Empowerment Strategies for Nurses
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To the many nurses who, in their efforts to support the health and well-being of patients, confront challenges, yet are able to persevere, thrive, and be an inspiration to us all.
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In the last decade, technology, social media, and globalization have had huge impacts on the way our community operates, on the way news is reported, and on the way we interact with others. Migration patterns, whereby millions of people around the world are being displaced from their countries of origin due to war, famine, and environmental disaster, are likely to continue into the future, and the developed nations will increasingly need to respond to these challenges. Uncertainty and rapid change will have an effect on the health and mental health needs of the community. In order to face the challenges ahead and flourish, we need to intentionally develop and cultivate the resilience of the population.

Nurses will be key to constructing and supporting more resilient communities, and this book, Empowerment Strategies for Nurses: Developing Resilience in Practice, Second Edition, is a valuable resource in nurses' efforts to do that. Importantly, and as a first step, nurses need to develop personal resilience and support those we work with to do the same. As supporters, carers, navigators, and interpreters of the healthcare system, nurses have a particularly important role within that system. While of course nurses work as part of a team, within that team individual nurses often take on many roles at the same time they provide people what they need, in the way that they want it, all within a too-busy workplace that has its own demands. As a result, nursing work can be stressful, overwhelming, and exhausting. How can a nurse provide person-centered care in a kind, caring, and compassionate way if his or her fuel tank is empty?
It is not an indulgence for nurses to look after themselves, to nurture themselves, in order that they can more effectively provide care to others—in fact, it is essential; that is why this book is such an important tool for self-care. Nurses do not provide nursing care in the absence of our own life experiences—understanding this and learning how to develop and enhance your own resilience are crucial.

In addition to an important focus on self-care, this new edition provides nurses with knowledge, skill, and strategies to help people move toward their own recovery. As we know, empowering people to be leaders in their own healthcare, regardless of the symptoms or challenges that they experience, can only have positive outcomes. This book provides the reader with strategies to enhance practice, and motivate, empower, and support a strength-focused approach with the people under their care as well as their families and communities. It provides clear and relevant chapters, discussing not only the theories that lay behind resilience but practical strategies to consider and use in the workplace and personally.

Mathematician, meteorologist, and theorist Edward Lorenz (2000) identified the notion that small events can have large, widespread consequences. The “butterfly effect” he described has become a metaphor for the existence of seemingly insignificant moments that alter history and shape destinies. Typically unrecognized at the time they occur, these moments create threads of cause and effect that appear obvious in retrospect, changing the course of a human life or rippling through the global economy. In this context, nursing work can at times look simple, but nurses—myself included—know it is not. We know there are flow-on effects to the work that we do every day that impact the lives of the people we come in contact with, as well as the lives of their families and communities. This book takes you on a journey to look beneath some of those interrelationships and explores strategies for all people—identifying how nurses can be leading change agents in the world of healthcare, one small step at a time.

It is so pleasing that this book is being published at a time when healthcare can seem so complicated and difficult—whether for the consumer or healthcare professionals. I commend the editors and contributors for leading the way in such important work; small,
meaningful changes and every act of kindness, care, and compassion can have effects that last a lifetime.

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**REFERENCE**

Welcome to the second edition of the volume that began life as *The Resilient Nurse: Empowering Your Practice*, which was published in 2011. This new edition differs in many ways from the first and includes a majority of newly commissioned chapters and new authors. This was important, as the field of resilience has changed significantly since this book was first compiled. Furthermore, the first edition focused on the resilience strategies that nurses can implement to strengthen themselves. In this second edition, we extend this insight, adding information on what nurses can also do to strengthen and motivate patients with whom they work, and who may be susceptible to feeling helpless in the face of overwhelming stressors. We explain that resilience, therefore, has a double purpose for nurses—it is a tool for self-care as well as for supporting and building strengths within patients, families, and communities. In this last category, we include the community of nursing and the healthcare community more generally.

To Mahatma Gandhi, the Indian philosopher and leader, is attributed a famous quote charging his followers to, “Be the change you wish to see in this world,” although this—much misquoted—phrase was only actually used by a teacher, Arleen Lorrance, in the 1970s (see Lorrance, 1974, p. 85). Although not exactly Gandhi’s words, this simple, yet profound message reflects his ethos and drives the rationale for this book. That rationale is for nurses to clarify their purpose as change agents and implement strategies that promote health and well-being in patients, individual nurses, nursing as a profession, the healthcare system, and society. That sounds ambitious,
but that is how Gandhi lived his life. He chose to object to injustice, but he did this thoughtfully and carefully. Like many great leaders, he used both words and actions to great effect. He was not only a great orator, but also an aspirational role model for many others. Although he experienced personal conflicts and pain, he believed in active peacemaking and that this could be used for the benefit of the world and all its peoples. For these reasons, one of Gandhi’s enduring messages, and one which can be directly applied to nursing, is that the actions of each individual can make a difference, not only to the individual, but to all those with whom that individual comes in contact. For nurses, this means not only the patients (and family and friends) whose lives they touch, but also the other nurses he or she works with, the healthcare setting in which they work, and the entire healthcare service. Each nurse will also affect and influence others indirectly. People watch and learn from the nurses around them, and their lives may be transformed by a single encounter with a nurse.

Nursing involves complex work in global health systems that are themselves becoming increasingly multifaceted. While nurses can flourish in such systems, they can also suffer. If a nurse is not prepared for the emotional and cognitive labor involved with caring, then the work of nursing can become a burden, leading to stress, burnout, and neglectful care. If a nurse is not, moreover, prepared to call out poor practice and step up into a leadership role when necessary, the problems in healthcare systems will never be resolved and are likely to increase in severity and negative impact.

Wherever nurses go, they encounter loss and suffering. It is impossible not to be touched and sometimes hurt by this, but through understanding suffering and compassion; practicing self-awareness, self-care, mindfulness, and other reflective practices; and working to gain a sense of meaning and connectedness, nurses may be better able to care both for patients and for themselves. This is what we see as developing resilience practices.

Within this book, several workplace challenges are discussed, and a range of strategies are presented to assist in avoiding or resolving such challenges. This will allow readers to be more prepared for new, difficult, and challenging encounters. Rather than feeling powerless, readers can arm themselves with awareness and problem-solving strategies that will assist them in feeling more confident about being
a positive influence in their workplaces and their chosen profession. As a result, readers will feel less self-doubt and less tentativeness and suffer less emotional distress.

The aim of this book is to assist nurses to cultivate qualities and use proven strategies to retain personal professional strength. For, in the scheme of things, nurses have shown time and again that they are a precious and vital resource for society. Nurses are the hand that reaches out to offer comfort and connection. Nurses are the voice that translates jargon into understanding. Nurses are the actors that transform crisis into coping. Nurses are, and ought to be, the leaders in humanizing healthcare. Moreover, nurses are not alone in this endeavor. Every other clinician is charged with the same responsibility to move beyond the technique, the clipboard, and the technology to be a better human being.

Despite other clinicians’ skills and foci, nurses are the linchpins of health services. Nurses are the human face of health services, for when people think of hospitals, they think of nurses. When people think of care, they think of nurses. Therefore, when things go wrong in healthcare, when people are dehumanized or experience undue suffering, people look to nurses, their surrogate mothers or fathers, to look out for them, to take charge, and to bring back order and control. Thus, the nurse’s place in the healthcare environment, individually and collectively, is not only important, it is therefore formative in shaping the healthcare landscape.

Nursing is not an easy career, and no one will be a leader at the very beginning of that journey, or all the time even in a leadership position, but with determination and some words of inspiration, found, we hope, within the pages of this book, the personal qualities that lead individuals to nursing will be developed into mature leadership skills.

This book is structured into two parts that will help the reader to develop resilience and to be empowered to make changes based on thought rather than on reaction.

Chapter 1 introduces the concept of resilience—a response to adversity that requires psychological as well as social adaptive responses in order to release emotional tension and bounce back to a productive way of living and working.

Chapter 2 considers the qualities of nurses in history who made an enduring difference to the world and, of course, to nursing.
Chapter 3 explores the contemporary problems that exist globally and that challenge the resilience of patients and healthcare providers. That solutions have not yet been found means they have become wicked problems and it is these that nurses, as change agents, need to be prepared for and become armed with effective and creative solutions.

