Resilience and Nursing: A Case Study in Italy

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Abstract

Introduction: Resilience is an integrating concept. Many authors have explored the resilience concept, but in nursing there isn’t a real convergence, in the context of cultures and “theoretical models” adopted. The first aim was to explore if young nurses understand the concept of resilience and social capital. The second was to verify if there is a link between resilience and social capital in nursing work. The third aim was to mark the difference between Resilience and hardiness.

Materials and methods: This is a case study; a descriptive research. The sample was “young nurses newly employed at the Parma University Hospital from July 1, 2015, and June 30, 2016”. In order to explore their knowledge about resilience and social capital, a concept map was submitted. The records were inserted in T-lab® software to analyze frequencies between terms and in SISA® application for t-analysis. Each nurse was involved in daily writing experience about work, relationships with patients and caregivers, colleagues and organization. Resilience and Social Capital development were measured analyzing keywords association after six months.

Results: Nurses were born in different Italian Regions. In words analysis, the main differences were in Resilience and Social Capital definitions between Northern and Southern Nurses. Differences were statistically significant in defining Resilience (p=0, 01 and t=2, 0066) and Social Capital (p=0, 05 and t=2, 0096). The main association, in diary records, was social capital and trust.

Discussion: The research produced four results. First, to explain the difference between resilience and hardiness. The second, young nurses developed a better knowledge about Resilience and Social Capital. Third, “Trust” became the first concept related to personal and community development. Fourth, resilience and social capital may be learned, in favorable environments.

ABBREVIATIONS

RSA: Resilience Defining Attributes; ICNP: International Classification for Nursing Practice

INTRODUCTION

In Italy, and in other European countries, since the year 2008 many politicians presented, in their speeches, “resilience” as the resource for coping with the economic and social crisis, but the year 2016 has been focused on building a culture of resilience in the communities.

Nurses stress for each patient to use all his or her personal resources in order to cope with diseases, especially chronic ones. Resilience is a resource, often confused with resistance. Such confusion is common in organizational areas and it is shown as “resistance to change”. Resilience isn’t a new topic in nursing. There are many definitions and conceptualizations of resilience, and the most widespread usage in nursing is “ability to cope with stress” [1,2]. This idea of resilience is very close to the idea of adaptation. To adapt means to be able to modify and develop one’s own behavior in stressful conditions, and nurses experience the need for adaptation to the patients’ conditions every day, in addition to organizational needs, while patients have to face changes in health status.

In the last year, resilience has been referred to as “caregivers’ adaptation about relatives’ health problems and care [3,4]. The researchers demonstrated the relevance of resilience in nursing and in nursing practice, but most of the contexts in which resilience was studied were organizational environments [1,5,6]. Resilience is a process of overcoming adversities. It increases the abilities of patients or families to cope with illness [4,7] finding their own psychological and physical resources to face the modifications of Health status and dependence level.

Resilience is also connected to mental health [8] and to spiritual setting [9]. It is defined as a dynamic concept, and it is possible to measure it with different tools [10-13].
Resilience develops positive attitudes: integration, control, and coping. If resilience is not effective, it is frequently exhibited in anxiety, depression or suicidal ideations [16].

Challenges, modifications, and interruptions are all elements that introduce the process of resilience development. In their “Resilience Model”, Richardson et al. [17], stated that persons, adapting or not to life events, choose consciously or unconsciously how to react. These reactions allow them to learn what the resilience is or how to use their own resilient qualities and achieve goals [18]. Richardson affirms that the outcomes of resilience are positive for coping or adaptation.

A longitudinal study of Werner and Smith defined the panel of positive predictive factors to build resilience. The first group represents personal attitudes: easy temperament, positive relationship, and effective communication, sense of personal worthiness, sense of control of fate, positive social orientation, assertiveness, internal locus of control, flexibility, and sense of humor, interpersonal sensitivity, and high expectations.

The second group represents skills or results of experience: social intelligence, informal social support network, healthy expectations and needs, belief in her or his self-efficacy, desire to improve, problem-solving ability, decision-making ability, vision ability, trust in others/hope for the future, ability to have close relationships, critical thinking skills, ability to manage different emotions, adaptive distancing, effective in work, play, love.

The researchers explain that Resilience needs both attitudes and skills to be developed and both must work synergistically to achieve goals.

