

A CRC Press FreeBook

BUILDING RESILIENCE

A PRACTICAL RESOURCE
FOR HEALTHCARE PROFESSIONALS





TABLE OF CONTENTS

- 03 • INTRODUCTION
- 05 • 1: RESILIENCE
- 19 • 2: HEALTHCARE ORGANISATIONS:
CRADLED IN ANXIETY?
- 27 • 3: WHAT JEOPARDISES RESILIENCE
- 53 • 4: ATTITUDES THAT UNDERMINE
RESILIENCE BUILDING
- 71 • 5: STRENGTHENING OUR
PERSONAL RESILIENCE
- 86 • 6: ENHANCING THE RESILIENCE OF
EMPLOYEES THROUGH THE PROVISION
OF EMOTIONAL, INFORMATIONAL AND
INSTRUMENTAL SUPPORT



INTRODUCTION

In an increasingly volatile, uncertain, complex and ambiguous ('VUCA') world, individual and organisational resilience has become a hot topic in many sectors. Healthcare is not alone in this respect, but has the added complexity of an emotive, people-centred business. When things go wrong in healthcare the consequences can be deeply personal, individually catastrophic and very public.

To maintain high standards that assure patient safety in the face of constrained resources, increasing public demand/expectations as well as greater delivery complexity, requires a robustness which can be hard to define. There is a need for more understanding of how to help individuals, teams and organisations build resilience, not just to get them through difficult or stressful times, but also to enable them to operate with maximum effectiveness.

This book reflects a partnership between publishers Taylor Francis Group and the Faculty of Medical Leadership and Management (FMLM). Both organisations have an interest in encouraging the healthcare workforce to develop the physical and mental capacity to deal with the issues they face on a day to day basis while delivering care to patients.

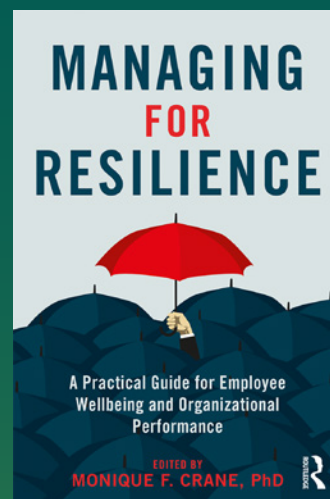
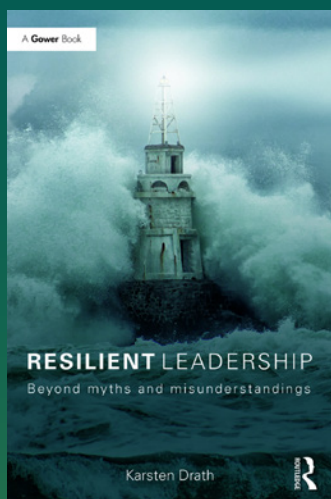
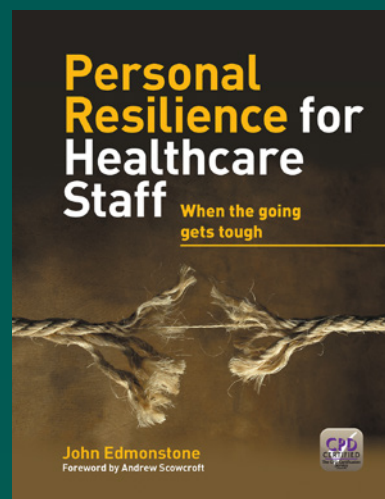
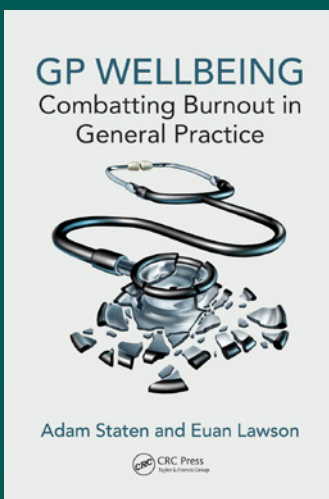
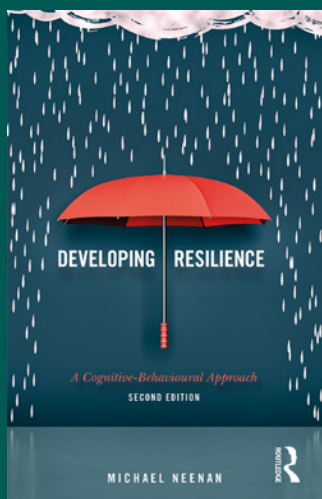
This compilation should help practitioners develop their understanding by bringing together the theory and neurobiology of resilience along with case studies of how resilience can be built. This includes practical approaches to develop these skills and highlights how doctors and other healthcare professionals can manage daily pressures, as well as seize the opportunities that go hand-in-hand with this level of responsibility: individually, as part of a team and as part of an organisation.

Mr Peter Lees, *CEO and Medical Director*

Dr Myra Malik, *Associate Medical Director*

Faculty of Medical Leadership and Management
www.fmlm.ac.uk

FEATURED RESOURCES ON RESILIENCE



BROWSE OUR FULL RANGE OF TITLES AT [CRCPRESS.COM](https://www.crcpress.com)
AND **SAVE 20%** WITH THE DISCOUNT CODE **MLM20**

CRCPRESS.COM

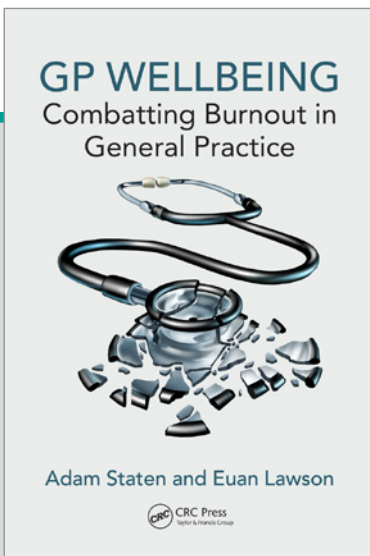
CRC Press, Taylor & Francis Group is a global publisher of world-class references, handbooks, and textbooks for the medical, scientific and technical communities including academics, professionals, and students. To hear about our latest titles and receive exclusive content and offers, sign up to our mailing list. [» SIGN UP HERE](#)





CHAPTER
1

RESILIENCE



This chapter is excerpted from
GP Wellbeing: Combatting Burnout in General Practice
By Adam Staten and Euan Lawson

©2017 Taylor & Francis Group. All rights reserved.

[LEARN MORE >](#)

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

The first questions that anyone might ask about resilience are: 'What is it? How do I know whether I have resilience? And, how do I develop it? There are few easy answers to these questions, but there is an emerging consensus on some of the factors involved.

When the term 'resilience' is applied to materials, it refers to a quality that allows for it to be bent, stretched or compressed and still return to its original shape. It is easy to think of this as a metaphor for resilience in people. It is the ability to bounce back from adversity.

Lown et al. define resilience as follows, and this closely fits with a similar definition from the American Psychological Association: 'There are many definitions of resilience but it is best considered as the individual's ability to adapt to and manage stress and adversity: essential qualities for GPs'.¹

Southwick and Charney have studied the quality of resilience in people who have been through trauma, both physical and psychological. Some had experienced trauma through being a soldier in a warzone, or through being the victim of a terrorist attack. Others had experienced trauma due to physical and sexual assaults, or perhaps through being involved in serious road traffic collisions. They noted that resilience is 'complex, multidimensional and dynamic in nature'.² Resilience is not a fixed commodity. It can vary across the life course, it could vary from month to month even, and it can also vary depending on the exact nature of the stressor. There are various tests that can measure resilience, and these tests are generally self-reported using Likert scales. They are most useful for research and are less helpful for aiding the creation of day-to-day strategies for individuals.

NEUROBIOLOGY OF RESILIENCE

This is worth dwelling on. One might assume resilience is a rather wishy-washy new age term that is nebulous, related to aspects of personality or other inner qualities that are undefinable. Increasingly, neuroscience is mapping out the specific pathways where resilience is found, and this leads to credible strategies to address concerns when those pathways bend or break.

ACUTE STRESS RESPONSE

This is how the mind and the body respond to persistent stress. We all know the hormones that rise in these circumstances: the fight-or-flight surge of adrenaline and catecholamines. There is a rise in cortisol levels and also in pro-inflammatory

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

cytokines. These are primitive responses, enormously helpful in the course of evolution to preserve us from short-term hazards. In modern life, these responses do not necessarily ebb away, and this persistent stress activation can damage us with changes in the brain tissue and maladaptation in the hypothalamic-pituitary- adrenal axis. This persistent stress is associated with chronic illnesses including cardiovascular disease.

The problem with sustained stress is that it impairs decision making. Martin et al. highlight other impacts³:

- Interference with empathy and communication
- Narrowing of the field of vision (literally and metaphorically)
- Decrease in generosity
- Decrease in cooperativeness
- Increase in xenophobia
- Increased likelihood of interpreting ambiguous expressions as hostile
- Increased likelihood of displacing frustration and aggression onto those around us

As David Peters puts it, 'it makes us more dull-witted and less friendly'.⁴ As these responses kick in, it has been shown that compassion and empathy diminish. Clearly, this is not ideal for anybody, and it is particularly worrying in the medical profession. However, this is a feature of medical training in general. There tends to be a decline in empathy over the course of training with an increase in 'professional numbing'.

