Resilience: A Necessary Requirement for Health, Well-Being, and Survival for Caring Professionals

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Resilience has been identified as an important health and life-saving approach for caring professionals who are experiencing stress and distress. There is a growing well-documented need for resilience in a world and nation that experience burnout, empathy/compassion fatigue/distress, and moral distress of caring professionals. Types of distress are fairly well defined in the literature, however, the concepts and strategies for building resilience are emerging as important to distressed societies. This article will primarily focus on resilience strategies/programs for caring professionals in educational institutions, healthcare systems, and communities. The author is solely responsible for the contents of this article. The author has no financial conflicts of interest.

Abstract

Resilience is a topic that is increasingly emerging in the literature as a necessity, not only for individuals who are suffering trauma in our society, but also for the health and well-being of caring professionals from first responders, interprofessional providers, and the clergy. The need to identify and develop more strategies to enhance resilience on an individual level is recognized as a priority for the health of these caring professional(s) in the United States and across the world. Newspapers and literature are increasingly filled with documentation, stories and statistics of the impact of stressors, emotional distress, burnout related to empathy/compassion fatigue, and moral distress caused by many different societal and workplace factors. There is a well-documented growing need for resilience in a world and nation that is experiencing burnout, empathy/compassion fatigue/distress, and moral distress of caring professionals. Due to the increasing numbers of mass shootings and documentation of workplace stress, bullying, and even suicide. Although most definitions of resilience are somewhat similar, there are different approaches including, but not limited to: emotional resilience, psychological resilience, and moral resilience which is rapidly emerging in the literature. This article provides the background for a thorough discussion of the critical importance of individuals recognizing the need for and adopting a workable strategy that fits

the individual's resilience; sometimes this is supported by resilience coaching and/or training. With increasing disruption, challenges, and distress in organizations and in society, resilience coaching is emerging as an effective strategy to assist individuals, groups, teams, organizations, and communities to recover and heal.

Keywords: Resilience, psychological resilience, emotional resilience, moral resilience, resilience coaching, stress and burnout, empathy fatigue, compassion fatigue, neuroscience of resilience, caring, ethics, self-compassion, and self-care

Introduction

This article will first explore the wide-ranging documentation and literature related to the stress and distress of caring professionals. This section will cover examples from interprofessional healthcare providers, first responders, and even clergy. Before exploring the different types of resilience, the growing crisis in the lives of caring professionals will be described. This section of the article will highlight the different types of crises which focus the need for individual caring professionals to recognize their personal need for resilience. Documentation of the challenges of caring professionals in many different settings and situations sets the stage for the importance of developing resilience and understanding it at a personal level. Although healthcare providers, organizations, and communities can offer services, it is ultimately incumbent on the individual caring professional to recognize the need to build resilience early and to address it before it becomes a problem. For example, in "A survey conducted by Nursing Standard magazine ... found 69% of nurses who reported depression, blamed work for their illness. A total of 229 nurses completed a questionnaire of whom 80% had had time off work for their illness ranging from two to six months. Nineteen had stopped working" (Laurance, 2000).

The second section will address the relationship of types of stress and need for resilience. Many individuals use the broad term resilience, but they may be describing either emotional, psychological, and/or moral resilience. It is important that these definitions be clarified. By differentiating these terms and diving deep into the issues related to the conceptualization of these terms, this article attempts to identify the relationship of the value of finding the right approaches to re-build resilience in many interprofessional roles in the caring professions. The emerging literature related to resilience is increasingly highlighting questions related to neuroscience and other physiological responses. More scientists are exploring how resilience affects the brain and body along with the relationship of this to stress, burnout, and moral distress. Included herein are historical definitions with the differentiating definitions of emotional, psychological, and moral resilience, along with knowledge and discussions related to how to address this before the caring professional becomes mentally ill or commits suicide.