Luthar [19-22] described “mastery” as an equivalent term, when a person is able to rebound from an adverse event of the life and the resolution is effective or healthy: “Resilience is the natural, human capacity to navigate life well. It is something every human being has - wisdom, common sense. It means coming to know how you think, who you are spiritually, where you come from, and where you are going. The key is learning how to utilize innate resilience… [23] “.

Wright et al., define Resilience as a complex compound: environment, attitudes, structured behavior, adversities, personal vulnerability, psycho-social competences, positive adaptation, ability to face and solve problems create Resilience. Wright's taxonomy confirms the Luthar et al., statement (1993) “When a factor always has a beneficial effect whether at low or high risk (e.g. a main effect), it is referred to as a resource factor [24]. The opposite of a resource factor is a risk factor, which also has a main effect on outcome, whereas the opposite of a protective factor is a vulnerability factor, which as little or no effect at low risk but magnifies a detrimental effect at high risk [25].”

About Social Capital, Francis Fukuyama [26] explains “Social capital is an instantiated informal norm that promotes cooperation between individuals. In the economic sphere introduces transaction costs and in the political sphere it promotes the kind of associational life which is necessary for the success of limited government and modern democracy. While it often arises from iterated Prisoner’s Dilemma games, it also is a byproduct of religion, tradition, shared historical experience and other types of cultural norms. Thus, while awareness of social capital is often critical for understanding development, it is difficult to generate through public policy” [27,28].

Robert Putnam in 1970-89 and Robert Desmarais in 1990-2001 studied social capital in Italy and the Desmarais [29] model about Social Capital shows three important components as predictors of social capital development: transparency, trust, and timing asymmetry [30-32]. Transparency brings trust; trust brings cooperation and gives value to the concept of timing asymmetry: I help you now; you will help me in the future, because we trust each other [33,34]. This article presents a focus on the resilience in Italian culture, in nursing care. Challenges, modifications, and interruptions are all elements that introduce the process of resilience development. The first aim is to explore if young nurses know the concept of resilience and social capital. The second aim is to verify if there is a link between resilience and social capital in nursing work. Resilience and hardiness are often used synonymously in our hospitals. The third aim is to mark the difference between these concepts [35-40].

MATERIALS AND METHODS

The descriptive research was divided in two steps. The first was the literature review to find a resilience model to apply to Nursing. The concept and model of Social Capital is commonly unknown in nursing teaching. For this reason, Social Capital Model was not explained, but extracted by recounting experiences. The second step was to test the resilience model in a group of young nurses.

The literature review was conducted in PubMed, Cinahl, McMaster library, Cochrane library, Harvard Business School archive. The keywords used were “resilience” AND “Model” AND “nursing” AND/OR “health outcomes; “social capital” AND “resilience”; “social capital” AND “nursing” OR “health outcomes”.

Found were116, 700 articles, reviews or books. To reduce the number of references AND “nurse experiences” OR “work experiences” was added. Abstracts read were 561, book summaries were 34 and 61 references were selected.

The Werner and Smith resilience model was selected and the key concept: rebounding/reintegration, high expectancy/self-determination, positive relationship/social support, Flexibility, sense of humor, self-esteem/self-efficacy was used and was associated to “social capital” and “resilience” in a concept map. The map was submitted to a sample of nurses and their descriptions were recorded at the start of the research. The records were inserted in T-lab® software to analyze frequencies or correlations between terms and in SISA® application for t-analysis. Each nurse was involved in writing daily experiences.
about work, relationships with patients and caregivers, colleagues and organization. Resilience and Social Capital development were measured by ethnographic method, analyzing keywords in the daily diary records of nurses in six months, using the literature concept maps like standard (Table 1).

The nurses sample was selected with the following criteria: nurses with less than 12 months of working experience (since July 1, 2015 to June 30, 2016), Italian females, with no previous experience in health care or other work areas, with a Bachelor of Nursing acquired in the last 36 months, in the same University - Parma University, working in Parma University Hospital at least for six months. Men were excluded because the sample was too small (6 men) to be compared to female sample (Table 2).