PHYSICIAN PERSONALITY AND RESILIENCE

Physician personality has been found to be associated with wellness. One Norwegian study found that neuroticism and conscientiousness traits predict stress in medical students.⁵ Workaholism and perfectionism have been traits associated with suicide in physicians.⁶ Lemaire and Wallace explored personality and doctors' perceptions with a cross-sectional study that surveyed more than

1000 Canadian physicians.⁷ They had previously noted that physicians tended to identify strongly (%) with three different personality types (**Figure 7.1**)

- Workaholic personality – 53%
- Type A personality – 62%
- Control freak personality – 36%

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

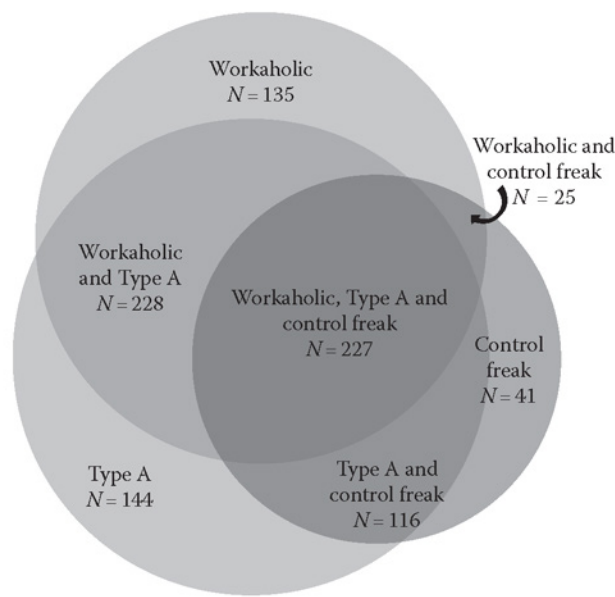


Figure 7.1 • Proportions of 916 Respondents Who Identified with One, Two or All Three of the Predetermined Personalities. (From Lemaire, J.B., and Wallace, J.E., *BMC Health Serv Res.*, 14, 616, 2014.)

They also compared the physicians who identified with these personalities with those who did not. Specifically, they wanted to see how they differed in how they perceived the impact of personality on professional performance and how they experienced wellness.

They found that most of the physicians did identify with at least one of these personalities. The workaholic personality was associated with one potentially harmful and three positive wellbeing outcomes. The control freak personality was associated with five potentially harmful outcomes.

There are several factors in play with physician personalities. There is an issue with selection, but there is also a culture within medicine that can exacerbate existing traits in physicians. Personalities themselves may not be malleable, but awareness amongst physicians of their own potential vulnerabilities, their inherent resilience and their ability to withstand burnout is crucial to manage clinician wellness.

OTHER FEATURES ASSOCIATED WITH RESILIENCE

Charney and Southwick found 10 factors associated with resilience.² Psychological and social factors associated with resilience

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

- Facing fear: an adaptive response
- Having a moral compass
- Religion and spirituality
- Social support
- Having good role models
- Being physically fit
- Brain fitness: making sure your brain is challenged
- Having 'cognitive and emotional flexibility'
- Having 'meaning, purpose and growth' in life
- 'Realistic' optimism

These are more encouraging because they are not all necessarily fixed traits. They can, potentially, be addressed.

'REALISTIC' OPTIMISM

What do we mean by optimism? Southwick and Charney regard this as a 'future orientated attitude.' Optimists tend to believe that the future will be bright and that good things will happen to people who work hard. Psychologists have developed tests to measure optimism. Some of the most resilient people that have been studied have been the most optimistic. Psychologists have investigated why optimists seem to be particularly resilient. It has been suggested that this leads us back to the fight-or-flight reaction that has already been described. It has been shown that when we have positive emotions it tends to reduce physiological arousal, so there is a direct mechanism to ensure that people get various benefits from their optimism. These are things such as improved attention and ability to actively problem solve as well as our greater interest in socialising.

FACING FEAR: AN ADAPTIVE RESPONSE

This factor associated with resilience is also linked to the fight-or-flight response. Pavlov's dogs and the phenomenon of classical conditioning are familiar to most people. We experience a response such as fear when exposed to a stimulus which would not otherwise cause distress but has been previously associated with some kind of traumatic event. This resilience-associated factor is particularly important to people who have had a very traumatic experience in the past.

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

ETHICS AND ALTRUISM: HAVING A MORAL COMPASS

The reason that Southwick and Charney included this ethics and altruism was because when they interviewed people who had been through trauma,

they found that many of the individuals who seem to be particularly resilient had a sense of right and wrong that was particularly valuable to them during periods of extreme stress. They also found that altruism, a concern for the welfare of others, was often part of that value system. Some trauma survivors, particularly those who had been involved in torture, had been forced to face some deeply difficult moral choices. To some extent, this may be less relevant to the medical profession where there is often already a strong code of moral and ethical behaviour. However, there could certainly be value in deepening the links and engagement with that moral compass – working with colleagues who reinforce those ethical positions and sense of altruism could be of particular benefit to health care professionals.

RELIGION AND SPIRITUALITY

Many people find that their religious beliefs offer them resilience. Southwick and Charney felt this to be as applicable to people who are atheists as to those with strongly held beliefs in any of the world's major religions. The important thing about this factor is that that does not necessarily denote having to believe in a particular God. It is more about people who are comfortable with their place in the universe. That said, many of the most highly resilient individuals were found by Southwick and Charney to have had particularly strong benefits from their spirituality or religion.

SOCIAL SUPPORT

Humans are basically social creatures. Having a social support network has been clearly associated with resilience. It has been shown that social support can promote physical and mental health. And the relationship seems to work both ways – it may even be the case that giving social support is more beneficial for physical health than receiving it. There is an underlying biology of relationships and specific neurobiological changes that occur in the context of relationships have been noted by neuroscientists. In particular, the hormone oxytocin seems to play a strong role in social communication and the formation of a sense of affiliation, as well as in other interactions such as sexual behaviour.

General practice may seem like a highly social activity, but it is entirely possible for general practitioners (GPs) to become very isolated. The work of seeing patients

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

does, by necessity, happen in isolation and behind closed doors. Those interactions with people are not necessarily social in the sense that is beneficial to the GP. GPs may go prolonged periods without the opportunity to socialise with colleagues in a way that promotes their own health.

Wallace and Lemaire studied positive and negative factors associated with physician wellbeing and noted the importance of co-worker support. Interestingly, this study also highlighted the role of patients in wellbeing. While being a source of stress, patients were also an important source of satisfaction and therefore wellbeing for doctors.⁸

HAVING GOOD ROLE MODELS

In some of the first studies to look at resilience it was shown that the most resilient children usually had at least one person who gave them genuine support and served as a role model. Southwick and Charney found similar findings in their own research. Their research established that everybody needs appropriate, resilient role models. Mentors form the critical role in inspiring and motivating their charges and fostering resilience. How does it work? This seems to be down to imitation – an innate ability and one that we have from the earliest infancy but that persists throughout our lives. Role modelling has been well established in medical education and for trainees at all levels but, perhaps, there could be further development of this area for more senior clinicians.

BEING PHYSICALLY FIT

The obvious benefits of physical exercise to our physical health seem also to extend to benefits to mental health including improvements to mood and cognition. Most importantly, there seems to be benefit in terms of resilience. There are clear neurobiological mechanisms that explain how this could function. The chemicals that improve mood such as endorphins, serotonin and dopamine are all increased after exercise. In addition the pathways that release cortisol are dampened by exercise. There are other potential mechanisms including neurogenesis which involve the making of new brain cells when specific genes are switched on.

One of the key points to remember about exercise and resilience is that we only get stronger and more physically fit by ensuring we have appropriate rest periods. This is often neglected. Physical exercise itself is the stressor but the adaptation only comes afterward. This means diet and sleep are key factors in developing resilience due to physical activity.

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

BRAIN FITNESS: MAKING SURE YOUR BRAIN IS CHALLENGED

Southwick and Charney found that people who are lifelong learners tend to have higher levels of resilience. They found that it is possible to do various different activities that can promote both cognitive and emotional improvements in brain function – mental training. There is still some scepticism around ‘brain training’, but there is certainly good evidence that there is an enormous amount of plasticity inherent in the brain and that this neuroplasticity can be developed in some form. It is also known that the use of techniques such as mindfulness can help us learn how to develop calm and an improved awareness of our emotions and perceptions. Even if people remain sceptical about interventions such as mindfulness, there is clear evidence for cognitive behavioural therapy, an obvious form of mental and emotional training.

HAVING COGNITIVE AND EMOTIONAL FLEXIBILITY

Cognitive flexibility is an important factor in resilience. We need to have the ability to accept the reality of the situations that we are in. It is obvious that avoidance and denial are not helpful in coping with changing circumstances. This concept of ‘acceptance’ has been identified by psychologists as an important ingredient in people being able to tolerate highly stressful circumstances. It has also been shown to be associated with better psychological and physical health.

This is been described by Southwick and Charney as cognitive reappraisal. This cognitive reappraisal can come in many different forms. One potential area is in the shape of gratitude. Resilient people that have been through particularly traumatic events often then appreciate the things they still have. They also suggest that humour is a form of cognitive reappraisal. It is a mechanism to help people reframe events and to face their fears. There is the possibility that it can be used as an avoidance tactic, but for many people the ability to see humour, even in the most tragic of circumstances, is an important factor in resilience.

HAVING ‘MEANING, PURPOSE AND GROWTH’ IN LIFE

The 10th factor described by Southwick and Charney is about having a purpose. Those people who have a clear sense of mission often have a very deep resilience and ability to withstand enormous stresses and strains. In many ways, in the United Kingdom, the National Health Service (NHS) has provided many clinicians with that sense of purpose in their clinical practice. As Nigel Lawson, a Conservative politician said, the NHS is ‘the closest thing the English have to a religion’. It gives many



RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

workers in the NHS a meaning that goes beyond the monthly pay packet. This requirement for meaning and purpose has been shown repeatedly in studies with soldiers who have embarked on missions. However, it has also been of importance in civilian workers who have been able to cope with work-related stress. This factor also highlights a potential unintended consequence of re-organisations and stress within the NHS system; it will, indirectly, erode the resilience of the workers within it.

THE PARADOX

One of the biggest challenges facing the medical profession is the fundamental paradox at the heart of managing burnout. There is an expectation that doctors will be cool, calm, and collected. Confident and yet still caring and empathetic.

