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What's wrong with resilience

Yesterday I managed to inveigle my way into a panel of people who are experts on resilience. We were invited to speak about the subject as part of a happening¹ at the Royal College of Nursing in London. There was an audience of seventy or so nurses, midwives, students and others. We were billed as representing different approaches to resilience and were given a chance to set out exactly what those approaches were as well as respond to some questions from the audience. On the panel was an NHS nurse manager, two speakers from the *DNA of Care* project funded by NHS England which collects audio-recorded stories from NHS staff, a worker from the RCN's counselling service and a PhD student investigating resilience. I had come to argue for my perspective which you will have the pleasure of reading about in a moment.

My apprehension about this kind of event, where different viewpoints on, apparently, the same topic are discussed is that the differences, both small and large, get oddly overlooked as each person hears the same uttered words in a slightly different way. And resilience has got to be one of those 'empty signifiers' marshalled for all kinds of purposes and causes. In its common usage among healthcare workers at the moment I think it is often a term that supports the status quo. It can leave staff who might be traumatised by organisational failures feeling personally responsible for those failures. I knew this was true in theory. Testimony from the audience that evening gave us some terrible examples of its operation in practice.

My main argument, to put it in a nutshell, is that resilience at the moment is a fad that has been taken up by many groups (we were there to look at it in nursing) superficially without proper understanding of where it came from or what has been left out from the original concept.

When you look at writing about resilience in nursing, it is overwhelmingly submissive. It is dominated by phrases like 'roll with the punches' or 'helping the nurse to survive at the bedside for longer'. Articles encouraging nurses to be resilient always start in the same way: 'you can't often choose what happens to you but you can choose how you react'. So, the largest clinical workforce in the UK (and most countries) with its 450,000 strong trade union has given up on influencing what 'happens to it' to use this passive phrase. Instead, the nurse promoters of resilience are telling the workforce to develop optimism, or a sense of humour, to bounce back or roll with the punches. Of course, their intention is good but what they end up doing is urging nurses to acquiesce, to support the status quo. I have never seen any article about resilience claim that resilience is the basis for activism and change. The promotion of resilience is a purely individualistic attempt to mitigate systemic problems. Individual nurses are, basically, being asked to take responsibility for political decisions and systematic failures. The promotion of resilience covers over more complex and disturbing issues for the individual and organisations. You could say that this is one reason why it is so popular. The individual is left to deal with issues themselves when

¹ Many thanks to Anda Bayliss from the RCN for conceiving and organising the event and to Jane Hughes for chairing it.

developing so-called 'resilience' fails to help them. The organisation gets off the hook but never solves its basic problems.

So where did this idea of resilience first gain popularity—at least in its current form? It was child psychologists working from the 1980s onwards who were puzzled by the observation that some children from tough backgrounds appeared to succumb to their origins while others seemed to thrive and escape its harmful influence. They first talked about 'invulnerable' children (Anthony and J. Cohler 1987) but soon swapped this awkward label for the term resilient. Their model was that protective factors modified the impact of adversity on children. And these protective factors could be operating at the neighbourhood, school, family or individual levels. Actions aimed at improving resilience tended to be community-focussed. In fact, early researchers in the field had the prescience to warn that the concept of resilience could be misused by policy makers as an excuse to withdraw services and encourage the socially disadvantaged to simply shape up.

Then, as psychologists brought their characteristic methodology and techniques of individual measurement to bear on the topic, an approach emerged where the communal dimensions of investigations into resilience were dropped. Many researchers focused purely on the attempt to measure this mysterious resilience by means of the psychological questionnaires that we are all familiar with. Personally, I think there is something seductive as well as more convenient in calculating Cronbach alphas and other statistics compared with trying to understand the messy world of social forces and interactions. We can see that 'pop-psychology' has taken up this individualistic approach with a proliferation of websites and articles urging us to learn some resilience skills.