The last section of this article will address the different approaches that an individual caring professional can explore to build and address the need for resilience. Since it is so important that individuals first understand their own challenges, it is critical that internal motivation and access to different approaches be explored. One approach that is becoming more common is that caring professionals are seeking "resilience coaches" to address their own symptoms of distress early to explore and implement individual approaches before experiencing illness, leaving their profession, losing their license to practice or even suicide. Some state license renewal systems can cause system-driven stress in the sense that physicians, for example, are expected to "gut it out or get out." "...the Oregon Medical Board disciplined six doctors so severely that they committed

suicide" (Leveque, 2009). Sometimes our systems are set to push out competent physicians because of perceptions of not being able to handle the stress and will cause the physician to make mistakes/cause problems. In coaching, according to the International Coaching Federation, the client is seen as "whole, resourceful and creative," and coaches do not impose solutions but assist caring professional clients to find their own strategies and motivation to build and/or maintain resilience (ICF, 2002).

The Growing Crisis in the Lives of Caring Professionals

Healthcare providers, first responders, and even the clergy today are exposed to stressors, some like those most people experience; however, there are some specific events and situations present in their lives that are not present in most people's lives. Experienced over time, these stressors can cause healthcare providers to look for a way out. Some continue working at their stressful jobs in a depressed and fearful state of mind, single-handedly battling post-traumatic stress syndrome (PTSD) or other conditions such as compassion fatigue. Some quit to look for respite, and some make the ultimate exit. In any of those cases, the United States healthcare system and its providers frequently suffer, and in some ways, patients do, too. Most individuals are not placed in situations that cause extreme physical, ethical, or moral distress, nor are they skilled in being resilient, or somehow mentally handling the distressing situation and returning to normalcy.

Suicides among healthcare providers are high nationally and internationally. Dr. Kelly says, "Occupations with high suicide rates are dominated by the medical professions" (Yazdi, 2017). In the United Kingdom, similar statistics are found. "Nurses and doctors are more likely to take their own lives than anyone in Britain. In this study, nurses had a suicide rate 37% above the population between 1991 and 1996. "The stressful environment of nursing can support many of the triggers and traumas of PTSD, Dr. Mealer said. Nurses see people die. They work on resuscitating patients. They try to control bleeding. They have end-of-life discussions. And sometimes they are verbally or physically abused by patients or visiting family members" (NYT, 2019).

> Among doctors, the rate was 47% above the average for male practitioners and ... higher for female practitioners" (Laurance, 2000). "Mitchell Hardison, 62, was a well-known family doctor in Raleigh, North Carolina. He had what appeared to be a perfect life with a family, success, and patients who respected him. But Hardison ended it all on a fall day in 2015. He drove to a secluded cul-de-sac a few miles from his office and shot himself in the chest. A construction worker found his body the next day. Hardison had a secret: He was depressed and felt he couldn't seek treatment without jeopardizing his career. He was 100% positive that if he came forward and said he needed help that there would be a reprisal of some sort" (Cochran, Machles, Narayan, & Terpstra, 2019).

> I'm realizing more and more how many physicians are suffering with PTSD, even residents and medical students at the very earliest stages in their careers....so tragic that the very people who save hundreds and thousands of lives yearly are left as mere shells of the people they used to be. They're no longer able to relax, feel joy. They're stuck in this never-never land of misery and pain. It's just so maddening to hear the same stories over and over when it feels so preventable" (Wible P. , Physician PTSD—Are you a victim? 2017).

According to Dr. Wible, there are five top things that "... lead to physician PTSD:

- Number one is medical training. We have a fear-driven medical education model that teaches us by terror.
- Number two, human rights violations that include chronic sleep deprivation, hazing, bullying, lack of access to food, water, inability to see your family, take care of your own bodily functions.
- Number three, vicarious trauma. Of course, high risk specialties like emergency department and neonatology and such are going to feel more of this vicarious trauma.
- Number four, losing colleagues to suicide. I bet there are hardly any physicians out there who do not know of another physician who has died by suicide and you've probably not been able to properly grieve the death of that suicide. This is terrible. You're going back to work every day feeling at risk yourself.
- Number five is just the chronic toxic workplace environments that we are in every day. Shoved in this assembly-line, big-box clinics, which are dangerous for our own health and the health of our patients (Wible P. , Physician PTSD—Are you a victim? 2017).