Chapter 4 elaborates on the concept of a resilience standpoint that assists in working out how nurses can relate to and communicate with patients in more facilitative and empowering ways than would a traditionally focused illness care practitioner and to relate to self and other nurses in ways that are supporting and motivating. The chapter also explores communication theories that explain some of the sources of misunderstandings in the workplace and provides strategies that can be used to interact assertively and effectively.

Chapter 5 looks at ethical thinking as an organizing framework to help nurses appraise situations with logic and reason and then to think through dilemmas that could otherwise cause distress.

Chapter 6 focuses on psychological thought processes, particularly our tendency to appraise people and situations automatically, which can result in hasty judgments that are colored by prejudice, past experiences, or faulty logic. In order to think more positively about challenges that may present, we must be aware of such tendencies.

Chapter 7 explores complex health needs of patients and the realization that, if nurses are to work collaboratively with patients, they need to articulate what a holistic or ecological view of health and well-being means. Patients are social beings, not just bodies with organs and systems that succumb to disease. Their health and well-being are impacted by, and promoted by, what is going on psychologically, socially, environmentally, spiritually, and politically.

Chapter 8 explores the reality that challenges the resilience of patients and clinicians—that people are no longer patients of just one healthcare system and that, because people do have complex needs and medicine and healthcare have diversified into specialties, patients and nurses cross many borders.

Chapter 9 examines the impact of severe stress and adversity on people and the novel strategies that can be put into place to restore resilience, health, and well-being.

Chapter 10 reminds nurses that one of the basic systems in which they work, nursing and multidisciplinary teams, is often an
unappreciated asset. Working in teams is a nursing reality and yet understanding how to make them work effectively is often taken for granted. By focusing on the dynamics of teams, this chapter reclaims team work, team leaders, and followers as a vital resilience strategy.

**Chapter 11** considers what happens after the working day is over, so that meaning is made of any adversity encountered. In this way, stress is processed and let go. The chapter explores different kinds of coping strategies, encouraging the discerning use of practices that will assist in living a healthy life where work and personal lives are in harmony.

**Chapter 12** provides examples of nurses who embody another potential source of resilience—leadership skills—so that qualities can be revealed and elaborated upon, internalized by readers, and shared widely with nursing colleagues.

**Chapter 13** brings the book to a close by discussing one further resilience strategy that promises to strengthen an individual nurse’s commitment and purpose—the power of professional unity. United groups know that there is strength in numbers.

Each chapter includes a series of activities that are designed to encourage readers to contemplate key concepts raised about resilience and how they can be adapted and implemented to support patients’ well-being as well as their own. We have also produced a companion to the book as a resource for nursing instructors. The companion, which draws upon the expertise of experienced educators from across the world, provides teacher-oriented activities, multiple-choice questions, and trigger questions that can be used in class or online to promote student reflection, stimulate discussion, and inspire learners to take effective action in their professional lives.

_Qualified instructors may obtain access to supplementary material (Instructor’s Manual and PowerPoints) by emailing textbook@springerpub.com._

Nursing is exciting, rewarding, and responsible work. Nurses bear witness to other people’s pain and may even experience vicarious trauma. To emerge positively and grow from all of the challenges they face, all nurses need to draw on the special quality of resilience and assist in developing resilient workplaces and more resilient and sustainable health systems that can better deliver the highest standards of person-centered care.

_Margaret McAllister
Donna Lee Brien_
REFERENCE


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Finally, as editors we would each like to thank each other. We have collaborated on many projects and brought to this volume our dissimilar scholarly and creative backgrounds, diverse approaches and networks, and different skill sets. We continue to learn with, and from, each other; perhaps because of this, working together has been one of the enriching pleasures of this project and, we both believe, at the heart of its realization.
Share

Empowerment Strategies for Nurses
Resilience in Nursing

Margaret McAllister and Donna Lee Brien

INTRODUCTION

Nursing involves complex caring work—nurses support patients physically as well as mentally. During critical times of illness, patients may be vulnerable to stress buildup and breakdown, unless they are able to access and use effective strategies to avoid, reframe, or relieve negative stressors. At these times, nurses themselves may be vulnerable to the negative stressors by association. Witnessing other peoples’ adversity can be traumatizing. Thus, the issues to be discussed in this chapter, the concept of resilience and how it can be developed, are relevant for nurses in two ways. Nurses can draw on knowledge about resilience to assist and encourage patients to withstand the pressures of ill health and to maximize their own strengths and supports to stay strong. Nurses can also apply what they know to their own health and well-being so that the physical, emotional, and cognitive labor involved with caring does not become a burden and deplete caring reserves.

The skill with which resilience strategies can be applied by nurses in their interactions with patients can be subtle and effective, yet when missing from care can leave patients feeling helpless and exposed.
Donna’s Story

Donna is in her late 50s and, after decades of good health, recently found herself in hospital having a major surgery. At the time of her operation, Donna was working as a senior academic in an Australian university in creative writing. Over the past 2 or 3 years, she had felt increasing pain in her groin, developed a pronounced limp when she walked, and had a decreasing scope of movement in her right hip. Neither over-the-counter nor prescription analgesics offered much relief. After numerous x-rays and scans, she was diagnosed as requiring a total hip replacement. This was very new for Donna. It was the first surgery she had needed since having her tonsils removed as a little girl. Her doctor recommended two local specialist surgeons and, after meeting them both, she was happy with her choice. The private hospital was conveniently nearby and had an excellent reputation. Donna had checked online for any issues with care and mishaps during surgery and was pleased to find news articles lauding her surgeon’s ability. She also spoke with a number of friends and colleagues who all spoke highly of both the hospital and these doctors. She followed all the preoperative directions carefully and felt she had prepared as well as she could for the surgery, although she was, she admitted to her closest friends, quite fearful of the procedure and, especially, the anesthetic.

The joint replacement surgery went well, and after the surgery Donna received excellent care from many nurses, but one particular encounter was distressing. Although she was soon up and walking, Donna felt very nauseous, so much so that she was diagnosed as at least very sensitive to (if not allergic to) opiate-based pain killers. As a result, she was provided with an electric version of an ice pack that circulated cold water through a pad that, when left pressed against the area of the wound, significantly reduced her pain. This allowed Donna to reduce her analgesic intake and was very effective as long as the tub of ice water was replaced whenever it warmed up. Most nurses checked its function and quickly replaced it if Donna mentioned it needed to be, but there was one nurse who rolled her eyes and said, “You don’t really need that anymore do you?” and removed the pad from Donna’s hip. While she was doing so, she looked at the cover of the popular crime novel Donna was reading and sniffed, “I wouldn’t have thought you would be reading that kind of book.”
The nurse then swept out of the room with the apparatus, making sure Donna also knew how busy and short staffed the ward was that day. Donna felt the pain returning to the wound and endured it for an hour or so. When the operated-on area felt very hot and sore, she rang her buzzer, but the same nurse came into the room and asked, quite cuttingly, “And what do you think you need now, Professor?” Donna felt completely crushed and asked for some water. When the nurse had left, she tried to rest the cool glass against her hip, but it could not provide anything like the relief the ice pack had given her. She began to cry, and when a student nurse came in to check her blood pressure, she asked Donna what was wrong. When Donna mentioned her pain and continued nausea, the student retrieved the ice pack and asked another nurse to come and see Donna; this nurse dispensed some medication to help relieve the nausea. When Donna later thanked the student nurse and explained that one of the other nurses had taken the ice pack away, the student admitted that not all of the nursing team were on board with the new treatment.

Later that evening, Donna was confiding with her friend, a nursing professional, about her ordeal—her pain, the tension that arose because of the inconsistent care, and the mean-spiritedness of one of the most senior nurses. Her friend admitted that some older staff, although more experienced, were dismissive of complementary approaches to pain relief, thinking them inferior to analgesics, much more time-consuming to apply, and nothing more than new-age nonsense. They both noted the student nurse’s attention and how much she had helped her patient.