The design of the research is described in the following chart (Figure 1). The sample was of 66 nurses and nobody was missed during the 6 months of observation. The concept map submitted is shown in the tab. N. 2. In Italy all workers have a period of traineeship when work starts. In an Italian hospital this period is 6 months. At the end, the Ward Nurse makes an evaluation about competencies developed and behavior. Each Nurse, the first working day, received the concept map and the diary. To describe concept map, the nurses had 2 hours. The diary form was an electronic sheet. Every record was a day. Every record couldn't have more than 150 words. The topics were “which concepts do you exercise or improve in your “training period” and/or “which concepts have relationships before unknown, in your experience”. The first submission of the conceptual map was on September 1, 2015, and the last record was collected on June 6, 2016.

Table 1: Defining attributes with corresponding RSA items [10].

<table>
<thead>
<tr>
<th>Attributes</th>
<th>RSA scale</th>
<th>Statement explaining RSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebounding/reintegration</td>
<td>Personal Competence</td>
<td>I know that I succeed</td>
</tr>
<tr>
<td></td>
<td>Personal Competence</td>
<td>I always find a solution</td>
</tr>
<tr>
<td></td>
<td>Personal Competence</td>
<td>I have a realistic plan for the future</td>
</tr>
<tr>
<td>High expectancy/self-determination</td>
<td>Personal Competence</td>
<td>I believe in my own abilities</td>
</tr>
<tr>
<td></td>
<td>Personal Competence</td>
<td>My future is promising</td>
</tr>
<tr>
<td></td>
<td>Personal Structure</td>
<td>I work best when I reach goals</td>
</tr>
<tr>
<td>Positive Relationship/social support</td>
<td>Family Coherence</td>
<td>There are strong bonds in my family</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>I have friends/family members who caring me</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>I have someone who can help me</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Social Competence</td>
<td>I easily establish new friends</td>
</tr>
<tr>
<td></td>
<td>Social Competence</td>
<td>I enjoy being with other people</td>
</tr>
<tr>
<td></td>
<td>Social Competence</td>
<td>It is important for me to be flexible</td>
</tr>
<tr>
<td>Sense of humor</td>
<td>Social Competence</td>
<td>It is important for me to make other people laugh</td>
</tr>
<tr>
<td></td>
<td>Social Competence</td>
<td>I easily laugh</td>
</tr>
<tr>
<td>Self-esteem/self-efficacy</td>
<td>Personal Competence</td>
<td>I believe in myself and it helps me to overcome difficulties</td>
</tr>
<tr>
<td></td>
<td>Personal Competence</td>
<td>I am pleased with myself</td>
</tr>
<tr>
<td></td>
<td>Personal Competence</td>
<td>I trust in my judgment and decisions</td>
</tr>
</tbody>
</table>

Table 2: Concept Map submitted to the nurses.

<table>
<thead>
<tr>
<th>Region of Birth</th>
<th>Months of working experience</th>
<th>Type of competence (personal, social, family, environmental)</th>
<th>Year of Bachelor</th>
<th>Concept explanation</th>
<th>Related to another concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concepts</td>
<td>-----------------------------</td>
<td>-------------------------------------------------------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Rebounding/reintegration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High expectancy/self-determination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Relationship/social support</td>
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<td></td>
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<tr>
<td>Flexibility</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sense of humor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem/self-efficacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is possible to describe more than one explanation for each concept and not more than one competence for each explanation.
RESULTS

The sample of nurses was n.66. The average age was 25 (24, 85), the youngest was 21 and the oldest was 31. The average delay time between Diploma and first occupation was 2.2 years: 16 nurses less than 12 months, 19 nurses 13-24 months and 31 nurses have 25-36 months. Even if the nurses studied in the same University, they were born in different Italian Regions: 35 in the South of Italy (Campania, Calabria, Sicily, and Puglia), 1 in Rome, 1 in Florence, 29 in North (Emilia-Romagna). All nurses wrote at least one statement for each concept, in the concept map. All nurses had a clear definition about concept, and similar definitions. T-lab® application didn’t show significant differences. The main differences were in Resilience and Social Capital definitions. The nurses used many words to define resilience and social capital and gave more than one explanation for each concept.

About Resilience, the words used were (Table 3): “Resistance” was used by all the nurses of Southern Italy in the first or second or third definition. “Waiting for a best future” were used in second or third definition by Southern Nurses: “Coping, facing, adapting” were used only by Northern Nurses. The differences, between North and South of Italy nurses, are statistically significant, with p=0,01 and t=2,0066.

