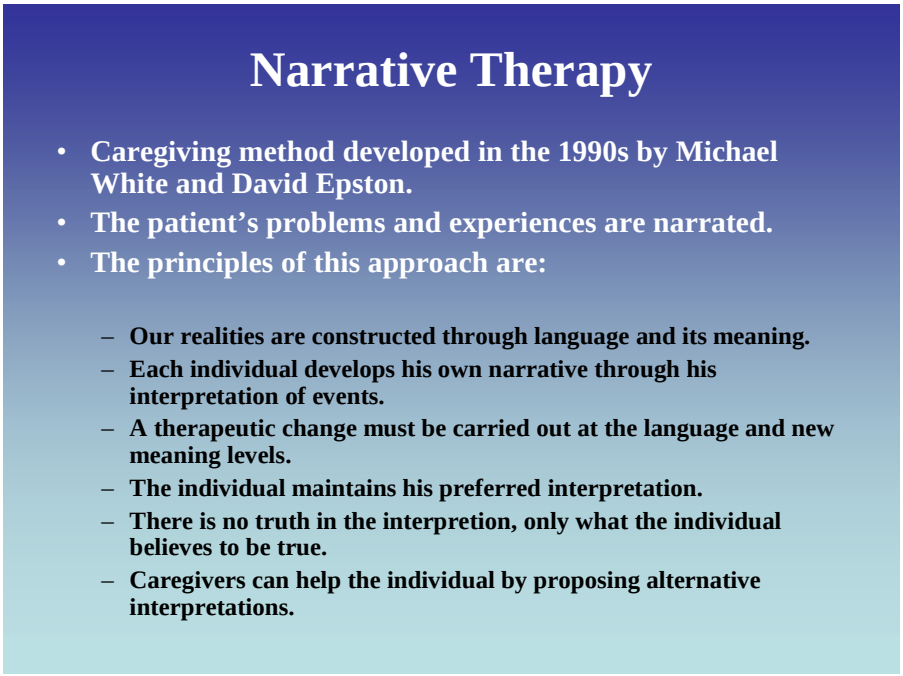
Everything depends upon our ability to get the individual to talk about his situation and to help him express his suffering verbally. Only then will we be able to extract important elements from him. Another important skill is the ability to identify the most painful elements of the patient's experience. This skill allows us to show understanding and empathy.

This final element - empathy - is often considered essential to the helping relationship. The effects of the nurse's intervention may be nullified if she does not demonstrate the ability to express empathy. The ***healing touch*** and ***warm pack behaviour*** are definite assets. Like a cocoon, they form a protective shell by isolating the individual from traumatizing memories

or images. Boris Cyrulnik noted that the expression of misfortune is more than merely the narration of facts: the narrator of the story is also its main agent or protagonist. The narrative in a way becomes a form of therapy that is essential to the individual's self-reconstruction. It allows him to unfold the fabric of his life.

The power of narration

Narrative therapy is an evolutionary process developed by two therapists - Australian **Micheal White** and New-Zealander **David Epston**. This therapy focuses on solutions which rely on the individual's strengths rather than on his weaknesses. The victim is considered the expert regarding his own situation.



The individual will be in a better position to develop coping or adaptive mechanisms that may help him change his situation if his problems are put into words and narrated. By doing so, he will be able to see his problems in their context and accept them. According to White and Epston, each individual develops his own narrative based upon his interpretation of events of which he is, in a sense, a prisoner. Helping the individual develop a more acceptable narrative and distance himself from a difficult situation allows him to build a new narrative in which he has control over his life and is able to get out of a difficult situation (**Michael White** and **David Epston**).[4] Talking about his experiences gives the individual the impression that in addition to being subjected to, even victimized by his situation, he is actually an agent with some control over the circumstances. Whereas the individual had suffered the whims of misfortune, he is now able to take control of his life and to rebuild his self-esteem.

Helpful acquaintances?

At the opposite end of the spectrum of narrative discourse, individuals who are close to victims may avoid raising painful subjects. Conversations become trivial and focus on the weather, the headlines and common events. Trivial conversations carry non-therapeutic value,

[4] Michael White and David Epston, *Narrative Means to Therapeutic Ends*. (New York, W. W. Norton, 1990).

even if engaged with the best of intentions. Unfortunately, what remains unsaid or unexpressed leaves a mark.