Learning From Donna’s Story

This is our own story of a recent healthcare experience. Elements within the story reflect empowered actions on the part of the patient—she took charge, for example, of finding out about her surgical staff and the hospital. It is also a powerful example of the foreseen and unforeseen stressors that added to the illness experience culminating in a tipping point where Donna’s self-caring resources were exhausted, and she was vulnerable to trauma. One nurse’s demeanor and behavior eroded the patient’s confidence to the point where she could not even ask for the care she knew she needed, and another’s built it back up again in two
actions that took, at maximum, 10 minutes. It is not clear how, or if, the nurses in the story consciously used resilience strategies in their interaction with the patient. It is also unclear whether they thought to apply resilience to their own work role. That there was tension between nurses, however slight, was evident, and if unaddressed, this could become draining and unproductive—and could even escalate. As a source of negative stress, peer tension can accumulate and one day it too could culminate in a tipping point for the student, who may decide that her ideals for practice are not shared by others and her commitment to nursing will fade. But what if that student were to develop positive communication strategies to reduce the tension, to clarify purpose, and to create a healthy workplace where patient comfort, well-being, and confidence remain a topmost priority?

The story reveals the simple things that patients and nurses can each do to foster their resilience. But it also reveals how nursing, like all other human service work, can be both taxing and rewarding. The purpose of this book is to maximize the strategies to make nursing work satisfying, effective, and empowering.

The story reveals the simple things patients and nurses can each do to foster their resilience.

**STRESS AND THE IMPORTANCE OF RESILIENCE**

**Expectations of Today’s Nurses**

Being prepared for the challenges ahead may make all the difference in being able to persevere in your career and make a success of it. An important element to consider is what employers may expect from you. As a nurse in the 21st century, it is likely that your expectations and needs as a worker differ from those of previous generations. Unfortunately, the large bureaucracies, characteristic of many health services, can be slow to respond to changing needs (Hodges, Keeley, & Grier, 2005)—whether needs of patients, or the workforce. Holmes (2006) has described several characteristics typical of today’s millennial workers and Glass (2007) adds some additional characteristics (Box 1.1).
If we add some of the negative characteristics of the typical health bureaucracy (Box 1.2), then we have the perfect recipe for conflict, stress, burnout, and neglectful care (Holmes, 2006).

Perhaps this is why some progressive health services are now instituting employee-friendly policies and practices and marketing themselves as great places to work (Figure 1.1).

BOX 1.1 Characteristics of the Y Generation (Also Known as the Millennials)

- Likely to have received a full high school education
- Envision many careers during their lifetime
- Technology-rich and multimedia literate
- Time-poor
- Impatient
- High expectations of employers:
  - Expect autonomy in the job
  - Less acceptance of seniority
  - Expect performance-based remuneration
  - Oriented toward results
- Need to see meaning and value in their workplace contributions
- Value work–life balance
- Unlikely to have loyalty to one employer


If we add some of the negative characteristics of the typical health bureaucracy (Box 1.2), then we have the perfect recipe for conflict, stress, burnout, and neglectful care (Holmes, 2006).

Being prepared for the challenges ahead may make all the difference in preventing undue stress, enjoying your work, and increasing success.
Sources of Stress

Aside from having to work in a bureaucracy, sources of stress in nursing work are numerous. Rising patient acuity, rapid assessments and discharges, and increased service use by clients mean that nurses are dealing with sicker people who are likely to have multiple conditions that may complicate both the treatment and the recovery (Gaynor, Gattasch, Yorkston, Stewart, & Turner, 2006). These pressures can lead to work-role overload and burnout.

BOX 1.2 Negative Features of Large Bureaucracies

- Uneven staff skill mix
- Rapid staff turnover and instability
- Work conditions are employer focused
- Economics is the bottom line (consequences include widespread unpaid overtime)
- Rigid and disparaging management
- Controlling (leading to limited worker autonomy)

Therefore, the health service that you join is unlikely to be the comfortable, predictable, friendly place that is depicted in some television shows and prevalent in the public imagination. For a start, the people in teams will probably change quite rapidly. Certainly, the client turnaround will be fast. You may be quite regularly rostered to new areas to fill workforce gaps. Hence, understanding more about stress, and ways to reduce, manage, or overcome it, will be an important asset.

*Understanding more about stress will be an important asset to your career.*

In the mid-20th century, psychology involved the study of the individual human brain, particularly the abnormal brain. It was concerned about causes and treatments of disorders and tended to be preoccupied with a deficit approach. In practical terms, what this meant was that abnormal psychology was given far more emphasis than normal psychology. Stress became synonymous with distress and trauma. It was thought that stress was something that was always to be avoided. Occasionally, there might occur some individuals who appeared to be invulnerable to stress and they became an object of curiosity and hypothesizing. These resilient individuals were thought to be the bearers of a number of enviable traits, such as being naturally “stress-hardy” (Kobasa, 1982). Research in this era concentrated on identifying these traits so that they could be enhanced, and psychologists encouraged people to avoid the noxious effects of stress.

As time has gone on, psychology has undergone somewhat of a paradigm shift. The positive psychology movement (Seligman, 1998), with its interest in strengths and well-being, has broadened the examination of stress and its harmful effects to also include an appreciation for the useful effects of stress. Now we know that not all stress is bad. Some stress can be motivating and indeed enhance performance (Howells & Fletcher, 2015). This kind of stress is called *eustress* and could include things like going on a holiday, starting a new job, having a child, or retiring (Selye, 1976). Stressors like these are likely to be positively valued, may cause temporary anxiety but will also result in a sense of accomplishment and are positively reinforcing. The more we face them, the more we like them.
Also, we now know that stress buildup and breakdown does not just occur for vulnerable people like patients or at-risk communities. It also occurs in occupations that are dynamic, fast-paced, and involve being a witness to tragedy, trauma, or moral dilemmas, such as the military, doctors, nurses, paramedics, and police officers (Howe, Smajdor, & Stockl, 2012).

Another important development in thinking that has come from psychology is that people are capable of psychological growth and making positive change even after they have been hurt by trauma. This is called posttraumatic growth (Calhoun & Tedeschi, 2014). In addition, neurobiological research into the human brain has revealed that neural circuits can be shaped by adversity, and because these brain cells demonstrate neuroplasticity and can regenerate, strategies such as cognitive therapy, mindfulness, and meditation may be helpful in retraining the brain to rebound, recover, and change (Davidson & McEwen, 2012).

The Stress Diathesis Model

The stress diathesis model suggests that accumulation of stress can lead to health breakdown (Figure 1.2). The model also proposes that people must first have a biological, psychological, or sociocultural predisposition to such disorders and must then be subjected to an immediate stressor to develop disease or other abnormality (Fontaine & Fletcher, 2003).

![Figure 1.2 The stress diathesis model.](image-url)
Most people go through life with predispositions to various disorders that are never expressed. What protects them from succumbing to the stressor, or what methods they use to moderate that stressor, are important to understand and underscore the significance of another important and now quite widely discussed concept—resilience.

Put simply, resilience is a phenomenon of positive adjustment in the face of adversity (Masten & Powell, 2003). Research into resilience has been going on for over 50 years and has now achieved greater clarity in differentiating resilience from other human phenomena, such as stress-hardiness and strength of character or actions such as coping and surviving. Being precise about the definition of resilience is important, particularly for researchers and educators, because having a clear meaning about the term influences what resilience interventions should comprise and what scales to measure resilience should contain. When researchers are all using the same definition and measuring the same phenomenon, systematic improvements in the resilience of clients and nurses can occur. A common language about resilience is important to achieve.

**Evolution of the Concept of Resilience**

Although the concept of resilience dates back to the 1800s, it was not until the 1970s that work on resilience expanded (Luthar, Cicchetti, & Becker, 2000). This was essentially due to the rise of psychology as a discipline. Initially, research was undertaken to explore a phenomenon seen in some children of parents diagnosed with schizophrenia who seemed to be thriving despite the adverse environment (Billings & Moos, 1983). The hypothesis emerged about there being a group of people who were invincible despite being vulnerable (Werner & Smith, 1982). Interest focused on the kinds of internal, psychological attributes that helped them survive ordeals. The work of Friborg, Barlaug, Martinussen, Rosenvinge, and Hjemdal (2005) identified four main psychological factors in such children: internal locus of control, optimism, bounce back, and stress-hardiness. An internal locus of control involves acknowledging one’s own part in resolving challenges. In stressful periods, resilient individuals can use these attributes to bounce back and look forward.

Further studies have looked at marginalized children and adolescents who had experienced low socioeconomic circumstances,
abuse, parental mental and chronic illness, violent communities, or tragic life incidents to find out what helped the survivors do well (Garmezy, Masten, & Tellegen, 1984; Jacelon, 1997). These and other studies showed that there are events outside the individual that seem to protect individuals from being overwhelmed by stress and became known as protective factors. Young people are likely to be able to deal with and overcome adversity better and are able to envision a future for themselves when there is social connection with family, peers, and other adults; when there is positive role modeling of winners or achievers; when there is unobtrusive monitoring of their well-being; and when there is coaching to help set goals and elevate expectations (Sroufe, Egeland, Carlson, & Collins, 2005).