Social capital was defined “resisting” and “power” mainly by Southern Nurses. Northern Nurses preferred to define social capital as “Trust, Accountability, Transparence, Cooperation, Coping, and Involvement”. The differences, between North and South of Italy nurses, are statistically significant, with p=0,05 and t=2,0096 (Table 4).

These different words used to define “Resilience” and “Social Capital” confirms the results shown by Robert Putnam in his book Making Democracy Work (1993). The diary records were analyzed after the six months of work. The records had 318,121 words. The concepts of the conceptual map associated in experience both to resilience and social capital were few. The results are shown in the Graph (1). The main association to Social Capital and Resilience was Trust referred as “faith in someone or something as organization, colleagues, future or community”. The main association to Resilience, as term, was coping, referred as “ability to face adversities increasing self-efficacy”. The main association to Social Capital was Community, referred as “reciprocity in group relationships”.

<table>
<thead>
<tr>
<th>Word</th>
<th>Frequency</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistance</td>
<td>155</td>
<td>53,82</td>
</tr>
<tr>
<td>Waiting</td>
<td>43</td>
<td>14,93</td>
</tr>
<tr>
<td>Coping</td>
<td>36</td>
<td>12,50</td>
</tr>
<tr>
<td>Facing</td>
<td>30</td>
<td>10,42</td>
</tr>
<tr>
<td>Adapting</td>
<td>10</td>
<td>3,47</td>
</tr>
<tr>
<td>Contrast</td>
<td>3</td>
<td>1,04</td>
</tr>
<tr>
<td>Opposing</td>
<td>3</td>
<td>1,04</td>
</tr>
<tr>
<td>Attending</td>
<td>3</td>
<td>1,04</td>
</tr>
<tr>
<td>Hardiness</td>
<td>1</td>
<td>0,35</td>
</tr>
<tr>
<td>Solving</td>
<td>1</td>
<td>0,35</td>
</tr>
<tr>
<td>Resuscitate</td>
<td>1</td>
<td>0,35</td>
</tr>
<tr>
<td>Overcoming</td>
<td>1</td>
<td>0,35</td>
</tr>
<tr>
<td>Reacting</td>
<td>1</td>
<td>0,35</td>
</tr>
</tbody>
</table>

DISCUSSION

In the Taxonomy of Nursing Science, resilience is included only like “coping” without a proper definition. But its presence is commendable in the Callista Roy Theory, when she introduces the “Adaptation Model” in Nursing. She also studied it as holistic nursing care [40,41].

The “holistic patient-centred paradigm” gives a great importance to the resilience in the nursing discipline. Nurses promote patients’ and families’ self-awareness, to develop coping and to face crisis situations. This self-awareness was described
by the taxonomy of NANDA International [42,43] as “resiliency promotion” (code 8340) that means “assisting individuals, families and communities, in development, use and strengthening of protective factors to be used in coping with environmental and societal stressors”. There are also other diagnoses like “impaired resilience” (00210) or “risk for impaired resilience” (00211) and “readiness for enhanced resilience” (00212) [44-50].

Also the International Classification for Nursing Practice (ICNP) introduced a diagnosis in this domain: “coping” (code 10005208), defined as “attitude to manage stress and having a sense of control and more psychological comfort” and “adaptation” (code 10001741), and defined as “ability to manage new situations” [50-53].

A related concept to “Resilience” is “Hardiness”. It is important to define differences because Nurses have to choose the right diagnosis, when the patient is assessed.

“Hardiness” is, in Cambridge Dictionary (2016), defined “strong enough to deal with bad conditions or difficult situations”. In the Merriam-Webster Dictionary (2016) Hardiness is defined “able to live through difficult conditions (such as a cold winter or a drought)” and “strong and able to accept difficult or unpleasant conditions”. It is also described as synonymous of resilience, but hardiness is a personality trait [45,46]. Literature shows that hardiness may help to face adversity or stress, more if it occurs for longtime [47-49,54], but the main difference between resilience and hardiness is that resilience is an adapting outcome, and hardiness is an enduring behavior that does not always lead to a positive outcome.

The Werner and Smith Resilience model was chosen because it refers to an international cross-cultural, lifespan studies that followed individual resilience development in high-risk conditions such as families with mental or health problems.