That is why it is necessary, depending upon the individual's willingness, to engage in meaningful conversations in which he is free to narrate his experience. If an individual refuses to speak with those who are close to him, a useful tactic is to get him to write down his story or to compose a letter, which he will keep for himself, to those who made him suffer (Boris Cyrulnick, 1993).[5]

One should also avoid repeatedly invoking his sad thoughts and showing empathy which leads him to endlessly relive his trauma and which maintains his impression of being a victim. Empathetic understanding is essential in helping relations. Yet one should always avoid being caught in a vicious circle in which the patient's sorrow and desolation are constantly reflected back upon him. To move forward in bringing the individual to question his goals, wishes, intentions and measures which he plans to implement, the nurse must use a variety of tools at her disposal, such as: reflective responding, questioning, communication and helping relationship skills. The patient/caregiver relationship is an emotional process which should not be too passive or diluted.

The long path to reconstruction

Sadly, expressing a problem is insufficient in itself and does not entail reconstruction. Fortunately, expressing a problem allows the individual to break his silence and to exteriorize or specify his thoughts and intentions. The individual will be in an even better position to get a grip on himself through the use of *self-actualizing tendency.* Even then, the individual might still need help.

Our intervention remains limited during the process of self-reconstruction; the drive must come from within. We can help generate the desire to overcome a problem, but our intervention remains indirect. Our intervention can be beneficial to the individual by reinforcing his self-esteem, dignity and self-perception - all essential vanguards of psychic well-being. These final items are important in giving the individual autonomy and the ability to decide for himself. As such, the actions and opinions of other individuals or events will no longer define him.

Taking charge of one's life

Success in helping an individual become resilient is measured by his ability to take charge of his own life. In order to help him do so, it is essential to determine what motivates the individual and what he desires for himself. In the first section, we noted the importance for individuals to find meaning and cohesion in their own lives.

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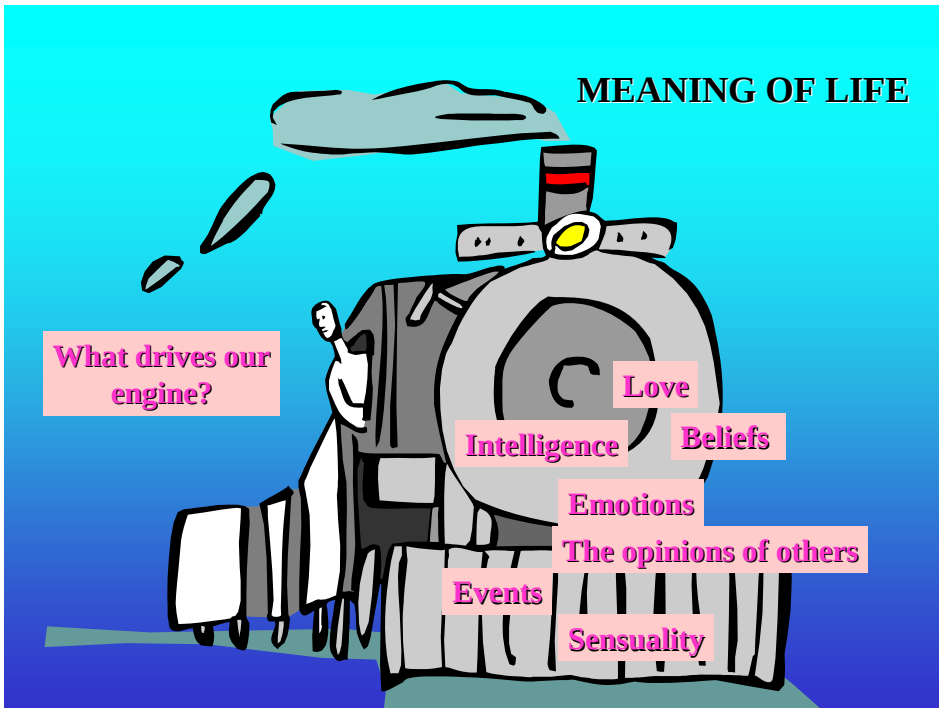
[5] Boris Cyrulnick (1993) *Les nourritures affectives,* Éd. Odile Jacob, Paris dans *Claudia Samson* Résilience. Notes de lecture : http://www.hommes-et-faits.com/Livres/Cs_Resilience.htm



The caregiver can ask the patient questions about his values in order to provide support and to help him find meaning. The caregiver may work with the individual to assess the time he spends on recreational activities, work, studies, friends, family. She might also examine his life goals or identify his destructive ideas in order to combat them. It is essential to identify the individual's source of motivation.