In Dayton, Ohio, Kayla Miller "...was running for her life when she spotted victims who had been hit by the flying bullets. I look down the sidewalk and see just a row of bodies," Kayla Miller told NBC's TODAY. People shot, some alive, some not; so putting her own life in danger, Miller, a critical care nurse, stopped to perform CPR on some of the wounded victims on the sidewalk. "I'm grateful to be able to be alive and talk to my family and friends and tell them I'm OK," she told TODAY, sobbing. "But my heart breaks for these families. It's just not fair," she said (Baker, 2019). "In caring for people who are ill, injured, and dying, nurses routinely bear witness to others' pain, loss, and suffering. In addition, hospital-based nurses work closely with family members who often feel anxious and fearful for their loved one's future. Although empathy allows many nurses to experience great satisfaction in their work, repeated exposure to others' emotions may lead to compassion fatigue--a term often used synonymously with 'secondary traumatic stress'" (Barkin, n.d.).

> Despite nurses' routine exposure to loss and tragedy, their reactions to these have not been systematically addressed. The most empathic and idealistic of us respond by intensifying our caring, trying to be all things to all people. When these nurses fail at this impossible task, they feel guilty and miserable. Other nurses respond by becoming indifferent and distant, busying themselves with tasks and technology. This reaction may be similar to the 'silencing response' as described by Baranowsky in which caregivers redirect, shutdown, minimize, or neglect the traumatic material brought by another to the care provider. When nurses respond to compassion fatigue by creating emotional distance, their patients, in turn, may feel neglected or abandoned. Nursing school does not prepare nurses for the experience of witnessing pain and suffering....our bodies bear the brunt of our stress. This may be expressed in irregular eating and sleeping, musculoskeletal tension, respiratory problems, substance abuse, and decreased immune system functioning. Too many of us teeter too close to the precipice of chronic illness. It is not surprising that a study by Welch found that 35% of nurses sampled were clinically depressed. The Academy of Traumatology/Green Cross has proposed the following standards of self-care: do no harm

to yourself in the line of duty while helping others, and, attend to your physical, social, emotional, and spiritual needs as a way of (providing) high quality services to those who look to you for support as a human being" (Barkin, n.d.).

Local violence can cause significant and long-lasting negative effects if not ameliorated via communal listening/interacting or other ways to increase resilience and to treat the condition. Dr. Alejandro Rios Tovar, a surgeon at the University Medical Center of El Paso, had just returned home from a 30-hour shift when he was summoned back to the hospital. The story of the medical staff who cared for the victims "is one of heroics in the face of violence," Kolata writes. However, she noted that in the wake of care the doctors and nurses struggled to live with the horror of what they had experienced. McLean said that, when she made rounds the next day, she noticed a lot of the medical staff were in tears. It's unreal what these patients went through, she said. The day of the shooting, Tyroch managed to keep from crying until he drove home. Weber said she barely made it to her car before she started sobbing. There is a sense of relief when they say, "OK, there aren't going to be any more victims"--that's the first time you take a deep breath," she said. Then, you go home and you cry and you pray and you hug your loved ones." (Kolata, 2019). Another example from Las Vegas . . . "For the survivors of the Las Vegas shootings, overcoming emotional wounds may be just as tough as recovering from their physical injuries. The psychological fallout is likely to hit countless others--doctors, nurses, and bystanders who treated them, along with eyewitnesses to the nation's worst mass shooting. Some of the victims and others may be affected long term and experience symptoms of post-traumatic stress disorder. Some studies suggest full recovery may take as long as three years, or longer for those who never receive treatment" (Tanner, 2017). And finally, "Outside of a Southern California hospital, an ER doctor crouched down against a concrete wall grieving the loss of his 19-year-old patient. A paramedic snaps a photo of the tender scene. His coworker, a close friend of the doctor, posts the photo (with permission). Minutes after the photograph, the doctor returns to work 'holding his head high'" (Wible P. , Heart-wrenching photo of doctor crying goes viral, 2015).

Aside from the above-mentioned stressors, there are other healthcare provider workplace stressors such as long hours, being on call at a moment's notice and bullying by patients, other healthcare providers, and administrators. And, healthcare providers can step into unexpected stress-filled situations. Theresa Mills warns, "Everyone seemed to have friends and family who returned from WWII who sometimes acted odd," she said. It was often referred to as shell shock. While the symptoms of PTSD are more widely recognized and studied today, she explains that healthcare providers need to remain vigilant in evaluating the patient's past experiences. "A healthcare provider could easily be mistaken for the 'enemy' and be at risk of injury by a patient with PTSD" (Mills, Theresa;, n.d.). Stressors in medical, nursing and dental education settings such as faculty or other student bullying also can add to healthcare provider stress (Randle, 2003) (Mukhtar, Daud, Manzoor, Saeed, & Javed, 2010) (Dellasega, 2009) (Rowland, et al., 2011) (Wood, 2006). Additionally, there are more system-driven stressors such as time spent at EHR computer terminals; those minutes spent on a computer mean less time with patients (LaPointe, 2018) (Snell, 2018) (Ford, Peterson, Menachemi, & Huerta, 2009) (Yu, 2016).