Meanwhile, ecology researchers developed an interest in resilience by exploring an eco-system’s capacity to absorb shocks and still maintain function (Folke, 2006). As concerns for sustainable environments increased, researchers began to identify and explore factors within a system that gave it capacity for renewal, reorganization, and development.

Research into resilience has since extended to adults. For example, research on people with schizophrenia ascertained that those with less severe symptoms were more likely to have positive outcomes in the areas of employment, responsibilities, and social relations, including marriage (Luthar et al., 2000). There have been studies on adults who survived childhood experiences of abuse and neglect but still managed to thrive in later life (Ben-David & Jonson-Reid, 2017). Similarly, survivors of domestic and family violence who turned their lives around (Dube & Rishi, 2017), people who live well despite AIDS (Fang et al., 2015) or cancer (Rowland & Baker, 2005), and people who endured terrorist attacks and natural disasters (Butler et al., 2005; Chang & Shinozuka, 2004) have demonstrated that succumbing to adversity is not inevitable. Insights from this work supported the justification of mental health interventions that targeted social and occupational factors in addition to symptom management.

The research also prompted thinking on factors to support well-being and productivity in other groups. A paradigm shift for health practitioners had begun. Antonovsky’s (1987) concept of Sense of Coherence, which is influential in the public health discipline, is an example. In terms of this concept, a person’s ability to cope in times
of stress depends on three factors: meaningfulness, manageability, and comprehensibility. Meaningfulness is the profound experience that this stressor makes sense in one’s life and thus coping is desirable; manageability is the recognition of the resources required to meet the demands of the situation and a willingness to search them out; and comprehensibility is the perception of the world as being understandable, meaningful, orderly, and consistent, rather than chaotic, random, and unpredictable.

Thus, continued research investigations in psychology, psychiatry, nursing, occupational therapy, health promotion, and sports science have shown the limitations of a deficit model that only examines problems as a result of stress and have deepened appreciation for the role that health and well-being have for individuals and societies. Thanks to this multidisciplinary lens now being trained on resilience, resilience-building has shifted from a narrow focus as a remedial measure to reduce stress and anxiety, to a broader focus on capacity building to enable people, teams, and organizations to sustain high levels of performance in challenging circumstances.

Currently, there is widespread agreement that human resilience involves being able to access psychological as well as social resources, and three levels of protective factors: individual, family, and community (see Table 1.1).

<table>
<thead>
<tr>
<th>Table 1.1 Resilience Resources at Individual, Family, and Social/Environment Levels</th>
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<tbody>
<tr>
<td><strong>Resources</strong></td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td><strong>Individual</strong></td>
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<tr>
<td>Psychological</td>
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<tr>
<td></td>
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<tr>
<td>Social</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Intelligence</td>
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</table>

(continued)
Table 1.1 Resilience Resources at Individual, Family, and Social/Environment Levels (continued)

<table>
<thead>
<tr>
<th>Resources</th>
<th>Protective Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication skills</strong></td>
<td></td>
</tr>
<tr>
<td>Developed language</td>
<td></td>
</tr>
<tr>
<td>Advanced reading</td>
<td></td>
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<tr>
<td><strong>Personal attributes</strong></td>
<td></td>
</tr>
<tr>
<td>Tolerance for negative affect</td>
<td></td>
</tr>
<tr>
<td>Self-efficacy and esteem</td>
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</tr>
<tr>
<td>Internal locus of control</td>
<td></td>
</tr>
<tr>
<td>Sense of humor</td>
<td></td>
</tr>
<tr>
<td>Hopefulness</td>
<td></td>
</tr>
<tr>
<td>Strategies to deal with stress</td>
<td></td>
</tr>
<tr>
<td>Enduring set of values</td>
<td></td>
</tr>
<tr>
<td>Balanced perspective on experience</td>
<td></td>
</tr>
<tr>
<td>Malleability and flexibility</td>
<td></td>
</tr>
<tr>
<td>Fortitude, conviction, tenacity, and resolve</td>
<td></td>
</tr>
<tr>
<td><strong>Family level</strong></td>
<td></td>
</tr>
<tr>
<td>Supportive families</td>
<td>Parental warmth, encouragement, and assistance</td>
</tr>
<tr>
<td>Cohesion and care within the family</td>
<td></td>
</tr>
<tr>
<td>Close relationship with a caring adult</td>
<td></td>
</tr>
<tr>
<td>Belief in the child</td>
<td></td>
</tr>
<tr>
<td>Nonblaming</td>
<td></td>
</tr>
<tr>
<td>Marital support</td>
<td></td>
</tr>
<tr>
<td>Talent or hobby valued by others</td>
<td></td>
</tr>
<tr>
<td><strong>Socioeconomic status</strong></td>
<td>Material resources</td>
</tr>
<tr>
<td><strong>Community level</strong></td>
<td></td>
</tr>
<tr>
<td>School experiences</td>
<td>Supportive peers</td>
</tr>
<tr>
<td>Positive teacher influences</td>
<td></td>
</tr>
<tr>
<td>Success (academic or other)</td>
<td></td>
</tr>
<tr>
<td>Supportive communities</td>
<td>Belief in the individual</td>
</tr>
<tr>
<td>Nonpunitive</td>
<td></td>
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(continued)
Based on all of this research, we now know that resilience does not only concern a person’s psychological or internal makeup. Resilience is not only about the way one appraises a situation (whether it is perceived as “a horrendous ordeal” or “a challenge to be surmounted”). It is also not about what the individual can personally do to change, but a shared social responsibility. Social actions, such as lending support, being a sounding board, and offering role models to inspire perseverance and a positive attitude can be effective in supporting resilience. In short, resilience is a combination of these elements. Two definitions are illuminating for nurses because one focuses on patient care and the other takes a more structural approach. They are:

1. Resilience is a constellation of characteristics that protect individuals from the potential negative effect of stressors. (Fletcher & Sarkar, 2012)

2. Resilience is the capacity of a system to use shocks and disturbances—to spur renewal and innovative thinking. (Stockholm Resilience Centre, 2016, p. 3)

These insights have supported mental health interventions that targeted social and occupational factors, in addition to symptom management. They also prompted thinking on what factors could

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Table 1.1 Resilience Resources at Individual, Family, and Social/Environment Levels (continued)

<table>
<thead>
<tr>
<th>Resources</th>
<th>Protective Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural resources</td>
<td>Traditional activities</td>
</tr>
<tr>
<td></td>
<td>Traditional spirituality</td>
</tr>
<tr>
<td></td>
<td>Traditional languages</td>
</tr>
<tr>
<td></td>
<td>Traditional healing</td>
</tr>
</tbody>
</table>

support well-being and productivity in other groups. As a result, a paradigm shift began for health practitioners. For many, this has meant a reorientation from a concern focused on illness to also considering well-being and how to foster it.

**Looking at Survivors to Develop a Science of Well-Being**

Aaron Antonovsky (1987) introduced the term *salutogenesis* to describe the support of health and well-being rather than a focus on the factors that cause disease. The concept has influenced public health (Gregg & O’Hara, 2007), psychology (Suedfeld, 2005), healthy aging (Wiesmann & Hannich, 2010), and nursing and midwifery (Cuellar & Zaiontz, 2012; Perez-Botella, Downe, Magistretti, Lindstrom, & Berg, 2015; Stock, 2017). It has also been applied to the workplace and organizations, and their design and management (Bauer & Jenny, 2013; Nilsson, Andersson, Ejlertsson, & Troein, 2012).

The term *salutogenesis* comes from the Latin, *salus* meaning health and the Greek, *genesis* meaning origin. Antonovsky studied the influence of various stressors on health and was able to show that relatively unstressed people had much more resistance to illness than those who were more stressed. In his analysis, Antonovsky argued that the experience of well-being constitutes a *sense of coherence*. He defined this as, “a pervasive, enduring though dynamic feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected” (Antonovsky, 1979, p. 123). We might understand this as believing the world is a rational place and approaching this with an optimistic and positive outlook.