These may not be obviously mutually exclusive: the neurobiology of the human brain rather suggests that, to some extent, they are exactly that. Doctors are faced with people going through tremendously intense emotional experiences while unwell. Yet, clinicians need to suppress the parts of the brain – limbic and reptilian – that regard these experiences as highlighting a threat. Patients push our limbic brain buttons, even if it is happening subconsciously.

CLINICAL SUPERVISION

Dr. Rebecca Farrington

GPwSI in Refugee Health, Clinical Lecturer, University of Manchester

Dr. Jude Boyles

Psychological Therapist, Manager of Freedom from Torture North West Centre in Manchester

As part of my role as a GP for asylum seekers, I sought clinical supervision from Freedom from Torture, a credible and reputable organisation working with a similar group of patients. This has proven essential for me in avoiding vicarious trauma and keeping my work life sustainable. My experiences have helped me realise that clinical supervision is also valuable for GPs in mainstream practice. We are all exposed to extremes of emotion and the difficult lives of our patients on a regular basis. Maintaining our humanity and retaining our compassion are important.

The role of supervision is to provide a reflective space to explore our work with patients: the treatments offered or the relationships and dynamics in the

RESILIENCE

Dr. Euan Lawson – *Director of Community Studies, Faculty of Health and Medicine, Lancaster University*

Excerpted from *GP Wellbeing*

consultation. Sometimes, we find ourselves being confused about our emotional responses to a patient or feel ill equipped to manage a particular presentation. It is not therapy but supervision that gives us a non-judgemental opportunity to examine new or different ways of practicing or communicating. It is a chance to think about the impact of the work and ensure we continue to practice safely, healthily and ethically.

The supervisor should not in any way be personally connected to the supervisee so that they can be as objective as possible. The supervision is confidential, but the supervisor has similar duties to other health care staff in that if the supervisor considers that the practitioner is unsafe to practice or has not acted appropriately around safeguarding, the supervisor is expected to act upon these concerns.

I have found it useful to have a non-GP clinician as my supervisor on a one-to-one basis. Others may find that sharing experiences collectively, such as in Balint groups or Schwarz rounds, suits them better.

Resilience is our ability to soak up that neurobiological stress and not develop the adverse consequences of persistent stress and arousal. The need to develop resilience in trainees has been recognised. In one study GP trainees on a scheme in the south of England were found to have significant levels of burnout in their first year of training.⁹ It was also noted that less than half of the trainees were under-estimating their levels of burnout.

If the innate resilience of doctors is being stretched as this early stage in their careers, it suggests that we need to start building on that innate resilience at medical school, during training, and on through our careers, to future proof ourselves against the increasing stresses of our working lives.

RESILIENCE

GP WELLBEING: LESSONS LEARNED FROM A TRAINEE-LED INITIATIVE

Dr. Duncan Shrewsbury – *GP Registrar, Chair RCGP AiT Committee*

Excerpted from *GP Wellbeing*

It is unfortunately the case that those training and working within the medical profession are at significantly greater risk of mental illness and suicide than the general public.¹⁰ At a time when junior doctor morale in the United Kingdom was believed to be at a nadir, several cases where junior doctors had turned to suicide were reported in the UK mainstream media.¹¹ This highlighted the issue of morale, but also wellbeing. Anecdotally, trainees experienced a lack of understanding, empathy or even basic kindness when approaching colleagues and seniors for support with issues relating to distress caused by their own mental illness, or that of peers.

GP trainees on the Royal College of General Practitioners (RCGP) Associates in Training committee wanted to take action to address this issue. We collectively felt saddened, disappointed and incensed that a colleague or friend would find himself or herself in a situation where the only option that they felt able to take was to end their own life. Even more, we felt that the rhetoric around such tragedies, and the response that trainees received to similar problems, denied the sympathy and humanity that we would wish to afford our own patients in times of great distress.

At a February meeting of the whole committee, we discussed and developed an idea to address the situation. We wanted to support a vision of happy, healthy colleagues who were able to invest in and maintain their wellbeing. We wanted to change the conversation around needing, seeking and providing help for doctors experiencing difficulty. However, we acknowledged the challenge of stigma around such issues and were wary of adding to negativity. The simple idea of trying to achieve change positively prompted us to look wider. We drew on ideas from positive psychology (literally, the study of how positive outcomes are achieved,¹² rather than the study of pathological psychology), and took inspiration from work done in the teaching profession.¹³

A group of teachers had started a campaign called #Teacher5aDay. It was largely facilitated through social media (hence the hashtag) but involved coordinated activities taking place in schools across the United Kingdom. It was so popular, in fact, that a national conference grew out of the initiative after less than 2 years. Their campaign centred on the five themes that emerged from a systematic review published in 2008, which looked at wellbeing across society, and how it can be improved.¹⁴ The five themes were connect, be active, take notice, keep learning, and give. We re-deployed this as #GP5aDay (with the blessing from the #Teacher5aDay team). The key messages being that by building activities in your daily life that facilitated your social connections, kept you physically healthy, allowed you to pause and reflect on the good in your life, and enabled you to engage in acts of altruism,

RESILIENCE

GP WELLBEING: LESSONS LEARNED FROM A TRAINEE-LED INITIATIVE

Dr. Duncan Shrewsbury – *GP Registrar, Chair RCGP AiT Committee*

Excerpted from *GP Wellbeing*

there was a good chance you would be better and happier for it and be more resilient to some of the factors that are believed to be contributing to the burnout of those working in general practice.¹⁵

Crucial to this story (although, ironically, not the campaign) is that the teachers had given out 'wellbeing bags' to their colleagues. These bags contained little messages about the campaign, and treats that were aligned to the messages, such as tea bags (to connect with someone over a cup or tea). Instead of leaflets further highlighting the negativity around working in health care at present, we felt the wellbeing bags offered an alternative form of campaign collateral that would help signpost key messages and resources as well as catalyse conversations when taken by trainees and shared with their peers and colleagues.

Our proposal gained support from leadership within the College. Members of staff were excited by the potential to work on something immediately tangible that could help make a difference. The campaign collateral was refined, re-designed and then piloted with trainees and early-career general practitioners, and then showcased at a meeting of college council. The feedback had been largely positive. The 'well-being bags' had morphed into boxes. The tea bags were still present, but they were now joined by a mindfulness colouring book and gratitude journal (both of which have a growing body of evidence suggesting their utility in mental health¹⁶⁻¹⁸).

Separated from the aims and messages of the campaign, an image of the mindfulness colouring book made its way into social media and trade-press. Subsequently, general practitioners across the country became enraged at the idea that they may be posted a colouring book to solve the issues that they face due to over-stretched and under-resourced workforce issues. Our objective, and morals, were questioned. The idea of the campaign was challenged. Plans to embark on a wider trial were slowed.

Amidst the negativity, however, came requests for sharing of work and ideas from other professions (law, veterinary medicine, policing) and requests from colleagues for the 'wellbeing boxes'.



RESILIENCE

Excerpted from *GP Wellbeing*

REFERENCES

1. Lown M, Lewith G, Simon C, Peters D. Resilience: What is it, why do we need it, and can it help us? *Br J Gen Pract* 2015;65(639):e708–10.
2. Southwick SM, Charney DS. *Resilience: The science of mastering life's greatest challenges*. Resilience: The science of mastering life's greatest challenges. New York: Cambridge University Press; 2012.
3. Martin LJ, Hathaway G, Isbester K, Mirali S, Acland EL, Niederstrasser N, Slepian PM, et al. Reducing social stress elicits emotional contagion of pain in mouse and human strangers. *Curr Biol* 2015;25(3):326–32.
4. Peters D. The neurobiology of resilience. *InnovAiT* 2016;9(6):333–41.
5. Tyssen R, Dolatowski FC, Røvik JO, Thorkildsen RF, Ekeberg, Hem E, Gude T, Grønvold NT, Vaglum P. Personality traits and types predict medical school stress: A six-year longitudinal and nationwide study. *Med Educ* 2007;41(8):781–7.
6. Beevers CG, Miller IW. Perfectionism, cognitive bias, and hopelessness as prospective predictors of suicidal ideation. *Suicide and Life-Threat Behav* 2004;34(2):126–37
7. Lemaire JB, Wallace JE. How physicians identify with predetermined personalities and links to perceived performance and wellness outcomes: A cross-sectional study. *BMC Health Serv Res* 2014;14:616.
8. Wallace JE, Lemaire J. On physician well being-you'll get by with a little help from your friends. *Soc Sci Med* 2007;64(12):2565–77.
9. Sales B, Macdonald A, Scallan S, Crane S. How can educators support general practice (GP) trainees to develop resilience to prevent burnout? *Educ Prim Care* 2016;27(6):487–93.
10. Brooks S, Gerada C, Chalder T. Review of literature on the mental health of doctors: Are specialist services needed? *J Ment Health* 2011;20(2):146–56.
11. <http://www.dailymail.co.uk/news/article-3331748/Newly-qualified-doctor-voted-Trainee-GP-Year-hanged-worrying-failed-alcohol-test-work.html>
12. Styles C. *Brilliant positive psychology: What makes us happy, optimistic, and motivated*. Harlow: Pearson Education; 2011.
13. Martyn Reah's #Teacher5aDay.
<https://martynreah.wordpress.com/2014/12/06/teacher5aday/>



RESILIENCE

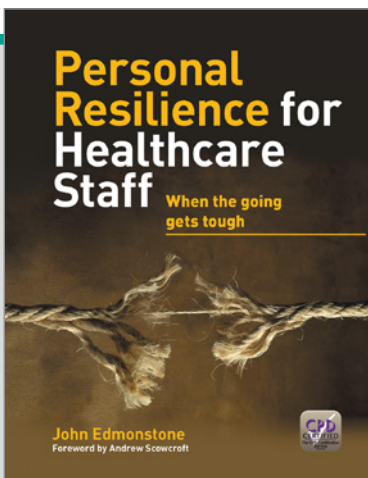
Excerpted from *GP Wellbeing*

14. Aked J, Marks N, Cordon C, Thompson S. *Five ways to wellbeing: A report presented to the Foresight Project on communicating the evidence base for improving people's well-being*. New Economics Foundation; 2008.
http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqq5.pdf
15. Doran N, Fox F, Rodham K, Taylor G, Harris M. Lost to the NHS: A mixed methods study of why GPs leave practice early in England. *Br J Gen Pract* 66(643):e128–35.
16. Emmons RA, Crumpler CA. Gratitude as a human strength: Appraising the evidence. *J Soc Clin Psychol* 2000;19(1):56–9.
17. Van der Vennet R, Serice S. Can colouring mandalas reduce anxiety? A replication study. *Art Ther* 2012;29(2):87–92.
18. Shapiro SL, Brown KW, Biegel GM. Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Train Educ Prof Psychol* 2007;1(2):105–15.