In recent years, another important group who struggle with maintaining resilience are members of the clergy. This group of caring professionals increasingly find themselves consoling

victims of manmade violence, shootings, and terrorist attacks. "One of the biggest challenges pastors will face is the pressure to explain why someone would do something like this. Yet, no answer will take away the pain and heartache. What will be most helpful to those struggling is to meet them in their suffering by creating space for lament, providing comfort, encouraging community, and reminding others of the hope we have in Christ," Jamie Aten, Humanitarian Disaster Institute at Wheaton College founder and executive director said. (Shellnutt, 2018). These efforts may help reduce the severity or longevity of trauma following mass shootings.

According to the Council of Religious Leaders of Metropolitan Chicago, "We are outraged by the increasing normalcy of racist violence in a sacred space. The victims at Tree of Life join the victims at the Sikh Gurdwara in Oak Creek, Wisconsin, and at Emanuel African Methodist Episcopal Church in Charleston, South Carolina... We pray for comfort and hope for the families and friends of those affected by this act of hate." (Response to the Synagogue Massacre in Pittsburgh, Pennsylvania, 2018). Although they recognize that our democracy is very diverse, they are very concerned about some individuals and groups expressing their differences through violence.

Pastor Mark LaFollette writes eloquently about the pain and PTSD that creates challenges for pastors to bounce back after traumatic events in their communities. He states, "When I compare a pastor's pain with PTSD, I am not equating church stresses with the terrors of war. But when you get inside the causes and symptoms of PTSD, you can find parallels." (LaFollette, 2016). LaFollette further comments on how physical violence and the threat of trauma are frequently associated with a PTSD diagnosis. In addition to these traumatic situations that are impacting churches and synagogues, he speaks to "non-violent" conflicts and situations in churches that can also have a traumatic impact with three symptoms common to PTSD. So, today, pastors, families and congregations are challenged with some of the PTSD symptoms, including avoidance, self-protection, constant alert, dreams/flashbacks. What is so difficult for pastors and families is that they cannot always get away from those members/situations that hurt them.

And last but not least, another group of caring professionals are first responders, who also have their share of traumatic experiences. First responders have always been the earliest on the scene in these traumatic and violent attacks as well as in natural disasters. Their challenges were highlighted after the Parkland shooting and the Pulse nightclub massacre in Orlando, with Aboraya also highlighting historical national incidents like the Columbine shooting and the mass shooting tragedy in Las Vegas. Aboraya discusses that, "PTSD, which is characterized by reliving an event through flashbacks and nightmares, often isn't diagnosed immediately in the aftermath of a tragedy. Being hypervigilant and startling easily are normal reactions to experiencing or witnessing trauma. It becomes a disorder if the symptoms don't subside in a month or two, or start causing trouble at home or at work." According to Jim Brinkley, director of occupational health and safety for his firefighters union, "There is a fear that if you reach out for help within your own department, there may be adverse action. You may be removed from duty and you're not allowed to get back on the rigs. By having those who serve outside the area come in, we find the members are more likely to open up and tell us exactly how they're feeling." (Aboraya, Parkland Shooting Gives First Responders PTSD Bill New Life, 2018).