Smith (2002) suggested that a strong sense of coherence assists a person’s ability to cope and consists of three factors: meaningfulness—understanding that this stressor makes sense in one’s life and, thus, coping is desirable; manageability—the recognition that there are resources required to meet the demands of the situation and a willingness to search out those resources; and comprehensibility—the perception of the world as understandable, meaningful, and orderly and consistent rather than chaotic, random, and unpredictable.

Survivor stories, mostly told in the form of personal memoirs, are today a recognized genre of literature and read by many. Narratives by those who survived the Holocaust such as Elie Wiesel (1958),
Viktor Frankl (1963), and Primo Levi (1979) have inspired work in psychotherapy, philosophy, peace studies, and literature. Frankl, for example, emerged from the Holocaust without the deep emotional injuries found in many survivors of the Nazi death camps. His compassion for his fellow prisoners led him to want to develop ways to help them maintain their will to live. In fact, this terrible experience ultimately enriched Frankl’s life and that of many others. Thus, the long-term consequences of even such unimaginable extreme trauma may include increased personal strength and growth. This phenomenon, now known as posttraumatic growth, is a growing area of research within psychology and psychiatry (Calhoun & Tedeschi, 2014; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004).

Primo Levi wrote an influential book on the ability of the human spirit to rise above suffering. This volume has been motivating and inspirational to many who have needed courage to endure. Similarly, Elie Wiesel’s famous statement “to remain silent and indifferent is the greatest sin of all” was his life motto as he pursued a lifelong commitment to world peace. In 1986, this was recognized when he was awarded the Nobel Peace Prize. Another example of thriving through adversity is the story of Lt. Commander Charlie Plumb (1995). Plumb was a navy pilot shot down early in the Vietnam War. He was taken to a prison in Hanoi and kept in a stone cell for 6 years, where he was tortured and deprived. He said of that experience, “It’s probably the most valuable 6 years of my life. Amazing what a little adversity can teach a person. I really felt there was some meaning to that, to my experience itself” (quoted in Siebert, 1996, p. 6). Many other examples can be found in the memoirs that people have written as survivors of various illnesses, abuses, bereavement, or other adverse situations. Segal (1986) summarizes the significance of this survivor research thus:

Those who have suffered and prevail find that after their ordeal they begin to operate at a higher level than ever before. . . . The terrible experiences of our lives, despite the pain they bring, may become our redemption. (p. 130)

This survivor-focused research has relevance to the processes of building resilience in health professionals. Evocative, moving stories from survivors about their experiences can contribute to others’
learning by enhancing awareness of the power of the human spirit to endure and overcome and by revealing the value of generative practices such as concern and altruism. Using storytelling may also be a powerful and effective way to “inoculate” students of the health profession against future stress and burnout by raising their awareness of resilience strategies and providing them with examples of how to transcend adversity (McAllister & McKinnon, 2009).

Positive Appraisal of Stressors, Coping, and Transcendence

Although psychological assets are only part of the picture for resilience, it is important that individuals learn how to maximize their own capacity to moderate stress and cope with life’s challenges. The internal or psychological traits of resilience are termed "resiliency." Whether we see a stressor as good or bad, leading to eustress or distress, depends on our cognitive appraisal of the situation. This concept is explored more fully in Chapter 6, Appraising and Moderating Stressful Situations.

Research has produced new thinking on how we can develop good, or adaptive, coping skills to manage stress (Holton, Barry, & Chaney, 2016). Essentially, there are three broad categories of coping strategies (Table 1.2).

As well as how we personally adapt to the situation, there are social strategies that may enhance or impede our resilience. How the family functions and supports each other, whether a person is active or passive in the ways they cope, are all strategies and predictors for

<table>
<thead>
<tr>
<th>Table 1.2 Three Types of Coping Strategies</th>
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<tbody>
<tr>
<td>Problem focused</td>
</tr>
<tr>
<td>Approach strategies such as seeking support; situation control, such as limiting other stressors; make positive self-statements</td>
</tr>
<tr>
<td>Emotion focused</td>
</tr>
<tr>
<td>Minimization, short-term avoidance, cognitive restructuring—&quot;it will teach me something,&quot; positive reframe</td>
</tr>
<tr>
<td>Maladaptive</td>
</tr>
<tr>
<td>Denial, numbing (substance use), avoidance, disengagement, rumination, resignation, venting/displacement, aggression (this can be inter-group; patient/nurse; and cyclical)</td>
</tr>
</tbody>
</table>
how well we are likely to adapt to stress such as illness and adversity in our lives. Adaptive coping strategies can be applied across the life span and thus nurses need a good understanding for how they might facilitate coping in childhood through to old age. Mullins et al. (2015), for instance, found that an intervention that focused on decreasing parent distress associated with uncertainty over their child’s illness and treatment improved the child’s adaptation to cancer. In another study, McAllister, Knight, and Withyman (2017) found that engaging early high school students in imaginative discussion-based activities about the challenges of adolescence extended their coping repertoire. The intervention in this study focused on exposing participants to role models who were winners in challenging scenarios, able to transform conflict into turning points, and active peacemakers. In older adults, too, resilience work is flourishing. For example, interventions that encourage and develop “self-transcendence,” which involves a sense of connectedness between a person and the wider world, and a reflection on the ways stress has been accepted or accommodated in his or her life, has shown positive impact on the resilience of older people (Haugan, 2014; Teixeira, 2008).

**Resilience May Involve Context-Specific Skills**

Psychology no longer exclusively focuses on individuals and the inner workings of their brain. Now they acknowledge that individuals are social beings and their strengths and vulnerabilities can be shaped by their surroundings. Structural factors in society, such as entrenched poverty or advantage, can have an effect on whether a person will be resilient or break down (Metzl & Hansen, 2014). Similarly, problems in the social world may not be simply a fact of life that needs to be coped with, but perhaps seen as an issue that needs to be changed. No longer are clinicians preoccupied with deficit models of care (Windle, Bennett, & Noyes, 2011). Deficit models are those that focus on problems and deficiencies, and clinical interventions tend to focus on repairing the problem. But such an approach tends to be reactive and not proactive. It also does not involve the client in actively engaging in healthy living and maximizing their own strengths and potential.

Another view of resilience is the notion that resilience is contextual and dynamic (Gu & Day, 2007). That is, individuals may not display resilience in all aspects of their lives, and various life transitions may activate different genetically determined biological reactions that require different coping mechanisms, social supports, and spiritual
strength. In addition, some resilience resources that individuals possess may be readily available in some contexts but not in others. For example, social supports may be forthcoming in situations that involve publicly acknowledged crises. However, when a crisis is associated with a situation that brings stigma or shame to a person, then supports may not be accessible, and maintaining resilience may require coping of a different magnitude or quality (Deveson, 2003). Seen from this viewpoint, resilience has an added contextual dimension involving an interaction among the stressor, the context, and personal characteristics (Figure 1.3).

**Resilience Across Cultures and Communities**

Resilience has also been viewed as a complex cultural construct that involves a dynamic interaction between an individual and the family, with the maintenance of positive adaptation occurring despite adverse experiences (Walsh, 2015). This viewpoint notably includes the concept of the family as an entity that can possess a group resilience, rather than only individuals demonstrating resilience.

Across cultures, similar factors have been found to contribute to resilience. Lothe and Heggen (2003), for instance, found resilience in survivors of the Ethiopian famine of 1984–1985. These survivors commonly demonstrated faith, hope, and valued memories of their homeland.

Through the study of vulnerable cultures and communities, there is now an increased knowledge about community resilience, that is, the ability of a community to deal with adversity and in so doing, reach a higher level of functioning. Hallett, Chandler, and Lalonde (2007),

![Figure 1.3 A dynamic framework of resilience.](image-url)
for example, found that North American aboriginal communities with the following features tended to be more resilient: self-government, land claims, education, health services, cultural facilities, police and fire, and use of own language. Numerous researchers have found that cultural identification or attachment and communities that build positive self-image improve these groups’ resilience (Hegney, Eley, Plank, Buikstra, & Parker, 2006). If they work on reducing risk factors and breaking any negative cycles, resilience also grows. In indigenous communities, there are two main risk factors: discrimination and historical trauma that involves unresolved grief (Fleming & Ledogar, 2008). Specific risks that occur in a community, such as drug misuse may compound these primary risks.

This notion of attachment and positive identity is equally relevant to health practitioners who operate as a community, and within communities.