Generally speaking, we are all *zapping* away. We quickly put aside our behavioural analysis and serious reflection. Macbeth states in William Shakespeare's tragedy: "Life … is a tale told by an idiot full of sound and fury, signifying nothing."[6] Many people experience this as reality, and when an unfortunate event occurs, the individual is easily diminished. It might then be beneficial to take to time to reflect upon events. That is the price of change and self-reconstruction (Image Akayen).[7]

Working with children who have suffered neglect, abuse or abandonment

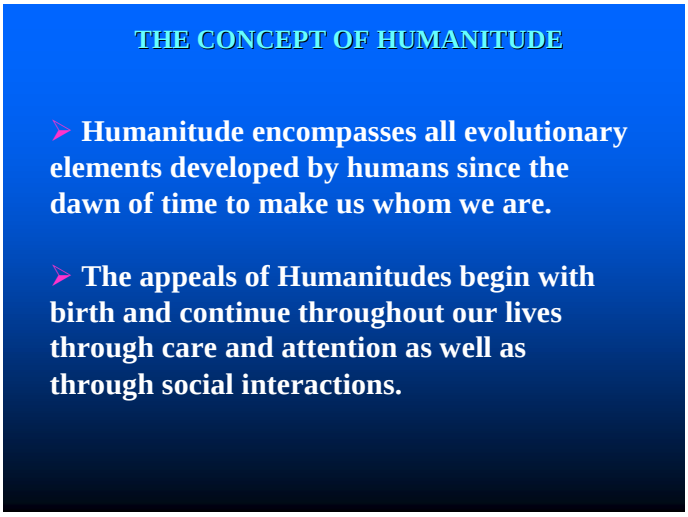
Children who lack affection in the first months of their lives often develop attachment disorder. Attachment begins during biological pregnancy in combination with the mother's psychological desire to have the child. The conditions imposed upon the mother will necessarily have an impact on the child. Modern imagery techniques shed light on the sensorial existence of the foetus. The secretion of hormones during a pregnancy (i.e. ocytocin)

[6] William Shakespeare, *Macbeth* (United Kingdom: Oxford University Press, 1998), 205.
[7] *Tournesol*. Courtesy of Askayen. Available at: http://www.casafree.com/modules/xcgal/displayimage.php?pid=12267

binds the love between the mother and her child.[8] This bond is then further developed through the mother's gaze, voice, odour and physical contact with the child. The baby's first life experiences are strictly sensorial. These experiences are evoked through *humanitudes* (*sic*) which have prevailed throughout the ages in the child's development (Margot Phaneuf).[9]

The attachment grows through the mother's response to the child's physiological needs, her gentleness, and the expression of her love and tenderness (i.e. hugs).

In this way, the child develops his basic confidence or a sufficient sense of security required for his further development and his exploration of his environment.



The attachment is reinforced through the child's various life experiences. It eventually becomes his model for interpersonal relationships in his future life. The child remains somewhat dependent upon this primitive relational model which he will have integrated (see Michel Odent).[10]

Reaction of children who have suffered adversity

The child who is affected by neglect, violence or abandonment is a survivor who faces a great risk of experiencing difficulties due to his mother's primal lack of affection. Whether the child is put up for adoption or not, he risks developing behavioural and learning problems. He may adopt either one of two opposite attitudes: he might continuously seek love and affection in which case all is fair to attract attention. The child then attempts to position himself as a leader or a victim. The child might also react like *Teflon*, which means nothing sticks to him. The child reacts neither to kindness nor to brute force. He generally rejects authority, doesn't trust anyone and refuses to establish physical or eye contact. This child is often manipulative, destructive, and marginal. He may experience learning disorders.