Resilience: Definitions, and Interprofessional Perspectives

In order to clarify what resilience is, it is important to examine a variety of early exploration and definitions. "Resilience has been most frequently defined as positive adaptation despite adversity. Over the past 40 years, resilience research has gone through several stages. Contemporary researchers have found that resilience factors vary in different risk contexts and this has contributed to the notion that resilience is a process (Fleming & Ledogar, 2008). The American Psychological Association defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress (para.4)" (The road to resilience, 2014). It is clear from several sources in the literature that beyond this definition, resilience is very complex. "Determinants of resilience include a host of biological, psychological, social and cultural factors that interact with one another to determine how one responds to stressful experiences. In defining resilience, it is important to specify whether resilience is being viewed as a trait, a process, or an outcome, and it is often tempting to make a binary approach in considering whether resilience is present or absent" (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). Another perspective used in resilience coaching is assisting individual clients to differentiate between resilience and resiliency. According to Carol Pemberton, "Resilience is sometimes approached as though it is a bank account that has a balance figure that can be drawn upon when needed. . . how confident, decisive, creative and able to manage emotions. Resiliency is the degree to which you are able to put that credit balance into action" (Pemberton, 2015).

In the literature, there are at least four different types of resilience that are relevant to this article: psychological resilience, emotional resilience, nurse resiliency, and moral resilience. "Psychological resilience is the ability to mentally or emotionally cope with a crisis or to return to a pre-crisis status quickly (de Terte & Stephens, 2014). "Resilience exists when the person uses mental processes and behaviors in promoting personal assets and protecting self from the potential negative effects of stressors" (Robertson, Cooper, Sarkar, & Curran, 2015). Emotional resilience relates to an adaptation to events or situations that the person experiences as stressful. And to some degree, "Emotional resilience is also related to some factors that aren't under your control, such as age, gender, and exposure to trauma" (Scott, 2019). "Nurse Resiliency" is specific to "...the ability of a nurse to accurately perceive and respond well during stressful situations" (Sieg, 2015). Moral Resilience "...is an emerging concept that leverages resilience concepts and research to specifically focus on the moral adversity that arises in clinical practice and the capacities needed to transform moral distress and other forms of moral suffering from only a negative experience to one of hope and positive forward movement" (Holtz, Heinze, & Rushton, 2017).

As previously mentioned, moral resilience is one of the newer and most relevant areas of resilience that is beginning to emerge in order to address various type of ethical and moral challenges that contribute to moral suffering and moral distress. The elements of moral resilience are still being organized, discussed, and studied, so there is no widely accepted definition. However, some elements of moral resilience seem more important and fruitful for future exploration and discovery such as adaptation to the situation, return to a normal life, and as the author believes, communal support during and after the distressing event. Rushton posits that "...moral resilience requires ongoing inquiry to discern the boundaries of integrity preserving action." With this, she offers an expanded notion of ethical awareness by leveraging

somatic cues that accompany threats or alignment with integrity to guide action, suggesting that self-regulatory functions of mind, emotions, and bodily sensations are necessary tools in upholding one's beliefs and adhering to core values" (Young & Rushton, 2017).

To further explore this new and emerging concept of moral resilience, it is important to note that moral distress was first identified by Jameton as occurring "...when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6) (Jameton, 1984). Sometimes different people respond differently to the same situation. "Moral distress has been further developed introducing the differentiation between initial and reactive moral distress. Additionally, the factors which can rise to moral distress have been identified, such as factors internal to the caregiver, factors external to the caregiver and clinical situations" (Defilippis, Curtis, & Gallagher, 2019). If distress is caused by the person's response to the difficult situation, then strategies such as individual and organizational remedies such as coaching can counteract the distress and increase the person's resilience.

Building Resilience: A Deliberate Personal Journey to Health, Well-Being, and Healing

One of the primary purposes of this article is to focus on the individual and the opportunity for each caring professional to realize that resilience starts and ends with each person recognizing their own vulnerability and committing to taking the specific action(s) needed to begin the very personal journey to health, healing, and well-being. Putting resilience in context, the author sees the following sequence; first, there is a caring professional who has accepted certain responsibilities to/for other individuals, along with a set of beliefs, core values, ethics, and morals. Secondly, a situation develops wherein the caring professional realizes that as she/he carries out responsibilities or may be required to act in situations that violate beliefs, core values, ethics, or morals, causing herself/himself significant stress or strain. The situation causes the person to realize that the pain of "caring" is so great and/or there is no "right" pathway because the pathway sometimes being pushed upon the caring professional feels impossible or sometimes even the like the "wrong" path. So, the caring professional experiences distress. Merriam-Webster defines distress as pain or suffering affecting the body, a bodily part, or the mind and this author would add "the spirit." In addition to the impact on the body, it is the "of the mind" and "of the spirit" portion(s) of the definition that are also of importance in assisting the person with strategies for health and well-being.