At the most fundamental level, resiliency research validates prior research and theory in human development and which unfolds naturally in the presence of certain environmental attributes.

Resilience Defining Attributes are characteristics of the resilience concept noticed in literature and present when the resilience is acted [32]. The RSA were determined comparing lists of protective factors indicated by researchers and others characteristics associated to resilience. Every Attribute was defined with statements explaining the specific meanings and each one was classified as personal competence, personal structure, social competence, social support, family coherence.

Nurses at the start had many differences in defining Resilience and Social Capital, with the main difference between northern and southern nurses. Putman and Desmarteau suggest that differences have roots in social culture: the North of Italy initiated historical social cooperatives, and art and craft associations. In the South, the people are obedient to historical powers.

It is important, in this variance, that nurses showed a convergence, in tracing relationships among concepts. Trust was associated both to social capital and resilience; community (as reciprocity in group relationships), cooperation and equality were associated to “social capital” and coping (as ability to face adversities increasing self-efficacy), adapting, reacting were associated to “resilience” [55].

Resilience is also a group/social competence and it is important in building and associated to social capital. Social capital increases every strength in community as demonstrated by Putnam and Desmarteau. James Coleman defined social capital as “omissis... a variety of entities with two elements in common: they all consist of some aspect of social structure, and they facilitate certain actions of actors...within the structure” [56-58]. Ledogar and Fleming stated “Social capital, as an asset or a resource for resilience, can be a characteristic of the community or the individual. As an individual asset, social capital consists of a person’s relationships to available social resources. As a characteristic of communities, it consists of attributes such as trust, reciprocity, collective action, and participation. Closely related to community social capital is the concept of collective efficacy [56]. That is, social capital. It is anything that facilitates individual or collective action, generated by networks of relationships, reciprocity, trust, and social norms, increasing trust and shared value, multiplying the ability to positively react and enhances the power of resilience, bringing people to overcome adversities and to achieve better outcomes or better social functioning.

“An individual’s positive impact on performance is characterized by having confidence (self-efficacy) to take on and put in the effort to succeed at challenging task, making a positive attribution (optimism) about succeeding now and in the future, persevering toward goals (motivation to accomplish goal), and hope to succeed and sustaining and bouncing back and resiliency to attain success” [56].

Nurses can use trust [59] to improve their own performance [56], constructing hope, confidence, resilience, self-efficacy and optimism [59] in the relationship with patients and caregivers. Trust increases their own sense of responsibility toward community (family, society, colleagues) helping people to do their best [60-61]. This is very important because in educational processes, patients and caregivers learn attitudes before observing nurses’ behavior, and only trust achieved by the patients can allow the nurses to educate them.

CONCLUSIONS

The research produced four results. First, to explain to Parma Hospital Nurses the difference between resiliency as the ability to cope/face/react positively to the adversities, and hardiness, the strength to accept unpleasant or difficult conditions.

The second result was to confirm, by conceptual maps, that young nurses in Parma University Hospital developed a better knowledge about Resilience Model, personal traits, personal competences and experiences, recognizing Resilience and Social Capital as protective factors from the risks of the daily life. Both these concepts are very important for pre-discharge education in chronic patients. Third, when social capital works in a group, “Trust” becomes the first concept related to personal and community development. And last, resilience and social capital may be learned, in favorable environments.
Limits of the study

This study utilizes a sample too small to have transferable results. It is a “case study” and needs to be submitted to a large, multinational research entity to obtain strong evidence. Literature about resilience and social capital presents a lot of evidence about the importance of resilience in individual wellness and the impact of social capital on health and community wellness. The Health care field is the most favorable to increase resilience in nurses and other professionals and support the birth or the increase of social capital inside and outside the hospitals between professionals and families and patients.

Implication for the future

The results obtained suggest to develop a specific teaching program in the Nursing Course about social capital, its impact on society and it’s develop and to start a “coaching” process for nursing students to develop resilience. These two actions will support young nurses to have more self-efficacy, to develop trust and use it like a “lever” in the relationship with the patients.

ACKNOWLEDGEMENTS

This article doesn’t receive any grants or funds. Thanks go to Prof. Mary Jean Bujdos, Saint Francis University, Loretto, Pennsylvania, for the linguistic review.

REFERENCES


44. International Council of Nurses. ICNP ® definition. 2015.


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Cite this article