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[8] Petits yeux, petites oreilles : Comment la violence envers une mère façonne les enfants lorsqu'ils grandissent sur Centre des enfants des familles et le système de justice. http://www.phac-aspc.gc.ca/dca-dea/publications/healthy_dev_partb_6_f.html
Public Health Agency of Canada. *Personal Health Practices*. Retrieved on Dec. 4, 2007, from http://www.phac-aspc.gc.ca/dca-dea/publications/healthy_dev_partb_6_f.html .

[9] Margot Phaneuf. Le concept d'humanitude : une application aux soins infirmiers généraux. Infiressources, Carrefour clinique, section Soins généraux : http://www.infiressources.ca/fer/depotdocuments/Le_concept_d_humanitude_application_aux_soins_infirmiers_generaux.pdf
Albert Jacquard popularised the humanitudes concept. It has been put into application by Yves Genest and Rosette Marescotti. See: http://perso.orange.fr/cec-formation.net/

[10] Michel Odent. Dossier de presse : http://www.alternatives.be/presse/michel_odent_dossier.htm

Overall, attachment is critical to the child's normal development and eventual success in:

- Dealing with stress
- Accepting frustrations related to his social environment, school and work
- Managing fears and anguish, and dealing with eventual problems and threats
- Developing balanced interpersonal relationships
- Developing intelligence and logic
- Achieving independence and optimal human development
- Developing the ability to be resilient.

The nurse's intervention

The nurse's intervention often targets parents who fail to understand what is happening to their child. Nurses might also intervene with children who are sick. Every child is different and has his own life experience. Adopting the behaviour that best suits the child's needs can be difficult.

The nurse must first understand the child's experience and then realise that his socially unacceptable behaviour is a reflection of his distress which is the result of lack of affection. Earning the child's trust can lead to the development of other relationships. Nurturing the child's sense of security and self-esteem is always a worthwhile investment. The nurse who shows appreciation and respect for the child might eventually earn his trust; however, it should be understood that having been abandoned, molested or betrayed by adults, he might be defensive and refuse to open up to others. Time and patience are therefore critical elements.

If the child is old enough, reminding him of his sense of responsibility and reflecting his manner of dealing with others can help him evolve and think about his dreams and how he plans to achieve them. This process is long and demanding. It requires a considerable investment of time and patience.

Working with adults who have survived adversity

Adults who have experienced traumatic events (accident, rape, assault) or who have survived a natural disaster often end up in the emergency room. Such an adult is in a state of shock or intense reaction against his plight or assailant. Adversity can have a deep-lasting impact on the adult. Interventions may vary, depending upon when medical staff attend to the victim. The limited duration of stays in medical facilities might not provide him with sufficient help or care. Here are a few suggestions which nurses can use to help such individuals:

- Warmly welcoming the individual and showing empathy are essential. First impressions are always lasting.

- Listening to the individual demonstrates that he is worthy. The nurse's attitude must be respectful and she must show empathy towards the victim.

- Reinforcing the victim's coping mechanisms may be a practical first step. These mechanisms include: **avoidance** during conversations with others in order not to evoke painful memories; **waking dreams** to soften the pain; **affiliation** to confide in key individuals whom the victim trusts; **altruism** to avoid dealing with one's problems by helping others; **sublimation** which allows the individual to channel his psychic activities into acceptable beliefs, etc. Some people consider prayer soothing.

Locus of Control

- **Theory developed by Rotter according to which an individual possesses his own decision-making locus or centre.**
- **It can be internal, meaning that the individual makes decisions according to his own criteria.**
- **The centre can also be external, meaning that the person makes decisions according to the opinions of others and current trends.**
- **The internal locus of control provides greater autonomy and boosts an individual's self-esteem.**

- Reflecting the individual's personal skills and calling upon his past successes to make him realize that he has more strengths than he realizes. These can include success at school, at work, in love, and so on.