CHAPTER
2

HEALTHCARE ORGANISATIONS CRADLED IN ANXIETY?



This chapter is excerpted from
Personal Resilience for Healthcare Staff

By John Edmonstone

©2013 Taylor & Francis Group. All rights reserved.

[LEARN MORE >](#)

HEALTHCARE ORGANISATIONS

CRADLED IN ANXIETY?

Excerpted from *Personal Resilience for Healthcare Staff*

'If anyone feels secure, satisfied with what he thinks of as his established position in life, he is a fool. The forces that control our lives are as unpredictable as the behaviour of idiots. There is no such thing as certain happiness.' (Euripides, *The Trojan Women*)

This chapter considers whether healthcare organisations are a 'special case' where employees experience greater anxiety and stress than those in other sectors – particularly in industrial and commercial enterprises. The title is taken from the instigator of action learning, Reg Revans, who once described the hospital in particular as an 'institution cradled in anxiety'.¹ It is well recognised that a number of healthcare professions (most especially medicine and nursing) are subject to excessively high risks of stress.² In this respect, for example, the NHS in the UK has one of the worst sickness absence levels in any sector, claimed to be almost verging on epidemic levels.³

All healthcare systems around the world face inherent tensions and these are shown in Box 3.

A focus on individual patient care	A focus on care for an entire population
Reactive health services	Preventative health services
Effective treatment of ill health	Promoting good health
Treating acute episodes of illness	Managing chronic ill health
Demand-led services	Needs-led services
Utility	Equity
Citizen perspectives and priorities	Professional perspectives and priorities
Generalist practice	Specialist practice
Appropriate standardisation	Appropriate diversity
National standards	Local sensitivity
Current service delivery	Developing the future workforce

Box 3 • Tensions within healthcare systems

The most seminal work addressing these issues was undertaken by Isobel Menzies Lyth in the late 1950s and early 1960s.⁴ Noting that the purpose of a hospital was to care for ill people who cannot be cared for in their own homes, she identified that the major responsibility for such caring lay with the largest constituent part of the healthcare workforce – the nursing profession, who provided continuous patient care – what we would now describe as '24/7'. As a result, nursing bore the 'full, immediate and concentrated impact' of the distress, tragedy, death and dying which arose from patient care and which is not part of the typical working experience for most of the public.

HEALTHCARE ORGANISATIONS

CRADLED IN ANXIETY?

Excerpted from *Personal Resilience for Healthcare Staff*

The sources of such stress included close and regular contact with people undergoing suffering and death; the undertaking of 'distasteful, disgusting and frightening' tasks; coping with personal feelings of pity, compassion, love, guilt, anxiety, resentment and envy; and 'carrying' the depression, anxiety, fear and disgust of patients' relatives and friends.

Menzies Lyth claimed that, in order to deal with this anxiety, nurses unconsciously created and operated socially structured defence mechanisms. These included:

- an emphasis on task-focused, rather than patient-focused care
- depersonalisation and categorisation of patients. Nurses in training, for example, often show a preference for 'real' nursing – sticking needles and tubes into people – the physiological rather than the psychosocial (relational and emotional) skills
- the cultivation of professional detachment and self-control – a 'caring but distant' demeanour which suppressed and controlled emotions.⁵ This has been described as 'emotional labour' – the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for^{6,7}
- ritualistic task performance to detailed and precise standardised procedures and instructions
- the checking and rechecking of decisions
- delegation upwards to seniors as a means of avoiding taking responsibility for decisions
- avoidance of change.

While the human state requires us to manage our anxiety to prevent it from overwhelming us and a certain level of emotional detachment is therefore healthy, in the longer term, the emotional dissonance arising from the constant suppression of such powerful emotions can lead to personal burn-out.⁸ This powerful emotional cost to caring is rarely if ever discussed in the media, where coverage takes little or no account of such issues.

It should also be noted that nurses, doctors and other clinical professionals are, by training and socialisation, expert 'fixers' through clinical interventions. Patients with long-term and incurable conditions or who are dying can therefore potentially represent failure to them.

Menzies Lyth later reflected that she had over-emphasised the nature and effects of anxiety *within* the hospital without adequately reflecting the broader structural and

HEALTHCARE ORGANISATIONS

CRADLED IN ANXIETY?

Excerpted from *Personal Resilience for Healthcare Staff*

management context.⁹ Subsequently, Bain extended the focus from the single healthcare institution to what he termed the wider 'system domain fabric',¹⁰ which included:

- the organisational structure, roles and relationships and authority and accountability systems
- policies and procedures and information systems
- professional education and training
- technology and technical systems
- organisational culture
- funding arrangements
- trade unions and professional associations.

So it seems that these unconscious defence mechanisms against anxiety operate at the level of the individual and the group, but also at the larger organisational level. They permeate healthcare organisations (especially hospitals) as 'emotional toxins',¹¹ evidenced in structures, roles and work processes, and thus have a major (but largely unrecognised) impact on the way they operate.

Healthcare organisations are, of course, professional organisations¹² where the frontline clinical professionals possess a high degree of control. Accordingly, the ability of managers in such organisations to *directly* influence clinical decision making is significantly more constrained and contingent than in other kinds of organisations¹³ and because decision making within clinical professions is typically collegiate in nature, there is a premium on leaders with professional backgrounds leading change. Clinical professionals form what has been called the 'operating core' of healthcare organisations¹⁴ – what they control is what Marxism would typify as the 'means of production'. Attention has also been drawn to what is termed the 'disconnected hierarchy' in healthcare – a disjunction between those who are responsible for frontline *management* and those who *deliver* frontline services.¹⁵ This is, in effect, an inverted power structure in which people at the 'bottom' generally have greater influence over clinical decision making on a day-to-day basis than those who are nominally in control at the 'top'. As a result, the role of healthcare management particularly at or close to the frontline, is often to lend support to clinicians in making changes, through the provision of finance, time and other resources, although the advent of general management may have convinced some healthcare managers that a simple command-and-control relationship exists *vis-à-vis* clinical professionals.¹⁶

HEALTHCARE ORGANISATIONS

CRADLED IN ANXIETY?

Excerpted from *Personal Resilience for Healthcare Staff*

In this respect, it has been claimed¹⁷ that the advent of the 'new public management' (of which general management in healthcare is an expression) from the 1980s onwards has exacerbated those tensions between clinical professionals and healthcare managers by ignoring these emotional and psychological aspects of work. The suggestion is that prescriptive assessment and risk management procedures taken together with other bureaucratic elements of work may serve a defensive purpose in allowing clinical professionals to spend less time with patients or service users. Reassurance and relief from anxiety can be found through the performance of such ritual tasks – the completion of tick-box forms, checking and counter-checking and so on. In addition, prescriptive timescales and guidance, complicated recording systems, increased use of IT-based reporting, etc. all add to workload and generate anxiety about meeting deadlines and 'keeping on top' of paperwork.

All this serves to limit the degree of discretion which can be exercised by clinical professionals whose role it is to deliver 'frontline' care. The exercise of discretion rather than prescription of what is permissible was seen to be a key feature of the work of 'street-level bureaucrats'¹⁸ – service providers across the public sector, such as doctors, nurses and therapists who worked face to face with their clients – partly because they operated in complex situations which could not easily be reduced to programmatic formats, partly because the situations they encountered might require compassionate treatment, and partly because the exercise of initiative in itself could inspire the trust of clients both in the individual professional and in the agency he or she represented. Latterly, however, it has been recognised that the advent of such managerial practices has increased levels of bureaucracy and deskilled professionals.¹⁹

While this emphasises the impact of healthcare management on the clinical professional, the way in which such healthcare leaders and managers tend to frame the problems which they experience also has a major impact. Grint²⁰ indicated that there were three such ways.

- **Critical:** this is a crisis situation where there is little or no time for discussion, disagreement or dissent about the problem or for worrying about procedures that get in the way of rapid resolution. It involves the use of coercion and authority 'for the public good'. The leader/manager acts as a *commander* and the message is '*Just do it – it doesn't matter what you think*'.
- **Tame:** in such situations, tried and tested procedures exist to resolve the problem because management has previously encountered this situation and has 'solved' it – just like a puzzle. There is clear agreement about the exact nature of the problem and the solution necessary. Facts can be clearly defined and analysed.

HEALTHCARE ORGANISATIONS

CRADLED IN ANXIETY?

Excerpted from *Personal Resilience for Healthcare Staff*

The leader/ manager acts as a *manager* and the message is *'I've seen this before and I know exactly what process will resolve it'*.

- **Wicked:** here there are no easy answers because the problem is a new, unknown situation that different people understand in different ways. It might be embedded in other problems so that actions taken may have unanticipated consequences. There is poor problem focus and little agreement about possible ways forward. The leader/manager therefore has to *lead*, asking appropriate questions and engaging collaboration. The message is *'I've never seen this problem before and we need to get a collective view on what to do'*.

Grint suggests that in healthcare, problems are typically seen or interpreted as either Critical (*Don't panic!*) or Tame (*Been there, done that, got the T-shirt!*). In relation to the tendency to define Wicked problems as Tame ones, other authors²¹ have commented:

'Our learnt instinct is to troubleshoot and fix things – in essence to break down the ambiguity, resolve any paradox, achieve more certainty and agreement and move into the simple system zone.'