**Resilient communities transcend adversity because members feel bonded to each other and to the community.**

**Resilience at Work**
The knowledge gained from research into resilient communities has also been applied to communities of workers, such as nurses, because it is not just vulnerable or ill individuals who experience adversity and need resilience—the well-being of workers is also important.

The resilience of workers, like the resilience of vulnerable communities, is currently under threat because of several issues, including the pressures of austerity policies. When the global financial crisis occurred in 2008, many nations’ governments severely tightened their welfare spending and put a freeze on wage rises. Since this time workplace conditions have gradually deteriorated so that workers are expected to do more, with fewer rewards. In healthcare, austerity policies mean that problems such as short-staffing, uneven skill mixes, wage-freezing, casualization, violence, bullying, and burnout have festered and created a situation where workers feel distressed, angry, or unfulfilled and are not working to their fullest capacity (Schrecker, 2016).

Even without the pressure of tight policy constraints, the health environment is stressful, making it highly likely that clinicians will experience workplace adversity. Hunter and Warren (2014), for
example, found that in the UK midwives are experiencing rising levels of adversity because of a constellation of factors: the unabating national shortage of midwives, rising birth rates, and increased numbers of women presenting with complex care needs. The impact of this adversity on individual midwives and the profession is significant—low morale, increased sickness, and high attrition rates feed into a cycle of dissatisfaction and workforce churn, itself putting more pressure on already overworked midwives. Studies have repeatedly found that nurses and other healthcare workers are vulnerable to stress breakdown, which seriously affects processes and outcomes in health systems (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Khamisa, Oldenburg, Peltzer, & Ilic, 2015; Schaufeli, Leiter, & Maslach, 2009).

Consequently, in the last decade, workplace resilience interventions have flourished (Foster et al., 2018; Mehta et al., 2016; Pipe et al., 2012; Sull, Harland, & Moore, 2015). In a systematic review of workplace resilience, Robertson, Cooper, Sarkar, and Curran (2015) found that successful programs were those that used a range of strategies. These include: (a) realistic simulations of adverse conditions so that participants could be exposed to relevant stressful incidents, (b) rehearsal of ways of confronting and moderating the associated emotional and physical pressures, and (c) transforming the way stress is perceived and managed.

Robertson et al. (2015) found that several cognitive rehearsal techniques were effective in promoting clarity of thought. These were mindfulness, meditation, and self-compassion to assist in calming anxiety, self-talk to allow self-regulation, and assist in problem-solving. Another useful inclusion in these interventions is to provide coaches who model coping and an optimistic outlook, reframe stressors, and support people to keep focused on goals, bounce back from any critical stressors, and attain success. It is also important to include opportunities for participants to reflect on practice so that actions taken can be reviewed and revised. Finally, workplace resilience requires a combination of interventions focused on the individual and the community. Thus, personal support strategies as well as strategies to foster a healthy workplace culture are vital (King, Newman, & Luthans, 2016).

Ongoing interest in resilience in the workplace has led to an agreement that resilience is a capacity that can develop over time in the context of person-environment interactions.
Healthy work environments have the capacity to improve overall health and well-being of the workers.

Relevance of Resilience Research to Nursing

Resilience research presents some important concepts that are readily applicable to nurses. Most of the literature divides resilience into factors that either protect people or put them at risk. Protective factors such as positive coping mechanisms and the ability to harness and use social supports and personal spirituality, which are known to help children, youth, older people, and those surviving traumatic experiences, are readily applicable to nurses. Moreover, evidence suggests that these positive qualities may be developed through learning experiences. Some of the risk factors that have been identified in groups such as soldiers, prisoners of war, and displaced or traumatized people may also be directly applicable to nurses. However, exploratory and intervention-based research to examine resilience as a tool for dealing with stress in healthcare workplaces is only just beginning, and there is much more to discover (Gillespie, Chaboyer, & Wallis, 2009; Hegney, Rees, Eley, Osseiran-Moisson, & Francis, 2015; Slatyer et al., 2017).

An aspect of resilience often overlooked and certainly often ignored within the context of the health workplace is the action that can be taken and the changes implemented to moderate the impact of stress and adversity on workers’ lives. This means that everyone should be proactive about resilience in the workplace. Healthcare work is always going to be busy, unpredictable, and emotionally demanding of clinicians, and so nurses need more than good defenses against stressful workplace cultures. They also need to receive support to develop positive strategies and outlooks, in such ways as via mentoring and education. Survivors of adversity show how this can be done. For people like Frankl, survival was not about being helped by others; it was about him searching for and locating something resourceful and sustaining deep within himself. Then, it was about him giving back to others in order to assist them through this process. This generativity, as demonstrated by Frankl’s altruism, and his setting a good example, by mentoring, leading, coaching, and motivating others, is a practice that can be learned by, and strengthened in, those entering the health professions.
Nurses need more than good coping mechanisms and should be proactive about resilience in the workplace.

Furthermore, a *systems approach* to resilience may assist nurses to understand that change can be facilitated at many levels: with the client, the clinician, and the healthcare environment.

**CONCLUSION**

Resilience is a complex combination of personal attributes, social actions, and learned strategies to protect a person or group from succumbing to the negative stress arising from adversity and trauma. Useful cognitive strategies that can be applied and learned include abilities to calm down and self-soothe, problem solve, transcend the difficulties, and replace judgment with compassion. Resilience does not involve simply accepting negative stress and minimizing it. Also, resilience in one aspect of our life may not necessarily mean that we will be resilient in other aspects. Resilience is contextual. Future-focused social strategies are also important in building resilience. These may include efforts to strengthen self and group identity, resolve any ongoing grief and loss issues, and adopt an outlook that crises can be viewed as a predictable disturbance in the system that to be rectified, requires confrontation, problem-solving, and an optimistic expectation. The system is unlikely to repair itself without creative solutions.

Understanding that the way individuals approach and view an event determines the outcome, rather than the event itself, is a powerful message to carry through one’s career. Predictors of resilience such as cognitive ability, adaptability, positive self-identity, social support, coping skills, spiritual connection, the ability to find meaning in adversity, and generative skills are all qualities that can be learned or strengthened. Hence, *you* can do something about developing a patient’s resilience as well as your own. As Donna’s story suggests, the actions patients take to be active participants in their own healthcare are a vital yet sometimes hidden resilience resource. Nurses can search for and validate these with every person. Respect for a patient, attuned listening, validating self-care and coping strategies, and being responsive to a patient’s needs are
small acts that foster resilience. Ignoring stressors that occur for nurses may be one way to cope in a busy environment where values clash between peers, but it is not a long-term solution. Undercurrents of conflict that flow unabated can accumulate and culminate in trauma sometime in the future. This is why honest, respectful communication of values and ethics needs to be learned and enacted as an everyday resilience tactic. It can change the culture and put patients’ needs first.

TIPS

There are many healthy ways to manage and cope with stress. You can either change the situation or change your reaction. As everyone has a unique response to stress, there is no “one-size-fits-all” solution to managing it. No single method works for everyone in every situation, so experiment with different techniques and strategies. Focus on what makes you feel calm and in control. This can be summarized as follows:

Dealing With Stressful Situations: The Four As

*Change the situation:*

- **Avoid** the stressor
- **Alter** the stressor

*Change your reaction:*

- **Adapt** to the stressor
- **Accept** the stressor

LEARNING ACTIVITIES

1. Access the resilience inventory at http://www.resilience-scale.com/. Complete the test and then reflect on your strengths and your vulnerabilities. If you feel comfortable doing so, share these insights with your peers in a group discussion.
2. Make a table of Donna’s strengths and vulnerabilities. In the left column, list the strengths she revealed that potentially supported her resilience. In the right column, list the things that occurred that eroded her resilience. Are there any nurse-initiated actions in either column?

3. What strategies could you suggest that the nurses engage in to reflect on how the care for patients such as Donna may be improved now that you have a fuller understanding of resilience and well-being?

