Resilience promotion

Its role in clinical medicine

There is an increased awareness of the words 'resilience' and 'spiritual' in both the community and the media. This has introduced the need for a new dimension of clinical care that can be addressed by considering the implications of 'resilience promotion'.

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Anne Deveson, in her book *Resilience*[1] suggests that resilience is: 'a life force that promotes regeneration and renewal' and 'the ability to confront adversity and still find hope and meaning in life'.[2] This identifies resilience as an essential component of the healing process, particularly in the presence of chronic illness.

There are many indicators that a new approach to illness prevention and minimisation, focused on 'resilience promotion' is being absorbed into the health system. Programs designed to strengthen the 'fight back' capacity of patients are being discussed, implemented and evaluated.

What promotes resilience?

Professor Graham Martin[3] commenting as Chairman of the National Conference of Suicide Prevention in Australia held in 2003 said: 'As people recover, if you ask them what it is that has helped, supported, dragged them through whatever it is, they will say, 'It has been my belief... my belief in God', 'I've still got a job to do, I've still got something that I believe in that needs to be completed'... 'we have to accept that and work with it'.

The foreword to the New South Wales Elderly Suicide Prevention Network's 3rd State Conference in November 2003 'What's resilience got to do with it?'[4] spells out the goals of resilience promoting programs. 'In an era where Australia's population is aging, building resilience to cope with the adversities of later life has become increasingly important. Promoting wellness, social connectedness, and a sense of meaning and purpose for older Australians can potentially reduce the burden of an aging population on aged care and health services, increasing the quality of later life and enhancing elderly suicide and depression prevention efforts'.

Elizabeth MacKinlay's invaluable study of the aging does not use the word 'resilience'. The word 'transcendence' is used to describe the ability to rise above the limitations of older age. Humour, connectedness and the ability to 'look inside' are some of the many resilience promoters that she identifies.[5] Connectedness is acknowledged by Deveson as one of the strongest factors to produce the resilience without which 'children fail to thrive, families become emotionally impoverished, communities grow vulnerable'.[1]

Resilience promotion and the GP

Primary care doctors have the best opportunity to develop a supportive relationship to nurture this internal source of strength. Whether they use their opportunities to develop and express an understanding of the patient's perspective may be determined by their training. In the absence of such training it is all too easy to see that expressing compassion for a patient's situation may be seen as too risky, too involving, too time consuming.

In the field of psychiatry Russell D'Souza's[6] work introduces the close relationship between resilience and spirituality, both secular and religious. He defines the problem that has kept the medical profession from participating in one of the forms of resilience promotion, supporting belief systems. 'As doctors we have been trained to be objective and to keep our beliefs and practices out, but over time we have strayed into keeping the patient's beliefs, spiritual, religious needs and supports out, thus potentially ignoring an important aspect that might be the core of their coping and support system, that is integral not only to recovery but to their wellbeing'.

Practical ways to promote resilience

Promoting resilience is based not only on having good communication skills but being able to use them professionally.

In their book *The worst is over* Judith Acosta and Judith Prager[10] explore the difference that key words can have on the resilience and healing potential of a distressed human. Their work particularly focuses on the moments after an accident when the victim can be moved away from their physically and mentally shocked state by the application of a definite and scientifically proven sequence of words and actions. Understanding the needs of the inner dialogues of humans in distress and providing a better communication pattern can optimise this. Simple phrases for every day practice situations such as:

- 'You must be finding this difficult to handle'
- 'This must be having a bad effect on your previous lifestyle'
- 'Would you like to talk about the things you are missing most in the activities you've lost'

establish a positive, trusting connection and, through this, sets up a better climate for healing. It is important to recognise that the emphasis here is on empathy, being with the patient's feelings and not moving rapidly into the comfort zone of the 'Mr Fixit' position. The primary aim is to provide a feeling of being understood; one that gives the reassurance for the individual strengths and self management potential of the person to be launched.

On a deeper level, there are many conditions that commonly present early to the general practitioner's door. The common factor in this group is low self esteem. The two most striking examples of this are teenage identity crises, and depression in any age group. The use of phrases that indicate to the patient that their primary carer understands the darkness, isolation and loneliness of their struggles can provide an anchor from which their ability to bounce back – their resilience – can start to be regenerated.

For more difficult situations such as these, communicating 'connectedness' and 'respect' in the statements we make is important:

- 'Progress in sorting this out is very slow, but please be reassured that I'll stick with you along the difficult pathway you're travelling'
- 'At the moment this illness seems to be progressing in spite of all our efforts but there's always something to be done and we'll work on it together with your family'
- 'If I were in your position, I think I'd be feeling abandoned, powerless'
- 'Lets look together at some of the times from your life when you've overcome adversity'.

These phrases indicate an understanding of the patient's own story, they nourish the patient's resilience and calm their panic and fear.

Relating to the possible deep inner dialogues and needs of patients as they search for meaning in the suffering associated with their illness provides a solid basis for improved communication.[8] Placing a resilience compartment at the centre of the holistic biopsychosocial framework that has been widely used in aged care[9] and general practice adds a dimension to care; one that provides the energy needed to drive self help programs. The use of the word 'resilience' avoids the awkwardness of the religious affiliation that has to date been generated by the word 'spiritual'.

Professional resilience

We owe it to our patients, partners and family to be aware that the caring we do can drain our energy, sometimes unexpectedly. There is ample evidence that there is a challenge of failed resilience in our midst. Jack Warhaft, in his report of the Victorian Doctors Health Program,[10] reports the reasons for contact of the 220 participants supported in the years 2000–2003: 92 alcohol or other drug problem, 82 psychiatric, 40 stress related or emotional problem, and six, a physical condition.

These alarming figures are countered with a very timely article by Jill Benson and Karen Magraith.[11] They provide information through which all practitioners can carry out a self evaluation, both for symptoms and for a preventive personal program. They highlight the key symptoms of compassion fatigue as helplessness, confusion, exhaustion and dysfunction; and highly commend the peer support system of Balint groups. These regular facilitated meetings are defined as a means to 'debrief, normalise emotional reactions, reduce stress by sharing experiences, reinforce the value of work, and reformulate boundaries'.

Fortunately, programs that deal with this need for ongoing professional resilience are now being built into medical training under the heading of 'personal and professional development'. But the majority of graduates should look very carefully at the warnings of burnout risk, particularly from the long list of organisational frustrations provided: chronic shortage of GPs, inadequate rebates, increased paperwork, professional isolation, limited resources, time pressures, fear of litigation, and societal attitudes.[11]

Understanding the complex dynamics of resilience development is an excellent stepping stone to self development, one that will achieve benefits on both sides of the doctor-patient relationship.

Conclusion

Resilience theory and its practices represent a new and expanding area of medical care. There are many advantages of placing it alongside the modern emphasis on technical knowledge and procedures. Application of the concepts of whole patient or holistic care has been a difficult challenge for the medical profession. Placing 'resilience' at the centre of the holistic model promotes regeneration and renewal and assists patients to develop 'the ability to confront adversity and still find hope and meaning in life'.

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