So we can conclude that healthcare organisations operate in society as 'containers' of the emotions and anxiety of patients' relatives and families and that because of this, the experience of acting as a leader or manager of clinical professional staff in such a context is different from that of an industrial or commercial enterprise. Managerial initiatives from the 1980s to the present day have served to increase and bolster the potential defence mechanisms in play in order to deal with the inherent anxiety of working in healthcare. Increased bureaucratisation of professional work has also served to increase prescription and to decrease discretion. The labelling of Wicked health (and social) care problems as Critical or Tame (and therefore amenable to quick and repeatable solutions) has exacerbated this process, which is little understood by the rest of society and over- simplified (if addressed at all) by the media.

HEALTHCARE ORGANISATIONS

CRADLED IN ANXIETY?

Excerpted from *Personal Resilience for Healthcare Staff*

REFERENCES

1. Revans R. The hospital as an organism: a study in communications and morale. *Proceedings of the 6th Annual International Meeting of the Institute of Management Sciences*. London: Pergamon Press; 1959.
2. Broughton A. *Work-Related Stress*. Dublin: European Foundation for the Improvement of Living and Working Conditions; 2010.
3. Andolo D. Time to talk about workplace stress. *Guardian*. 2012; 3rd October.
4. Menzies Lyth I. *The Functioning of Social Systems as a Defence Against Anxiety: a report on a study of the nursing service of a general hospital*. London: Tavistock Institute of Human Relations; 1970.
5. Bolton S. Changing faces: nurses as emotional jugglers. *Sociol Health Illness*. 2001; 23(1): 85–100.
6. Sawbridge Y, Hewison A. *Time to Care? Responding to concerns about poor nursing care*. Policy Paper 12. Birmingham: Health Services Management Centre, University of Birmingham; 2011.
7. Hayward R, Tuckey M. Emotions in uniform: how nurses regulate emotions at work via emotional boundaries. *Human Relations*. 2011; 64(11): 1501–23.
8. Hochschild A. *The Managed Heart: commercialisation of human feeling*. Berkeley, CA: University of California Press; 1983.
9. Lawlor D, Webb I. An interview with Isobel Menzies Lyth with a conceptual commentary. *Organis Social Dynam*. 2009; 9(1): 93–137.
10. Bain A. Social defences against organisational learning. *Human Relations*. 1998; 51(3): 413–29.
11. Hinshelwood R, Skogstad W. *Observing Organisations: anxiety, defence and culture in health care*. London: Routledge; 2000.
12. Mintzberg H. *The Structuring of Organisations*. New Jersey: Prentice-Hall; 1979.
13. Ham C. Improving the performance of health services: the role of clinical leadership. *Lancet*. 2003; 361: 1978–80.
14. Mintzberg H. *Structure in 5s: designing effective organisations*. New Jersey: Prentice-Hall; 1983.
15. Best G. *Managerial Hierarchies and Healthcare Reform: a precautionary tale for the millennium*. London: OD Partnership Network; 1999.
16. Edmonstone J. Clinical leadership: the elephant in the room. *Int J Health Plan Manage*. 2009; 24(4): 290–305.

HEALTHCARE ORGANISATIONS

CRADLED IN ANXIETY?

Excerpted from *Personal Resilience for Healthcare Staff*

17. Lees A, Meyer E, Rafferty J. From Menzies Lyth to Munro: the problem of managerialism. *Br J Social Work*. (epub ahead of print December 2011).
18. Lipsky M. *Street Level Bureaucracy: dilemmas of the individual in public services*. New York: Russell Sage Foundation; 1980.
19. Taylor I, Kelly J. Professionals, discretion and public sector reform in the UK: re-visiting Lipsky. *Int J Public Sector Manage*. 2006; 19(7): 629–42.
20. Grint K. Wicked problems and clumsy solutions: the role of leadership. *Clinical Leader*. 2008; 1(2): 54–68.
21. Plsek P, Greenhalgh T. Complexity science: the challenge of complexity in health care. *BMJ*. 2001; 323(7313): 625–8.



CHAPTER
3

WHAT JEOPARDISES RESILIENCE



This chapter is excerpted from
Resilient Leadership

By Karsten Drath

©2016 Taylor & Francis Group. All rights reserved.

[LEARN MORE >](#)

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

In the previous chapters I have presented numerous principles and qualities which constitute resilience. But what exactly is it that is potentially detrimental to individual resilience? What we know now already is that individual resilience is the result of a lifelong, dynamic process of adaptation which begins in childhood. Hence, resilience is not static, like a physical characteristic, but rather dynamic like a variable blood value. Raw resilience, also known as 'trait resilience', which I described in the section 'The Spheres of Individual Resilience' (3.3), constitutes the only exception in this respect. Similar to the Kondratieff cycles, with which we can derive a structure from the evolution of human society over the past 250 years, it is actually therefore in actual fact possible to draw a conclusion only about a person's ability to resist external pressure in retrospect.

PROTECTIVE AND RISK FACTORS

It is possible to describe only someone's personal disposition for resilience in advance. This is composed of various factors: the levels of individual resilience. The manifestation of these factors determines the individual capacity for resilience available to the person for handling stressful situations. The environment or field in which a person moves has an immediate impact on his resilience. Depending on the quality of this field, a person's individual ability to 'bounce back' will become stronger or weaker. In addition to internal and external protective measures, there are also risk factors at various levels which may jeopardise individual resilience in the face of crises. Since they are usually taken for granted by us these days, we don't even perceive them as a risk within the context of resilience. It is therefore all the more important to recognise and become aware of them again.

The factors that constitute a risk to individual resilience can roughly be categorised into social, organisational and individual factors.

SOCIAL FACTORS: LIFE IN THE VUCA WORLD

Concealed behind all the dynamic and sometimes rather chaotic developments in society and the economy, many people hope to find a higher structure or systematic order that – with enough effort – can be deciphered. After all, the human being is always seeking to understand and handle his environment, and to try – as best he can – to anticipate future developments in order to be as best prepared as possible for the imponderabilities. But it is precisely this which is becoming increasingly difficult to do, as a glance at the last 70 years shows. Following the end of World War II, the

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

Description	Meaning
Volatility	Refers to the increasing frequency, speed and scope of changes taking place
Uncertainty	Describes the increasing unpredictability of events
Complexity	Refers to the increasing number of linkages and dependencies, which makes topics difficult to comprehend
Ambiguity	Describes the ambiguity of the facts of the situation that increases the likelihood of misinterpretations and wrong decisions

Table 5.1 • The meaning of VUCA

world was divided into a two-front system, known as the 'Cold War'. There were two main geopolitical camps: the USA and the USSR, with their respective allies, who aligned themselves – politically, militarily and economically – towards their respective hegemonic power. The enemy images on both sides were clear, making it relatively easy to predict future developments. Following the collapse of the USSR, the two-front system has developed into a four-front system. At the US Army War College in Carlisle, Pennsylvania, future generals are trained in strategy and warfare. This was also where, at the end of the 1990s, the acronym for this new and much more complex world order was coined: VUCA, standing for volatility, uncertainty, complexity and ambiguity. It was initially used mainly by the college lecturers employed there. The term was then adopted by management pioneers, who recognised the increasing complexity not only in the military and power-political realm but also in the development of the globalised economy.

VOLATILITY

If we take a look at a broad range of companies, it is remarkable, for example, that the number of company insolvencies in Germany since World War II has never been as high as in the past five years (Figure 5.1).

Nevertheless, the German share index, which is a leading indicator of the German economy since 1987, is today at its highest level ever. How can this be explained? The answer is volatility.

What has also increased is the frequency and intensity of the fluctuation of share values of German companies – that is the volatility of the DAX, as can clearly be seen in Figure 5.2.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

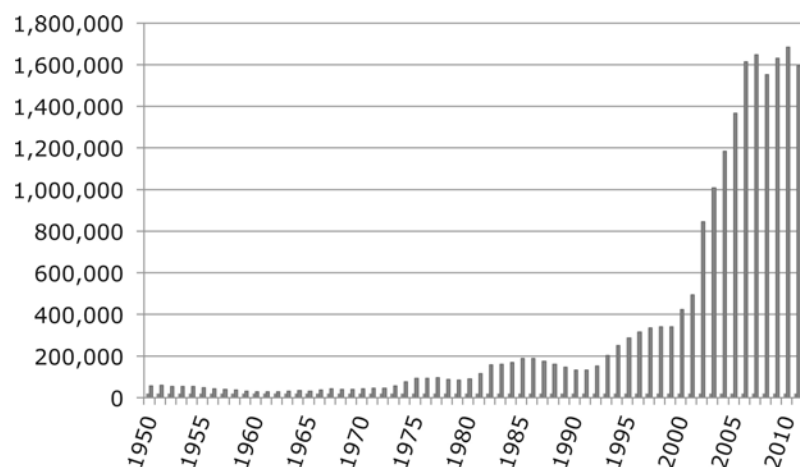


Figure 5.1 • Number of company insolvencies in Germany 1950–2010. Source: Statista, Federal Statistical Office, 2013.

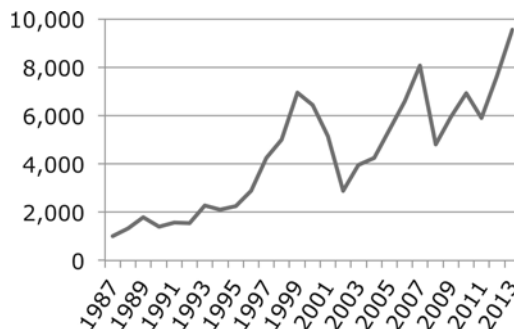


Figure 5.2 • DAX values 1987–2013. Source: Statista, Federal Statistical Office, 2013.

Internationally, the volatility trend is even clearer. According to a study by the Boston Consulting Group from the year 2012, half of all turbulent financial quarters of the last 30 years have occurred since 2002. The fluctuations of corporate revenues and profitability have more than doubled since the 1960s. By contrast, the duration of turbulences has increased by a factor of four. Changes occur faster and more frequently, and their impact is longer and more extensive than in the past. Why is that so?