4. How might these strategies be directed inwardly toward nurses and nursing?

REFERENCES


INTRODUCTION

One of the defining characteristics of modern life is an orientation toward the future. Nurses and nursing students are often very aware of the changes happening constantly in healthcare because of biotechnological discoveries and inventions. The future for health workers is awe-inspiring. As all workers, and all people more generally within society, need to contemplate the future and how it may change daily life, there is a formal interdisciplinary field called Future Studies or Futurology, which works to predict future trends and events (Bell, 2003). With change occurring at an unprecedented rate in almost all parts of life, in the future all aspects of existence, including work, will be very different from today in significant ways. Futurology proposes that it is, therefore, important that everyone in society—from governments, industry, businesses, professions, and organizations to single individuals—think about the future effects and ramifications of these changes, in order to make the best decisions now and face the future with a sense of optimism. As Futurology recognizes, however, purely
forward-focused thinking not only diminishes conceptions of the value of the past, but can also limit the potential to understand both the present and the future. This chapter hones in on the notion that understanding the past can help nurses think more critically about both the present realities of, and future directions in, nursing and healthcare. We argue that this critical thinking is a life resource for making sense of challenging issues and wicked problems. It is, we believe, a resilience strategy—invaluable for nurses themselves, but also a strategy to encourage patients to consider. Thinking about the past illuminates the directions one wants to take in the future.

**Understanding the past can help nurses think more critically about both the present realities of, and future directions in, nursing and healthcare.**

In 1840, French historian and diplomat Alexis de Tocqueville wrote that, “When the past no longer illuminates the future, the spirit walks in darkness” (Project Gutenberg, 2013, n.p.), and many have paraphrased these thoughts about why a knowledge of the past is important. Peter N. Sterns (1998), the founding editor of the *Journal of Social History*, outlined a number of reasons why knowing about one’s own history is important. He explains that history helps us understand not only “people and societies” (p. 2), but also “change and how the society we live in came to be” (p. 2). Additionally, Sterns also writes about how an understanding of history promotes the development of both “moral understanding” (p. 4) and a sense of one’s identity, as well as making good citizens who contribute to society. Sterns also writes how a knowledge of history is useful in the working world—helping people think clearly and enhancing their abilities to adapt and be flexible (p. 8). More recently, Penelope Corfield has proposed that people are “living histories,” the sum of all the legacies of the past (Corfield, 2008, n.p.). This recognizes that each individual inhabits a society whose languages, cultures, behaviors, and social norms have evolved over time.

Having an understanding about the past also has benefits beyond the level of the individual. In 2014, for instance, a report to the UK government formally outlined the positive—and essential—contribution a knowledge of the past makes to policy making (Haddon,
Devanny, Forsdick, & Thompson, 2014). In this, being aware of history was useful not just in terms of trying to not repeat the mistakes of the past and identifying useful models for contemporary decision-making, but also in helping to deal with change. This is because having historical knowledge enabled those with it to “challenge existing paradigms and identify major paradigm shifts” (Haddon et al., 2014, p. 2). Earlier work has recognized the importance of historical perspective for informed government (Neustadt & May, 1988) while recent research continues to stress the importance of a knowledge of history in a range of disciplines as diverse as business and marketing (Belasco & Scranton, 2014), teaching (Goldstein, 2014), and law (Ho, 2018).

Nursing has a rich and multilayered history as both a practice and a profession. A national study of nursing education (in Australia) found, however, that this history is neglected within the undergraduate nursing and midwifery curricula. This lack is, moreover, undermining students’ ability to develop a strong professional nursing identity, and who are, instead,

a generation of professional orphans—unaware of who they are and where they’ve come from, unaware of reasons underlying cultural practices within the profession, lacking in vision for the future, insecure about their capacity to contribute to future directions, and not feeling part of something bigger and more enduring. (Madsen, McAllister, Godden, Greenhill, & Reed, 2009, p. 9)

The importance of teaching nursing history has also been echoed in studies in the United States (Alpers, Jarrell, & Wotring, 2011; American Association for the History of Nursing, 2001). When nursing history is taught, or discussed in nursing programs, it tends to focus on such famed and iconic figures such as Florence Nightingale, setting such heroic individuals and their actions apart from the “ordinary” nurses who provide day-to-day care today (MacDonald, De Zylva, McAllister, & Brien, 2018). A careful consideration of the autobiographies of some historic nursing leaders reveals, however, that—in many ways—these nurses were in fact also quite ordinary individuals. They chose, however, to act in extraordinary ways when confronted with challenges, and this is why their life stories are important to note.
There are many inspirational people in nursing’s past; some of them are familiar to nurses all over the world, whereas others are well known only to a few. Some were formally trained as nurses, while others cared for patients before modern schools of nursing were opened. In very unique ways, they each chose to challenge the status quo by leading change and displayed great resilience in doing so. According to dictionary definitions, being resilient means being able to “withstand shock without permanent deformation or rupture” (Merriam-Webster, 2018, n.p.). In other words, to be able to bend without breaking. Many of the people considered to be the nursing profession’s (heroic) ancestors were ordinary nurses, but nurses who responded to the challenges they faced with considerable resilience. Not only did they bend without breaking—which can be read as a somewhat passive reaction to stress—they also proactively turned their personal resilience into action and this had an effect on others and the profession of nursing.

For over 30 years, Kouzes and Posner have conducted research on the qualities of effective leaders. They have observed that, “All leaders challenge the process. Leaders are pioneers—people who are willing to step out into the unknown. They search for opportunities to innovate, grow, and improve” (2007, p. 17). The nurses discussed in the following all proactively faced and confronted challenging situations with resilience and, in doing so, led a positive transformation for either, or both, their patients and the nursing profession. Although they are heroes of nursing, it is their resilience and what this enabled them to do, that is of interest in this discussion.

**FLORENCE NIGHTINGALE (1820–1910)**

Florence Nightingale was from a well-to-do British family (Figure 2.1). Even at an early age, she announced to her family that she had a Christian calling to become a nurse. Her parents were outraged because nursing was not, at that time, a career for respectable women, but she persevered in what became her vocation. She also had to overcome the restrictions of a healthcare system where medicine was valued far more than the kind of care, which could be, and was, offered by nurses. In her classic work, *Notes on Nursing: What It Is and What It*
Is Not (1860/1969), Nightingale acknowledged: “So deep-rooted and universal is the conviction that to give medicine is to be doing something, rather everything; to give air, warmth, cleanliness, etc., is to do nothing” (p. 9). Instead of feeling diminished or broken by the restrictive professional hierarchies she experienced in the healthcare system, Florence took action, using her keen knowledge of statistics and the scientific method in order to advance nursing as a unique profession.

It can be seen that Nightingale met the challenges of her time with considerable resilience. Despite resistance, she championed nurses’ role in observing and acting on early indications of changes in health status. She wrote that such observation was critical:

In all diseases it is important, but in diseases that do not run a distinct and fixed course, it is not only important, it is essential that the facts the nurse alone can observe should be accurately observed, and accurately reported. (p. 122)

Nightingale also challenged the hierarchical thinking of the day. Questioning the medical thinking that was then current, she courageously claimed that nature, not human intervention, actually performed the healing:
Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction, but does nothing more. And what nursing has to do in either case is to put the patient in the best condition for nature to act upon him. (Nightingale, 1860/1969, p. 133)

During the Crimean War, Nightingale put many of her ideas into action in the Scutari Barracks in Istanbul. Her attentive observation of wounded soldiers at night earned her the moniker, “The Lady with the Lamp.” Nightingale understood that fresh air, cleanliness, light, warmth, food, and attention to noise are the essence of healing and set out to define a methodology of care according to her beliefs (Nightingale, 1860/1969). She insisted that nurses be given uniforms, training, and instructions on how to improve the sanitation and the personal care of patients. Most of her efforts were not supported by the mainstream medical system of her day, but Nightingale was resilient in maintaining her course and staying true to her beliefs. As a result, she implemented changes that saved lives and forever altered the practice of nursing as well as the principles of healthcare more generally. She also brought about a profound change in how nursing as a profession is seen by the world. Although her legacy has been debated (Gill & Gill, 2005; Royle, 2000), her resilience is not to be challenged, and much can be learned from how she took an active stand against what she perceived as lacks and limitations in the system as it then existed, and how the idea of the professionalization of nursing remained at the fore of her thinking.

MARY SEACOLE (1805–1881)

Mary Seacole was born in Kingston, Jamaica (Figure 2.2). Her father was Scottish and her mother was Jamaican. Mary learned about herbal remedies and folk medicine from her mother who ran a boarding house for disabled soldiers. She overcame several traumas while still young. In the 1830s, she married a merchant, but he was sickly and his business did not prosper. In the 1840s, her family’s boarding house burned down; then, her mother died, followed by her husband.
Mary took to her bed in grief, but soon composed herself, not only rejoining the world, but also taking over her mother’s business and expanding her own nursing skills by traveling through the British colonies. Here she encountered and managed several epidemics of cholera and yellow fever.