There are many common-sense approaches that an individual can take initially to address burnout, empathy/compassion fatigue, and/or moral distress. The first and most important factor is for the person to understand what they are feeling and why (Scott, 2019). Additionally, it is critical that individuals recognize their symptoms of distress early and begin to address the impact of the distress early. For some providers, long hours and a stressful shift requires some form of quiet permission to release the tension or pressure in order to reduce the stress hormone, cortisol which can last up to 72 hours after leaving their workplace. Other strategies include relaxation techniques including yoga and different forms of meditation. Some find strenuous exercise helpful or just taking a walk and experiencing nature. Other individuals may just need to find space for quiet reflection and/or connecting to their internal spiritual place in the sanctuary of home or worship places.

The American Association of Colleges of Nursing has created a very thoughtful framework to alleviate moral distress. "Promoting a healthy work environment is a priority initiative of the AACN. To give nurses the tools to recognize and address moral distress in their work environment, the AACN Ethics Workgroup developed the 4 A's to Rise Above Moral Distress." "The first step is to ASK - to become aware of the moral distress one is experiencing. The next step is to AFFIRM - to recognize one's moral distress and one's professional responsibility to address this distress. The Third Step is that of ASSESSING--and analyzing the risks of doing what one believes is the right thing to do. And the Fourth Step is to ACT-- utilizing her/his newly acquired knowledge to allay the apprehensions of the senior management team and strengthen her/his resolve to assist the staff nurse, a valued member of the organization, while ensuring quality patient care" (McCue, 2010).

Social connection is another way that some can "escape their trauma" through strategies which include the development of a social support network with family and friends. These relationships with family and/or friends can allow time for a stressed out, sad, or compassion-fatigued caring professionals to share frustration, moral outrage, and the impact of compassion fatigue. "Even just slowing down for a long hug or look into someone's eyes can foster connections and understanding. **The Four-Minute Experiment** paired refugees with people in the host country--strangers--to just sit in front of each other and have eye contact for four minutes. The compassion, emotion, and openness that resulted was palpable." (Luest, 2019) (Luest, Connection--The Key to Healing and Resilience, 2019). It is also important to mention that there is growing research that encourages the use of music for resilience. "Active engagement with music has a number of intrinsic properties that mirror and enhance the protective factors of self-regulation, initiative, and relationships with others. Resilience supports learning in other areas in the same way that it supported better health outcomes in a music therapy study" (Ruksenas, 2014).

According to Carol Pemberton, "It is important to work with three themes in mind, Personality Traits, Protective Factors and Learning from Difficulty." And to work with the client's needs which encompass: "Building protection--through taking action; Building capacity--through developing resilience skills; and Building renewal--through being helped to use the learning from difficulty to move forward." She states that "Herbert Freudenberger first coined the term "burnout" in 1974. "Burnout builds slowly, but its key feature is that in order to burn out, a fire needs to be burning. It is when the fire is raging that the individual begins to recognize that they are being singed" (Pemberton, 2015). It is also important to recognize the impact of cortisol and weakening of the adrenal glands which as Pemberton says "... is distinct from loss of resilience." She further says that only when the client's body has somewhat recovered from the stress can individuals explore what they need to learn about what happened to them and why they were 'burned out" (Pemberton, 2015).

Two very important contributions to resilience come from Diane Coutu, a journalist. Based on her research about some of the Holocaust victims and prisoners of the Vietcong, she explored who did not make it out of the Nazi camps. She learned "it was the optimists." After more interviews and research, she posits that "Resilient people possess three characteristics: a staunch acceptance of reality; a deep belief, often buttressed by strongly held values, that life is meaningful; and an uncanny ability to improvise." Then, after exploring more about optimism, she wrote: "That's not to say that optimism doesn't have a place . . . but for bigger challenges, a

cool, almost pessimistic, sense of reality is far more important." She further learned that from Frankl's book, Man's Search for Meaning, "He realized that to survive, he had to find some purpose . . . Frankl created some concrete goals for himself. In doing so, he succeeded in rising above the sufferings of the moment." "Frankl's theory underlies most resilience coaching . . . what we now call hardiness--as a way for us to help people construct meaning in their everyday lives" (Coutu, 2002).