The significant role of the capital market

Richard Sennett is an American professor of sociology who today teaches at the London School of Economics. In his book *The Culture of the New Capitalism* Sennett describes how, over a long period of time, companies initially appear to be stable,

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

predictable systems that are both an iron cage and a home to their employees. Security and a livelihood have been provided for many decades in exchange for discipline, subordination in hierarchies and the provision of services. Since the end of the last century, this rigid order has given way to a growing flexibilisation, marked by a decline in stability and predictability.

The reason for this, in Sennett's view, is the altered role of the capital market. After World War II, the world economy was governed by the Bretton Woods system, which coupled the exchange rates of the world's leading economies via a band of exchange rates to the US dollar, which in turn had a fixed exchange rate to the gold standard. This system gave the participating economies stability, but it ultimately failed in 1973 as a consequence of the USA's current account surpluses: The dollar could no longer be sufficiently safeguarded by the gold standard. After the collapse of the global monetary system, vast amounts of capital became available worldwide, which sought short-term interest rates. As a result of progressive globalisation and the new possibilities offered by the emerging communication technologies, this 'impatient' capital flowed worldwide into corporate bonds, with the aim of making short-term profits from the rising share prices. The consequence was a more intense global networking of financial interests. Revenues were now hardly expected to come from dividends, which meant that it was no longer the stability of companies that seemed desirable, but the change in revenues with the aim of maximising the share prices. Since this development, the capital market system, along with the associated evaluation by financial analysts, determines the quarterly performance of listed companies.

This short-term competition for the favour of investors and analysts leads to widespread irrational behaviour on the markets, allowing a company's share prices to rise, for example, if it cuts back on R&D staff or restructures for no apparent reason. This type of behaviour, which is incomprehensible from an entrepreneurial point of view, allows the share price, and thus the market value of a company, to rise, which effectively prevents a company from being taken over. Companies that do not bow to this logic are undervalued in this new financial system and consequently end up being bought up by other companies that stick to the rules of the game. Therefore, in order for a company to retain its share price and ensure its long-term attractiveness as an investment object, the company must undergo constant change by the management. A change of strategy, restructuring, acquisitions, portfolio adjustments and downsizing, coupled with a good story for the market, have thus become an end in itself and a key feature of good corporate management. Long-term changes, such as the restructuring of a company as a result of a major change of strategy, are

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

hardly possible anymore. The consequences of these worldwide developments, coupled with ongoing globalisation and the increasing spread of modern communications technologies, shape the everyday work of managers today. High time and performance pressure, unconditional mobility, long working hours, permanent reachability, a constant feeling of uncertainty and a neglect of private life are the consequence of this.

The driving role of technology

Another driving factor for this growing volatility lies in the nature of technological innovations and the speed with which they are spreading. The spread of newer, more disruptive technologies, such as the mobile phone, is occurring at a faster pace today than 100 years ago. While it took landline telephony more than 120 years to reach across the world, mobile phones are expected to reach similar coverage within just 20 years – that is six times as fast. While it took nearly 90 years to build global electrical power grids, the Internet will have a comparable distribution within 30 years at most, which is three times as fast. Technologies such as email and smartphones, without which modern, everyday working life would be inconceivable, are 30 and nearly 10 years old respectively. Today, as many as 3.3 billion people use email, and 6.3 billion smartphones were bought between 2009 and 2012.

Permanent availability unquestionably simplifies many work and coordination processes and also increases efficiency. And yet there also appears to be a collective blind spot regarding the ubiquitousness of these technologies. Permanent reachability also creates stress for many people. But, in actual fact, we have been using these technologies for only less than one generation of managers. Seen from this perspective, it would actually be surprising if we didn't have difficulties adjusting to the enormous speed with which these technologies have been gaining in importance. Technological innovations also significantly increase the volatility at our workplace.

INSECURITY

Higher volatility in our environment – that is more frequent, intense and longer-lasting changes – makes the future less predictable. This decline in transparency affects the capital markets, the national economies, companies and their managers and employees alike, albeit with different consequences. Capital markets react more nervously to changes of any kind, national economies try to increase the funding available for innovation and companies take an increasingly tactical, short-sighted approach.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

Managers and employees respond to the growing volatility of their environment with increased activity and tension, which can quickly make people feel negatively stressed and overburdened.

Furthermore, progressive globalisation and the increasing transparency of the markets have led to more and more competition coming from emerging economies, such as China, India and Brazil, reinforcing this feeling of insecurity and unpredictability even more.

The new VUCA world we live in has fundamentally changed the relationship between a manager and the company he works for. While in the past it was clear that as a manager you would work for a company until you retired, provided you didn't steal the silver, today even consistently high performance is no longer a guarantee for the continuity of one's career. The outsourcing of business units, merging of departments, corporate amalgamations, frequently changing superiors and staff cuts appear to an individual manager to be 'forces of nature' over which he has hardly any influence and which can easily knock his career off course.

A further aspect of insecurity comes from global climate change, which is moving much faster than many had anticipated, and in many cases not linearly. In all probability, volatility and insecurity are not passing phenomena, but they will increasingly become part of our lives. So it is up to us to accept these circumstances and to adapt to them. But this is not all that easy, since insecurity is closely affiliated with fear and stress.

In the section 'Function and Effect of Stress' (4.2), I have explained the effects that the activation of the pain area of the brain can have on more advanced brain functions. The capacities for innovation, agility and prudence are the first abilities to be affected. It will therefore be increasingly necessary for future managers and employees to accept, endure and make the best of this tension.

COMPLEXITY

The worldwide geopolitical power dynamics following the collapse of the Eastern Bloc, the real estate bubble in the USA and its repercussions for the global economy, climate change and its consequences, and the recent euro crisis and the role of Greece are good examples of the increasing complexity in the VUCA world.

Complexity describes the state in which there is an abundance of interdependent variables, not all of which are known, and which do not always behave in a linear fashion – for example due to irrational mass phenomena, such as the fear or threat of inflation.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

Due to the amount of contradictory details involved, it is often not possible to adequately abstract or simplify a complex situation adequately by means of approximations.

Complexity is also characterised by the fact that, even in retrospect, no statement can be made about whether a decision taken was good or bad. Such statements are necessarily based on the comparison with alternative decisions, but their impact in complex situations cannot be predicted. It is therefore more difficult to learn from mistakes in complex situations. Another factor of complexity is that not all variables are known, or that there are interdependencies between various areas that, at first sight, are unconnected. A higher level of complexity therefore reduces the incomprehensibility and the ability to manage the environment that will tend to make leaders feel more stressed and overburdened.

AMBIGUITY

Ambiguity describes the ambivalence or vagueness of a situation. In contrast to a situation that is 'unclear', in which no meaningful conclusions can be drawn, there are several possible and equally valid valuations and interpretations possible in ambiguous situations that are mutually contradictory. Hence, ambiguity makes it more difficult to assess trends and hence to derive a sensible strategy and course of action.

If situations appear to be unpredictable and uncontrollable, many people will tend to react with discomfort and negative stress. Often a dangerous behavioural tendency can be observed, in which simple and ill-considered measures or systems of rules and a more linear way of thinking are used to re-establish order and structure. Crises of this proportion have the tendency to attract populists who claim to have simple solutions. Simple solutions give people a sense of security and orientation, but are often inappropriate.

ORGANISATIONAL FACTORS

The social influences of the VUCA world undoubtedly have an impact on companies and their managers and employees. The global financial crisis of 2009, after the American real estate bubble burst, is a good example of this. Such developments create a lot of stress for companies. Strategies, self-image and well-established practices are called into question. Stress makes certain unproductive personality traits, which would otherwise be compensated by learned behaviour, surface and dominate people's actions. A similar pattern can be seen in companies. If they come under pressure, this reinforces their dysfunctional behaviour patterns. Long-term

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

and indirect investments are cancelled, smouldering conflicts and power struggles erupt, decisions are made with a view only to risk minimisation, and the well-tryed appears more attractive than innovation. Continuity can easily turn to rigidity. Under pressure, the dark sides of corporate culture often surface, which may deviate considerably from the company's principles.

These developments shape an organisation's resilience field and are measurable via the organisational energy. I have described both in more detail in the section 'From Individual Resilience to the Resilience Field' (3.4). For individual managers, who are generally also employees in other contexts, the resilience field is affected by three major factors:

- Indirectly via the organisational energy of the business unit
- Directly via the type of leadership which one experiences oneself
- The quality of the relationships with colleagues and employees.

PROBLEMATIC CORPORATE ENERGY

The majority of managers and their employees possess an extensive degree of resilience, which can already be seen through the fact that practically everyone has already experienced a difficult situation in their life, but only a minimal proportion has suffered serious emotional harm, such as a depression or burnout, as a consequence. It becomes a problem only if people with an already weak or compromised resilience act in an environment in which their mental resilience is further diminished.

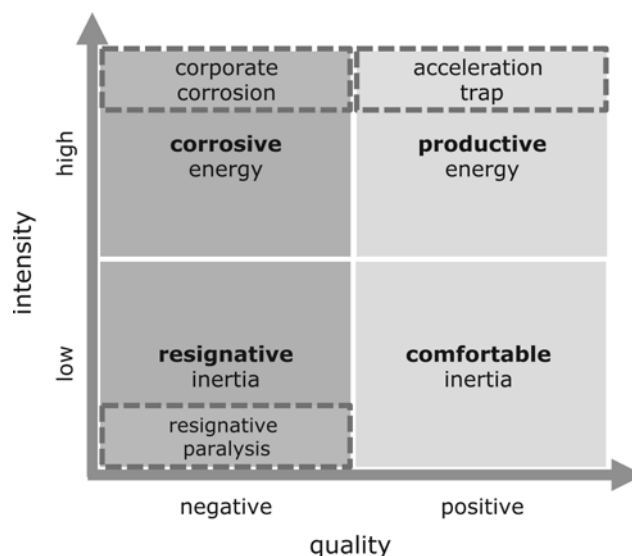


Figure 5.3
Problematic areas of
organisational energy.
Source: Heike Bruch, Bernd
Vogel, St. Gallen University.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

Heike Bruch and her team from St. Gallen University describe three states of organisational energy, in particular, that put the resilience of managers and their employees at risk (Figure 5.3):

- The acceleration trap
- Corporate corrosion
- Resignative inertia.