Learning about the Crimean war and the high number of British fatalities, Seacole travelled to Britain to volunteer in the war effort. However, perhaps because of prejudice, she was refused and, when Nightingale successfully convinced the army to allow a group of female nurses to go to the Crimea, Mary was not among those selected. In her autobiography, Seacole (1857/2005) wrote of her awareness of why she had been rejected, and how painful this was:

Did these ladies shrink from accepting aid because my blood flowed beneath a somewhat duskier skin than theirs? Tears streamed down my foolish cheeks, as I stood in the fast thinning streets; tears of grief that any should doubt my motives—that heaven should deny my opportunity that I sought. (pp. 73–74)

She did not, however, allow this hurdle to stop her, or let herself get distracted by self-pity. Instead, she responded creatively to this barrier in her path:
Then I stood still, and looking upward through and through the dark clouds that shadowed London, prayed aloud for help . . . Let what might happen, to the Crimea I would go . . . I would have willingly given my services as a nurse; but as they declined them, should I not go and open a hotel for invalids in the Crimea in my own way? (pp. 73–74)

And so she did go to the Crimea, but under her own auspices. She also made the most of this situation, actively seeking out ways of providing care and assistance. While Nightingale and the other nurses stayed within the confines of the army hospital in which they worked, Seacole ventured out onto the battlefield, selling goods and services. As well as moving her to action, her resilience kept her own identity from being defined and limited by someone else. Instead of giving way, she chose to rise above the societal prejudice she faced to follow her calling. She did not break and instead of reacting negatively, she took positively focused action for the benefit of many. Seacole wrote, “I love to be of service . . . And wherever the need arises—on whatever distant shore—I ask no greater or higher privilege than to minister to it” (1857/2005, p. 31).

These figures are role models for nursing because they were able to: (a) bend without breaking; and (b) turn their personal resilience into action.

WALT WHITMAN (1819–1892)

Women were not the only nurses who faced barriers in the 19th-century healthcare system because of their gender. Walt Whitman may be widely recognized as one of America’s greatest poets, but few may know that he, too, overcame considerable societal prejudice to deliver nursing care to those in need; in his case, during the American Civil War (Figure 2.3). Of this work, he wrote:

I supply often to some of these dear suffering boys in my presence and magnetism that which doctors nor medicines nor skills nor any routine assistance can give . . . I can testify
that friendship has literally cured a fever, and the medicine of daily affection, a bad wound. (cited in Morris, 2000, p. 6)

This radical (for the time) attention to the holistic human and psychological needs of wounded and dying soldiers were precursors to hospice nursing today. Whitman saw a need, took action, and used his empathy to provide relationship-based care under the direst of conditions. Instead of being limited by the gender stereotypes of his day, Whitman stepped in and was resilient in the face of considerable resistance and, as a result, he was able to deliver this much-needed care.

**SISTER ELIZABETH KENNY (1880–1952)**

Elizabeth Kenny dedicated herself to learning enough from others that she was able to become a district nurse in rural Australia (Figure 2.4). She volunteered as a nurse during World War I and, for her service, the Australian Army Nurse Corps awarded her the rank of “Sister” which is equivalent to that of first Lieutenant.

After the war, Kenny returned to Queensland and, during a 1930s outbreak of what is commonly known today as polio, developed an
unconventional treatment for children suffering with acute polio-myelitis. Established medical treatment of the day for this disease required immobilization of the limbs with plaster casts or braces; however, Kenny advocated hot packs and passive exercises. Children who were treated with Kenny’s method experienced significantly fewer polio-related disabilities than children who underwent the conventional medical treatment. Despite this successful treatment—and in part because this challenged current medical thinking—Kenny and her what were then seen as radical treatments were not well received by the medical establishment. While understanding the necessity for evidence-based practice, Kenny was saddened by the medical conservatism that was limiting innovation:

I can understand how necessary it may be that new methods should be examined critically and that all the evidence must be carefully weighed before approval can be given. But I have also wondered how many promising discoveries have been consigned to oblivion without being given an opportunity to prove their worth. (Kenny & Ostenso, 1943, p. 2)
She also wrote of how astounded she was at the resistance she faced: “I was wholly unprepared for the extraordinary attitude of the medical world in its readiness to condemn anything that smacked of reform or that ran contrary to approved methods of practice” (quoted in Kenny & Ostenso, 1943, p. 2).

Despite this conservatism and lack of understanding of her methods, Sister Elizabeth Kenny did not give up. Instead she continued to believe in herself and what she had discovered, took action, and led a major change in medical practice. She achieved this, in part, by looking outside of her current environment for support. Leaving Australia, she traveled to the well-regarded Mayo Clinic in Minnesota in the United States where physicians were impressed with her results. Eventually, as a result of her perseverance and persistence in the face of doubt, Kenny Treatments Centers opened all around Australia and thousands of children and adults affected by polio learned to walk again.

**Sometimes resilience involves taking action that goes against mainstream thinking in order to respond to moral imperatives.**

**LEARNING FROM THESE RESILIENT NURSES**

These nurses—Nightingale, Seacole, Whitman, and Kenny—all exemplify the qualities of resilient nursing. They not only endured hostility, doubt, ignorance and prejudice, they also bent in the face of the resistance they faced. They were not broken and, to the contrary, each courageously took action to advance, provide, and bring about better standards of care and treatment to patients, and to advance the profession of nursing. These nurses not only had ideas to share with nursing and society, but they also took a stand when faced with prejudice and resistance to their actions and ideas, and ensured that their ideas and the changes that resulted were implemented. For these reasons, they can be seen to be part of the pantheon of nursing’s heroes. It is important, however, to recognize that one does not have to directly experience such extremes of adversity in order to display such resilience. All nurses will encounter challenges at various points during their careers and should be ready to meet this with a resilient attitude.
These four nurses’ leadership has been an important theme of this chapter. Posner and Kouzes list five characteristics of effective leaders: challenging the process; inspiring a shared vision; enabling others to act; modeling the way; and encouraging the heart (2017). In each case, these nurses’ resilience enabled them to meet the challenges and resistance they faced and assume a leadership position in a situation that needed changing. These individuals exemplify the importance of action, as well as words, in being an effective and influential person. In different ways, each of these historical nursing figures showed leadership in order to bring about not just good practice, but—by bringing others along with them—to encourage enduring positive change in nursing and society. Chapter 4, The Resilience Standpoint in Nursing, discusses how these qualities of being proactive, of seeking to look to the welfare of nurses and their profession as well as of patients, and of considering the psychological and social ramifications of healthcare situations rather than the purely physical aspects of care, contribute to what can be called “the resilient standpoint.”

CONCLUSION

These stories illustrate the value of continuing to look back to the past to find stories of resilience-in-action in nursing history, in order to locate a source of inspiration for the present and guide confident and brave future actions. Much nursing history, as well as the biographies of resilient nurses, remains to be researched and written, and there is much work to be done to inspire others in the profession to engage with this history. Yet learning about, and from, the past has many benefits, including helping individuals to feel that they are not isolated, but part of a group that has a long history, and providing symbols of endurance and strength to emulate. Nursing history also reveals that some of the most innovative solutions in healthcare have come about when otherwise “ordinary” nurses resisted feeling helpless, claimed their power, moved beyond the dictates of the status quo, and innovated in order to bring about change. Today, every nurse has within his or her power the opportunity to not only respond to the challenges faced with resilience, but also to inspire and empower future nursing practice.
LEARNING ACTIVITIES

1. Visit the Florence Nightingale Museum on the web, located at http://www.florence-nightingale.co.uk/index.php, to learn more about this inspirational leader and her contribution to the nursing profession.

2. Revisit Posner and Kouzes’s (2017) characteristics of effective leaders:
   - Challenging the process
   - Inspiring a shared vision
   - Enabling others to act
   - Modeling the way
   - Encouraging the heart

3. What do you think “encouraging the heart” means? Think of someone from your life that you would consider being a good leader. How do they exemplify these characteristics?

4. For discussion: Think about the leadership qualities you might possess.
   - Are there some similarities you share with these historic nursing leaders?
   - Can you think of times when you conducted yourself in a manner similar to the way these leaders did?

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