For more critical needs and greater distress, it may help to bring some of the strategies used in resilience coaching such as "expressive writing" and/or using "art prescription." These approaches were originally introduced by James W. Pennebaker and John F. Evans. "Since the mid-1980s, an increasing number of studies have focused on expressive writing as a way to bring about healing. Expressive Writing (EW) can positively affect people's sleeping habits, work efficiency, and connections to others" (Pennebaker & Evans, 2014). Individuals were encouraged to write about their trauma, by hand . . . not by typing on a computer. In an experiment conducted by Pennebaker and Evans, individuals had "forty-three percent fewer doctor visits for illness than those who were asked to write about superficial topics." Another approach was a workshop called "Art Prescription: Write to Heal." In this workshop "cancer patients were asked to write about their experience with cancer at any stage of treatment. Then they were given watercolor painting materials . . . and instructed to paint any vision, any feeling the writing seemed to provoke in them" (Pennebaker & Evans, 2014).

In closing, long before James Pennebaker's research and contributions focused on resilience, it is very interesting to find a beautiful example of Clara Barton's creative "expressive writing." Clarissa Harlowe Barton, otherwise known as Clara Barton, was a pioneer nurse, teacher, and humanitarian who had an historic career helping others. Because of her experience helping victims of war and disasters, she founded the American Red Cross.

In 1869, she (Clara Barton) was scheduled to give a lecture but found herself before an audience, unable to speak. Throughout her life, Clara had experienced recurrent episodes of depression. It seems that the exhaustion of the travel involved in her work, coupled with the depressing effects of the constant repetition of her war memories, contributed to her physical and mental exhaustion. She consulted several physicians who advised her to spend some time in Switzerland to recover her strength. Her sojourn to Europe lasted until 1873 and introduced her to new ways of channeling her energies for her humanitarian efforts. (Barton, C. Angel of the Battlefield, n.d.).

The Women Who Went to the Fields
A Poem by Clara Barton
(A tribute to the Civil War nurses. Excerpts)

Show us the battle, the field, or the spot
Where the groans of the wounded rang out on the air
That her ear caught it not, and her hand was not there,

Who wiped the death sweat from the cold clammy brow,
And sent home the message; -'Tis well with him now,
Who watched in the tents, whilst the fever fires burned,
And the pain-tossing limbs in agony turned,
And wet the parched tongue, calmed delirium's strife
Till the dying lips murmured, 'My Mother,' 'My Wife'!

Did these women quail at the sight of a gun?
Will some soldier tell us of one he saw run?
Will he glance at the boats on the great western flood,
At Pittsburg and Shiloh, did they faint at the blood?

And the brave wife of Grant stood there with them then,
And her calm, stately presence gave strength to his men.
And Marie of Logan; she went with them too;
A bride, scarcely more than a sweetheart, tis true.
Her young cheek grows pale when the bold troopers ride.
Where the 'Black Eagle' soars, she is close at his side,
She staunches his blood, cools the fever-burnt breath,
And the wave of her hand stays the Angel of Death;
She nurses him back, and restores once again
To both army and state the brave leader of men.
She has smoothed his black plumes and laid them to sleep,
Whilst the angels above them their high vigils keep:
And she sits here alone, with the snow on her brow
Your cheers for her comrades! Three cheers for her now.

And these were the women who went to the war:
The women of question; what did they go for?
Because in their hearts God had planted the seed
Of pity for woe, and help for its need;
They saw, in high purpose, a duty to do,
And the armor of right broke the barriers through.
Uninvited, unaided, unsanctioned oft times,

With pass, or without it, they pressed on the lines;
They pressed, they implored, till they ran the lines through,
And this was the 'running' the men saw them do.

Twas a hampered work, its worth largely lost;
Twas hindrance, and pain, and effort, and cost:
But through these came knowledge, knowledge is power.
And never again in the deadliest hour
Of war or of peace, shall we be so beset
To accomplish the purpose our spirits have met.
And what would they do if war came again?
The scarlet cross floats where all was blank then.
They would bind on their 'brassards' and march to the fray,
And the man liveth not who could say to them na;

They would stand with you now, as they stood with you then,
The nurses, consolers, and saviors of men."

– Clara Barton
The Women Who Went to the Fields

Clara Barton
1821-1912

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