Acceleration trap

A company that has a high level of productive energy, persistently pursues its goals whereby relying on the employees' emotional identification, which is expressed in a distinct 'we feeling' and a strong commitment to the company goals.

Since managers and employees voluntarily contribute their high productive energy and pull together, it can easily happen that, despite a positive prevailing mood, the company is permanently acting close to the limits of its own resilience. If there are then difficulties on the market or special challenges, such as restructuring or other change processes that need to be overcome, then this can quickly lead to dangerous levels of fatigue. Frequently, managers respond to these signs of fatigue with more of the same – that is more pressure and speed – which will make the company sooner or later overheat or run into what Bruch calls the 'acceleration trap'. The symptoms for this are actionism, declining quality of work results, a dwindling capacity for innovation and flexibility in dealing with challenges, and an increasing tendency of employees and managers to appear overtaxed.

The acceleration trap works like a vicious circle: Due to exhaustion and declining efficiency, the company needs more resources to achieve its goals, which in turn leads to more exhaustion. Ultimately, this leads to cynicism, resignation and burnout for the whole company. The way out of this trap is not easy and requires analysis and conscious reflection at all management levels. Between the high-performance phases, consolidation phases need to be incorporated, and an awareness needs to be developed that 'more' or 'faster' is no guarantee for success, but is more likely to lead to failure.

Corporate corrosion

A company that permanently operates with a high level of inner intensity and has a very negative work atmosphere will eventually have a corroding effect on the resilience field, similar to rust, which, slowly but surely, eats its way through a car body.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

- This type of corrosion occurs particularly when top management does not do what they themselves demand of their managers and employees. One reason for this might, for instance, be the continuously surfacing conflicts and power struggles that dominate the board and lead to irrational behaviour – for instance that the initiative of one department is torpedoed by another one merely out of self-interest. Not only will an executive team that tolerates such behaviour lose its integrity and therefore the loyalty of the employees, but also sooner or later such dysfunctional behaviour will be imitated at the lower levels.
- Another reason for company corrosion is frequently based on the behaviour of top management, which is perceived to be unfair, unethical, insincere or not consistent with the corporate values. In a situation in which, for instance, a company is experiencing financial difficulties, accompanied by cutbacks in all areas, a simultaneous, generous increase in management bonuses will not only cause outrage among the staff for a short period of time but also lead medium-term to a loss of identification with the company management and a drastic decline in the staff's commitment. Another real-life example are restructuring measures, site closure or redundancies that are not understandable to medium management and the staff, because they are taking place at a time when the company is enjoying good sales revenues and profitability. Employees want to be able to believe that management decisions are meaningful and are willing to make a substantial contribution to change processes, but they have to be won over to the cause, and this is most likely to happen if there is a consistent story that makes sense to them and that is supported by the entire top management. Changes that don't seem to make much sense have a huge potential to have a corrosive impact on the company.
- Another source of inner corrosion stems not only from dysfunctional, unfair or incomprehensible management decisions but also from completely or largely absent managers – for instance as a result of a political stalemate on the board. A company management that does not make decisions or initiate any apparent actions, even though there is an obvious need, creates frustration and will eventually cause the loss of identification and commitment of its executives and staff members.

Corporate corrosion leads to a loss of credibility of top management and to an emotional and energetic negative spiral of the entire company that is hard to stop. The symptoms of this development are similar to those of the acceleration trap, except that they are accompanied by the employees' low identification with the company and a worse atmosphere. This is likely to result in executive and staff showing signs of cynicism, withdrawal, resignation, a decline in the quality of their

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

work, a severe reduction in their capacity for innovation and agility in dealing with challenges, and a greater tendency to be overworked.

The way out of this is for management to return back to their true values and common ground, and to constructively resolve the points of contention. This may also require a different form of employee communication based on a different attitude of the management towards the workforce. Frequently, however, these fundamental changes can be achieved only by replacing individual actors.

Resignative inertia

Companies who have been operating for a long time in a stable market environment without the need to adapt to changing market conditions run the risk of becoming internally rigid, coupled with a tendency towards mediocrity. On the one hand, competition stimulates development and innovation and, on the other, it holds opportunities to experience success. This raises the collective confidence in a company's efficacy, along with the belief that challenges can be successfully mastered. If a company has forgotten that it has to make an effort in order to be successful, these experiences of success remain absent and this leads to resignative inertia.

Symptoms of resignative inertia are chronically underused capacity, inner rigidity, reactive behaviour, mediocrity and increasing cases of bore-out as a reaction to the widely felt sense of meaninglessness.

The way out of this resignative inertia necessitates strengthened self-confidence or the reinforced belief in the possibility of one's own success. This initially requires many small successes and then a growing sense of common achievement, but without causing anyone to feel excessively overdemanding. For this it is necessary that these experiences of success are perceived as such and that middle management and the employees develop a sense of being able to make a difference. Among other things, smaller, more flexible structures are needed as well as a different form of internal communication, which can credibly recount stories about their own efforts and achievements.

DYSFUNCTIONAL MANAGEMENT

Managers are constantly under their employees' observation. A manager walking through the office with a sullen expression on his face will have just as much of an impact on his business unit's resilience field as a boss who is still answering his emails at 10 p.m. on a Saturday night strikes a false note with an employee in a

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

meeting or ignores him in the hallway. His role-model status means that he defines what is acceptable behaviour, thus decisively contributing to the atmosphere in his business unit or department. Managing employees, teams and business units therefore also always starts with the example of the manager's own conduct and emotionality. A large amount of literature on the subject of resilience has rather unthinkingly chosen to present the manager as the bogeyman. It is as if there was a secret training where managers are taught how to exploit their employees. Indeed, there is such a thing as 'bad management', but most of this is the product of the interaction of dysfunctional decision-making dynamics, which a single manager will indeed find hard to change. Orders that are not approved, decision documents that are not decided and corporate communication that is overtaken by the grapevine are but a few examples. Frustration and emotional friction are particularly high in middle management due to its relatively high level of responsibility, combined with low decision-making authority. It takes a huge amount of inner conviction, energy and perseverance to compete day after day against the administrative mills in order to breathe humanity and values into lifeless processes. But that is the job of a good manager. Without doubt, managing people belongs to one of the most difficult tasks that there is.

To make matters worse, most managers were never adequately prepared for their task since management, meaning the conscious use and control of emotions in a professional context, is at best still dealt with only on the sidelines in our education system and regarded as a minor matter in many companies.

There also often appears to be a lack of understanding about the importance of leadership with regard to a manager's own personal success. A professional understanding of leadership is these days absolutely indispensable. There is no other factor which can lastingly influence the quality of the resilience field so positively or negatively as the managerial behaviour of the direct supervisor. Good leadership can certainly lead to a positive and constructive atmosphere being prevalent in one area, whereas the rest of the company sinks into resignation.

Unfortunately, the opposite is much more frequently found to be the case. **Figure 5.4** shows the most frequent failures and weaknesses of managers whose careers have failed or stagnated prematurely.

There are rarely professional grounds for a career to stagnate. Most factors have to do with self-management and the development of favourable relationships. In a variety of scientific studies, around 50% of the employees questioned stated that they

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

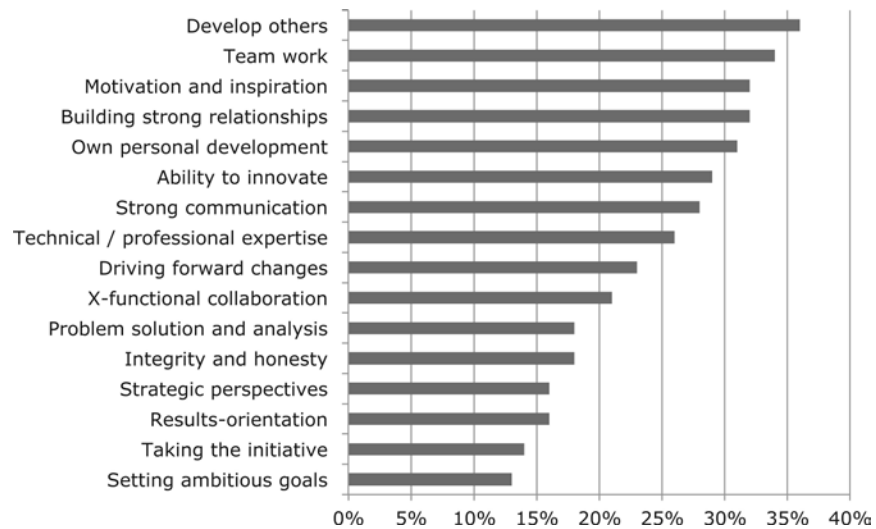


Figure 5.4 • Leadership weaknesses among managers. Source: J. Zenger and J. Folkman (2009). Harvard Business Review.

did not feel themselves to be well led by their boss. Managing people is certainly not an easy task, but neither is it a highly complex science. Having regular, appreciative and frank talks with subordinates is already a good starting point. Unfortunately, for many managers today even this is still a huge step.

A BAD ATMOSPHERE

Even if the quality of the resilience field in a business unit is strongly influenced by the respective manager, the team itself plays a significant role too. The measure of emotional support, trust, collegiality and 'we feeling' is positively shaped by each individual team member and, by the same token, it can also be damaged by each team member. As mentioned in the section 'The Spheres of Individual Resilience' (3.3), the resilience field is made up of various levels, on which disruptions can occur. Risk factors which might weaken the individual mental resilience of the team members are essentially to be found in disruptions on the inner levels 'composition', 'learning agility' and 'confidence and trust'. By contrast, the higher levels are primarily protective factors.