The next problematic move comes with the adoption of resilience in nursing research. Nurse researchers, in almost every piece of writing I have seen, understand resilience in purely individual—individualistic—terms. They hand out questionnaires to nurses to measure their level of resilience, saying sometimes that this could help managers 'target' resilience training. None to my knowledge have attempted to assess whole organisations or units for resilient characteristics. It is not far-fetched to think that a resilient healthcare provider would be one with built-in capacities and procedures that enable the maintenance of safe staffing levels even when a particular unit is short of staff due, for example, to sickness. To imagine, as some do, a resilient organisation as one where managers touch each other on the arm, make eye-contact and talk about 'taking care of yourself' is the result of being unable to conceive of resilience as anything other than a personal characteristic.

Many nurse researchers seem unaware of the history and the complexity of earlier resilience studies. Definitions of resilience in this literature show an over-reliance on other research written by nurses perpetuating a partial understanding of the term. They repeat in the introduction to their studies the unempowering mantra of resilience: 'you can't often choose what happens to you but you can choose how you react'. Paradoxically, at the same time as configuring the individual as one who bears responsibility to 'cope', they seem uninterested in talking to the individual to find out what adversity or protective factors mean to them with their unique history. Even worse—and this is the crucial point of my argument, they mix up and fail to distinguish between two entirely different sources of 'adversity' for nurses. The first source, you could say is intrinsic to the work itself: dealing

with the suffering of patients and their families, with the effects of extreme illness or mental distress. The second is the adversity that is the result of political decisions, under-resourcing, poor management, dysfunctional and insecure organisations, disempowered nurse managers, sexism, racism in the workplace, that all result in understaffing, perhaps, and high turnover. The first category of adversity you might say comes with the work and nurses have to develop ways of dealing with it. The second clearly does not and is the result, usually I would argue, of more or less deliberate decisions by politicians and policy makers pushing the envelope, to put it crudely, of what they can get away with.

Nurses who go on resilience courses or who urge others to go, with the best of motives I am sure, are simply playing into the hands of those who do not understand or perhaps value nursing work. And what is worse, they perpetuate a contemporary mind-set that promotes the individual bearing responsibility for situations that are the making of others. Many see this tendency as a feature of neo-liberal ideology that has dominated governments since the late 1970s. The possibility of collective activity: resistance, challenge, systemic change simply fades out of consciousness.

Faced with the kind of pressure I have just mentioned I think it better for nurses, better for the NHS and its patients in the long run that nurses resist rather than acquiesce. And I want to end this perspective with some ideas about exactly how they might do this.

‘Critical resilience’

So, what is the alternative to this individualistic and basically submissive form of resilience? I put forward something to you that we could call ‘critical resilience’. I wrote a recent book about it (Traynor 2017).

Critical resilience is about understanding: understanding ourselves and our experiences in relation to our society—to take a phrase from feminist consciousness-raising groups (Chicago Women's Liberation Union 1970). The combination of becoming informed about the political and policy forces acting on day-to-day working life with frank, mutually supportive discussion can develop critical resilience. Neither on its own is enough. Getting informed by reading a radical nursing blog on health policy or on the latest NMC initiative for example is just the starting point for responding. And discussion without information can too easily turn into complaint where the pleasure is not in the creative energy released by analysis and planning to do something, but in simply repeating expressions of suffering.

Critique is a practice that demands a rigorous engagement with its object. It is also productive because it can lead to action. I suggested, to nurses present at the event, and to readers today, that we explore the possibility of setting up groups with fellow students or colleagues to develop informed critiques about aspects of working life. These could be place-based or asynchronous—a nice word to describe social media and web-based discussion forums that are present even for nurses who are isolated in whatever way. Becoming an active member of the RCN or other trade union is, clearly, a good first step.

Getting together and getting informed are the twin foundations for developing critical resilience.

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Fifty-word bio

Michael read English Literature at Cambridge University, then completed nursing and health visiting training. He worked at the Royal College of Nursing in London and at the Centre for Policy in Nursing Research at the London School of Hygiene & Tropical Medicine. He is now Professor of Nursing Policy at the Centre for Critical Research in Nursing and Midwifery at Middlesex University. He is editor of the journal *Health: an interdisciplinary journal for the social study of health, illness and medicine*. He recently wrote *Critical Resilience for Nurses*, published by Routledge in March 2017. He is currently writing *Tales of Resilience: stories from the front lines of nursing*.

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