- Highlighting the need to develop a **locus of control** of which he is the centre. This can help the victim become aware of his potential and of the importance of not allowing events or the opinions of others to dominate his life. He is the master of his destiny. In itself, this is a good reason to warn him about the risk of bending to the whims of fate or to the decisions of others

Cognitive Distortions

- **Logical misinterpretations which maintain anxiety, depression and adaptation problems among individuals suffering from existential difficulties.**
- **Cognitive distortions lead to false and negative conclusions against oneself, others or life in general.**
- **They create the beliefs which underlie our decisions and behaviours.**
- **These distortions become more obvious in highly emotional situations. Our reactions to stressful events call upon this false manner of interpreting them.**

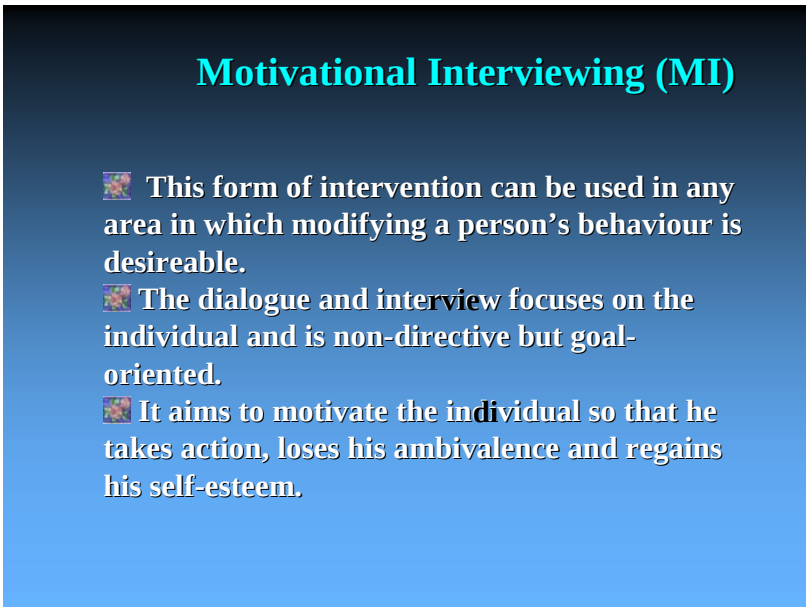
- Discussing choices with him. A good way to achieve this is to reflect upon choices which seem inappropriate (i.e. abandonment of life-time objectives, withdrawal, desire to feel numb, paralyzing anger, decision to no longer trust anyone) and to reinforce those which demonstrate a willingness to move ahead and change for the better. Such measures might include: writing a logbook, reading appropriate material, making better friends, getting away from toxic individuals, developing a correspondence, studying, travelling, finding a new job, and so on.

- Making the individual realize which negative defence mechanisms he is employing: **denial** which clouds reality; **regression** into illness; **compensation** by indulging in food, medication, alcohol or drugs; **activism** by wasting energy which creates the illusion of taking action; and **turning against the self**.

- Observing whether the individual repeatedly uses negative defence mechanisms is critical if one wishes to help him get out of a rough patch and help him improve his psychological well-being. Renowned psychiatrists have developed a number of scales to identify, assess and quantify the defence mechanisms used by subjects. Perry developed one which is widely used (**Charlotte Soultanian, Roland Dardennes, Stéphane Mouchabac, Julien Daniel Guelfi)**.[11]

- Pointing out the repeated use of **cognitive distortions** such as **generalizations** ("All men want the same thing"; "Nobody can be trusted"), **arbitrary inference** ("People stare at me at work and know what has happened to me"), **mind reading** ("I know what they're thinking"), or **maximizing negative events** and **minimizing positive events** ("I'll never get over what happened to me; my life is ruined").[12]

Such cognitive distortions can be considered a psychological barometer which measures the individual's level of pessimism. The repeated use of cognitive distortions reinforces and maintains the depressive state of the individual. Encouraging the individual to use positive language and to be aware of his negative speech may help him.[13]



- Remaining on the lookout for psychological needs and potential health problems, worrying about the individual's psychological pulse, and determining whether he is depressed or entertaining suicidal thoughts (increase surveillance if this is the case and intervene rapidly if necessary). Caregivers can use the Psychomédia evaluation grid for depressions to assess the patient.

