Personal resilience

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Introduction

Resilience is in fashion these days as being the answer to excess demands on time, dealing with adversity at work, and getting through the day without suffering too much.

At its basic level, resilience is about coping with demands on an everyday basis.

My interpretation is that resilience is a moderator between adversity and what we do about it. Active resilience is seen, by the resilient, as an opportunity, a chance to tackle a potentially stressful event without experiencing stress oneself.

For many, passive resilience is the only option available – the adversity is too great for an individual to deal with, so you retreat into a sort of hibernation hoping the adversity goes away and you emerge at some stage in the future unscathed.

Resilient is a choice. It comes into play when you are confronted by a potentially stressful event. Your immediate impulsive reaction to the threat is emotional, and it is at this point you need to decide whether to overcome the emotion and seek a solution to the threat or succumb to the threat. It is a choice based on your answer to 'What's in it for me to energise myself to overcome this threat?' The answer will depend on your appraisal of all the circumstances.

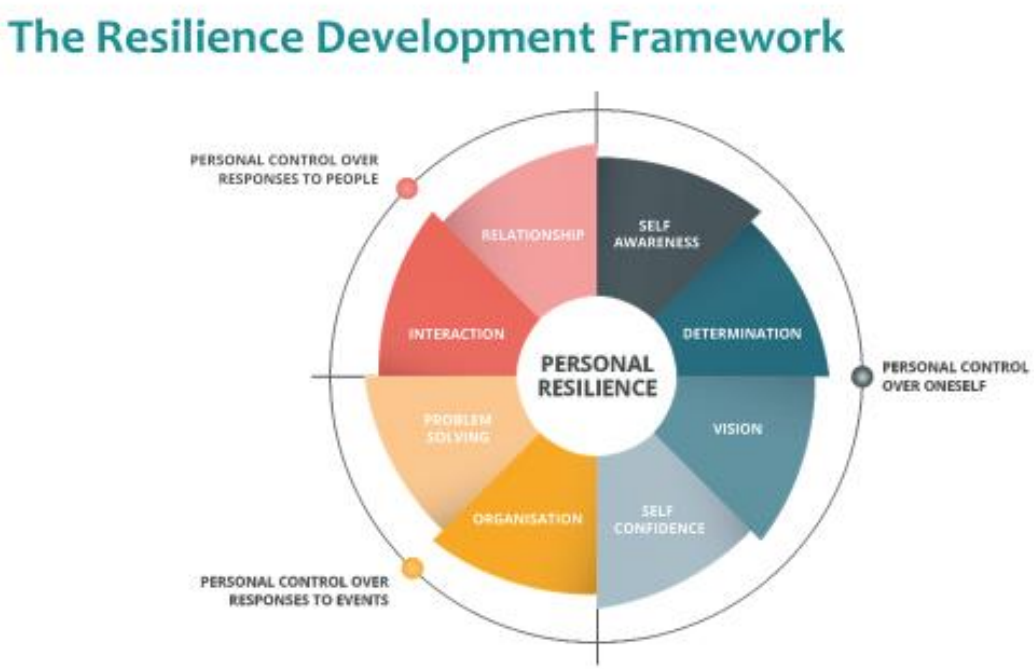
Case study

The level of suicides amongst doctors in training in the UK is quite high. The training process itself is very challenging, and combined with such factors as high flying, hitherto successful, individuals suddenly being exposed to the possibility of failure in treating someone or in doing the wrong thing, the risks of distress are very high. One way of helping is to strengthen the resilience of the junior doctors themselves.

This isn't the answer to the problem, but it is part of the mosaic of answers. Strengthening personal resilience can only go so far. People are not infinitely elastic. If the circumstances in which a threat occurs are unfavourable to the individual, the person is likely to become passive. So, the environment has to change and improve for individuals to respond more assertively to threats.

The development of junior doctors is being done via their supervisors. This is because the supervisors also need to strengthen their resilience, and if they know how to do this, they have another series of techniques in their armoury to help juniors, and, also, keep an eye on them to pick up signals if things are going wrong for the junior.

The programme has eight elements divided into three forms of personal control – control over oneself, control over responses to events, and control over responses to people. The outline is in the image.



The Resilience Assessment Questionnaire (RAQ 40) is completed to identify where individuals may be vulnerable.

Those who score low on any element are recommended to pay particular attention to that element in the development programme.

Each element contains a number of exercises. For example, the vision element asks participants to work out what they really, really, really want to do. For those who seldom, if ever, think of themselves, this question (along with all the other exercises) is challenging. In relation to doctors in training, this question asks them to reflect on their original idea of being a doctor, the identity this creates for them (together with the implications) and whether or not they now really wish to be a doctor.

The point of the exercises, in addition to providing tools and techniques, is that participants take control of themselves, and are provided with the opportunity to think about themselves, their situation and how they can energise themselves to change habits and behaviours to make them more resilient against adversity.

In addition to supervisors undergoing a resilience programme, there are sessions on team resilience and how supervisors can support their juniors. This latter programme includes understanding how resilience is formed, and how attitudes and choices are made in the face of adversity.

The changes that would make a real impact, however, include a different approach to supervision, combined with a more rigorous assessment of juniors from the outset to establish if they have the understanding that their success as a student and at school may be turned upside down by being exposed to inconceivable dilemmas, being alone at night caring for many people, and taking life sustaining decisions.

It is understood that people on the pathway to suicide feel little or no hope about the future. The resilience programme is built around the two main pillars of resilience – self-efficacy and self-esteem, both of which generate a belief in oneself and a belief that you can achieve the things you wish to achieve. There is a massive amount of hope built into those two elements. The issue here is capturing those at risk before they get onto the pathway towards suicide.

Conclusion

Supervisors have received this training very positively. It is too early to know if there is a significant impact on the resilience of junior doctors.

Derek Mowbray is an Organisation Health Psychologist who specialises in the primary prevention of stress at work. See www.mas.org.uk. See, also, the elearning programmes in Personal Resilience at the same address.