- Adopting ***motivational interviewing*** strategies for unmotivated individuals. Our interventionism and desire to do the right thing often lead us to adopt more or less directive behaviour with individuals. We used to believe in the need to resort to *confrontational* methods to alter rigid defence mechanisms. Authors William Miller and Stephen Rollnick

[11] Charlotte Soultanian, Roland Dardennes, Stéphane Mouchabac, Julien Daniel Guelfi, l'évaluation normalisée et clinique des mécanismes de défense : revue critique de 6 outils quantitatifs http://ww1.cpa-apc.org:8080/Publications/Archives/CJP/2005/october2/cjp-oct-2-05-soultanian-RP.pdf

[12] Neurolinguistic programming (NLP) seeks to identify cognitive distortions and works in order to help an individual become conscious of them.

[13] *Petite grille d'évaluation de la dépression.* Available at Psychomédia: http://www.psychomedia.qc.ca/squest1.htm

suggest an alternative investigative approach to prepare the patient for changes and to identify reference points during the dialogue. The directive approach has been replaced by a more motivational attitude.[14]

- Resorting to a solutions-based approach to find adapted methods to help the individual get out of his situation in accordance with his own values.[15]

- Getting the individual to express his dreams can build a relationship. Expressing our aspirations, goals and dreams can temporarily remove the feeling of victimization. This temporary escape can ultimately influence the individual and generate sufficient motivation to implement methods to achieve his dreams.

- Talking with the individual about the adaptive process, his personal development, and the attention that he pays to his emotions so that he can appropriate them. The ***casita*** model described in the first half of this text illustrates the importance of consciousness and the appropriation of emotions management in helping individuals become resilient (Margot Phaneuf).[16]

Solution-Focused Brief Therapy

- **Brief therapy developed in 1982 by Steve de Shazer, Insoo Kim Berg, and the Brief Family Therapy Center team of Milwaukee, Wisconsin, USA.**
- **This approach centers on the individual's resources and views him as an expert about himself.**
- **It focuses little on understanding the problem and its root causes.**
- **The caregiver focuses instead on the individual and his abilities.**
- **This method encourages change and attempts to push ahead or reinforce the individual's ability to find simple, adapted and achievable solutions.**
- **This method is practical and hands-on. It makes use of techniques such as narration, identifying achievable goals, miracle questions, perceiving extraordinary situations in which symptoms are less present, using quantifiable scales, and so on.**
- **The results obtained guide this method.**

- Convincing the individual to be himself despite pressure from others and demonstrating that only he can choose his own actions is important.

- Encouraging the individual to live for the moment, enjoy the present and not dwell upon the past.

[14] Margot Phaneuf. Motivational Interviewing. Infiressources, Clinical Crossroad, section Mental Health and Communication. http://www.infiressources.ca/fer/Depotdocument_anglais/Motivational_Interviewing.pdf
[15] Berg, Insoo Kim et Yvonne Dolan 9200) Récits de solutions. Saint-Hyacinthe, Québec, éd. Edisem.
[16] Margot Phaneuf. Resilience: Abstract concept or way of life. Infiressources, Clinical Crossroad, section Mental Health and Communication:
http://www.infiressources.ca/fer/Depotdocument_anglais/Resilience_abstract_concept_or_survival_skill.pdf

- Taking care to avoid mobilizing the individual against his will, which would be tantamount to infantilizing him and maintaining his status as a victim. Other elements to avoid: The individual who is suffering might wish to hang on to the caregiver and become dependent upon their relationship and stick to him like *Velcro* in a relationship built on dependence. This trajectory might seem absurd, yet it is in fact entirely possible. Caregivers must always remain alert.

Conclusion

We have just covered the basic elements that are necessary to help a child or indeed, any individual become resilient and rebuild his life after a catastrophe or hardship. Boris Cyrulnick describes this process in *Les nourritures affectives* (lit. Emotional Food). Nobody can predict his own destiny, but we can prepare ourselves to turn adversity into success. Nonetheless, we need help to achieve this goal. Regardless of our personal abilities, we need a helping hand or a receptive circle around us. That is the moment when the nurse or caregiver listens and demonstrates empathetic understanding to the individual who has experienced trauma.

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