Disturbances on the 'composition' levels basically have to do with dealing with different types of personality and character. Some people get on well with each other, others are okay, but some just don't get on at all, which inevitably leads to conflict and to excessive prudence in dealing with each other.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

The level 'learning capacity' incorporates the area of tolerance and appreciation for people who take a different approach to things. If there are problems on both levels, then one 'cannot' get on with each other in the team and is not willing or able to compensate this antipathy by means of professional appreciation or taking on a different viewpoint.

Disturbances on the 'trust and support' level lead to political or excessively prudent behaviour and to a lack of openness and collegiality.

Phenomena such as mobbing are more likely to occur due to misalignments on the inner three levels, but develop their full damage potential only if, in addition, there is a lack of strong leadership by the superior.

According to some studies, about a third of the employees feel that they are not sufficiently supported by their colleagues and complain about the negative atmosphere in their business unit, which – apart from the consequences of management – has the strongest impact on the resilience field.

The way out of this and towards more solidarity within the business unit is by working on the dynamics within the business unit itself – that is, through confidence-building measures, such as possibilities for informal communication, team development processes, advice among colleagues and strong leadership – and by managers being supported by a mentor or coach.

INDIVIDUAL FACTORS

The inner resilience of managers and their employees is burdened by social developments and in-house factors. Yet we are convinced that the greatest risk for one's own resilience lies in the person himself, and more concretely in the person's inner attitude to life in general and, more specifically, to his or her work environment. Of course, there are also risk factors for our mental balance in the other spheres of resilience, yet in our work with managers the topic of inner attitude resurfaces again and again, which – in addition to all the other sources of stress – also has a stress-reinforcing effect on the individual.

EXAGGERATED EXPECTATIONS

We live at a time when there is a surplus of opportunities. The current generations of executives and managers have never experienced war nor deprivation, at least not in their own country. The experience of trying to protect and nourish yourself and your

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

family in a difficult living situation is stressful and unpleasant, but extremely meaningful. However, today the struggle to survive has been replaced by the inner tendency to compare oneself with others and to self-optimisation, since this creates the feeling of social appreciation, which is nearly as good as meaningfulness. Similar to allergies which emerge in a body as a reaction to an underutilised immune system, the lack of a struggle for survival, accompanied by the loss of meaning in western industrial nations today, leads to the perception of negative stress, which in many respects is homemade. The reason for this is often exaggerated and unrealistic expectations towards life that are further intensively reinforced by the media. You need to have completed the right studies at the best university and have the most renowned company name as your employer standing in your CV, an international, above-average and interesting career and the accompanying status symbols. People strive to have an athletic figure and look trendy in order to have the perfect partner for their own happy family and live in a hip area, with an interesting circle of friends. In a nutshell, people today strive for perfection and uniqueness in nearly all areas of life, but that is of course difficult to achieve. What is often neglected is the question as to 'why' – in other words the meaning behind it all.

THE POWER OF BELIEF SYSTEMS

We often work with managers who, although they might on the surface appear to be successful and confident, have recounted how, in some situations, they feel like 'driven people', like they were no longer in control of their inner world. The situations in which this happens are typically marked by high pressure or insecurity. This account describes the typical effect of inner beliefs, which also constitute a risk factor, both for one's inner mental balance and for one's inner resilience.

Beliefs are decisions with regard to one's life that people have made in their childhood and internalised. Long before an employee or manager has to prove himself in the 'company system', he has developed success strategies in the 'family system'. A lot of managers don't like to think back to the time when, unlike now, they were small, weak and insecure, and feel like they are 'on the couch' when the topic of their childhood crops up. And yet, it was already at this point in time that the course was set.

As a child, each person already learns how best to handle the family system in order to be successful. Love and attention are the success criteria of a child. Beliefs are therefore strategies with which a child tries to obtain parental love and attention. In the corporate world, this is later known as 'visibility' and 'recognition'. When devising

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

its strategy, a child can of course only fall back on its childish logic. This is characterised by magical thinking – that is to say the belief that the child’s environment behaves as it does only in response to the child’s behaviour. Examples of magical thinking are: ‘I have to be obedient, so that my brother gets healthy again’, or ‘I have to work really hard at school, so that Mum and Dad don’t argue so much anymore’. These child-like decisions become consolidated as coping strategies in the course of the years, finding their equivalent in the brain in the form of neuronal stimulation patterns. This is why these strategies remain relevant into late adulthood, even though the system in which the person now moves is a completely different one.

Interestingly enough, in our work with managers we have noticed that the number of beliefs that these managers have internalised is limited. They can usually be reduced to a certain number of musts (i.e. positively formulated belief) and must nots (i.e. negatively formulated beliefs) (Table 5.2).

These beliefs surface more frequently when a manager is not in his comfort zone – for example because he is encountering something new, unfamiliar, particularly thrilling or threatening. Since neuronal patterns cannot be deleted, an old belief cannot simply be erased. Instead, a new and more appropriate behaviour strategy has to be developed and practised.

Musts	Must nots
I have to be perfect.	I must not show myself as I am.
I have to be quick.	I must not be different.
I need to please everyone.	I may not be successful.
I must be strong.	I must not be like everyone else.
I must make an effort.	I must not ask for help.
I must be careful.	I must not show my feelings.

Table 5.2 • Examples of dysfunctional beliefs

THE PHENOMENON OF THE ‘INSECURE OVERACHIEVER’

Since the 1950s, McKinsey & Company, one of the world’s leading strategy consultation companies, has been known to employ the best graduates from the best universities, and to use performance incentives and a very formative high- performance culture to shape these young, hungry ‘high potentials’ according to their requirements. After these young consultants are pushed to the maximum by their international projects, most of them voluntarily leave the company on good terms after three years at the

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

latest in order to take up leading positions in the industry and then to become potential customers of their former employer. Over the past few decades, this HR strategy and its accompanying high-performance culture were adopted in the field of professional services by the majority of international companies and are now also entering many more traditional industrial and service-based companies.

The expression which best describes McKinsey's employee profile is the 'insecure overachiever', who is to be found in many management positions today. This type of person is well-educated, intelligent, good-looking, mobile and highly performance motivated. However, the moment you look behind the shiny facade, which we of course regularly do in our work, you find people who are continuously plagued by the question 'Am I good enough?'

Of course there are many kinds of people walking through life with these or similar questions occupying their minds, but this group of persons compensates these nagging inner doubts with permanent high performance and success, not having any other available mechanism for accepting themselves in their state of imperfection, which effectively all of us are. This inner pressure is an enormous career motor and leads to a very specific way of life, which focuses on work alone. As long as insecure overachievers are successful, the flywheel continues to turn. Problems generally arise when they are no longer successful; then their identity crisis is inevitable and their downfall steep.

IDENTIFICATION OR MERGING?

Work, in general, and responsibility, more specifically, endow our lives with meaning – that is, they give people a reason to get up in the morning ready for action. People need to feel important, needed and wanted, and it is a wonderful feeling to love what one does, even if there are sometimes difficulties that need to be overcome.

Status, creative freedom, power and being granted a sympathetic ear by those who are even more powerful than us positively strengthen our own sense of selfworth – that is these leadership aspects make a manager's external image appear larger than he actually is. Only rarely do they actually lead to genuine personal growth. They are also a source of apparently unlimited energy, which enable the manager to travel around the whole world in a month without appearing to be worn out.

It starts to get problematic only when a high level of identification turns into a complete merging with the role. Then managers forget that the aura of power surrounding them and the authority they enjoy with their employees are not about

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

them, but about the role they fill. This is a small but important distinction to make. One indication of this might be, for example, that at one point a manager is so convinced of his own importance and uniqueness that he allows himself to behave in a way that is completely unacceptable. What happens then is that the aura of influence becomes a kind of ego drug, which the manager cannot get enough of, wanting as much as is needed to compensate the difference between his inner self-confidence and his outer sphere of influence. For this he is willing to neglect his family, friends, hobbies and other things that were previously important to him. This leads to an imbalance in his life that has repercussions for all areas of his life.

If such a manager falls out of the system due to illness or dismissal, then it is equivalent to full-blown narcissistic mortification. One then sees these managers in the burnout clinic, running around with their smartphones and answering emails, since they need this sense of importance to feel comfortable in their own skin.

MANAGERS AS VICTIMS

Another widespread risk factor for individual resilience is the victim role, which is usually the consequence of being overworked or experiencing a setback in one's career. Managers who are in the victim role are demoralised and feel helpless and unable to act. In this state, they are very vulnerable to negative stress, which can quickly become too much of a burden. Consequently, they regard everyone else but themselves as responsible for their misery. Interestingly enough, the victim mentality is not limited to middle management, but is certainly also to be found in the top echelons of management or the board of directors. And, indeed, the conclusive logic of the victims is very hard to refute, since they have often really had a lot of bad experiences. If one didn't know other people who had experienced similar or even worse circumstances and who dealt with them in a much more serene manner, one might – after a period of time – very well end up believing the perfectly understandable hopelessness and completely logical aporia of their situation.

Managers who are in the victim role see their situation as unfair and can't therefore draw any lessons from it, which makes dealing with them very tiring. This attitude is not only very unhelpful for the person himself but also draining for those around them. On the other hand, the victim role also has a concealed benefit, which people do not like to talk about. One empathises with a victim and feels solidarity towards him because he must be right. The notion of wanting to draw someone out of the victim role is as understandable as it is difficult. In order for a person to be able to drop the victim mentality, the person must first be prepared to recognise and

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

consciously dispense with the secondary benefit gained from this attitude. For this to happen, the person must assume responsibility for his own actions again and must activate his own self-efficacy – that is the conviction that the person can grow with the upcoming challenges. This decision must – for obvious reasons – be made by the person himself.

THE CONSEQUENCES OF A LACK OF RESILIENCE

Once a person's existing capacity for individual resilience is used up due to social, organisational and individual factors, then the downwards spiral inevitably begins. This may differ from one person to another in the individual stages, but it roughly follows a similar course as the one depicted in [Figure 5.5](#).

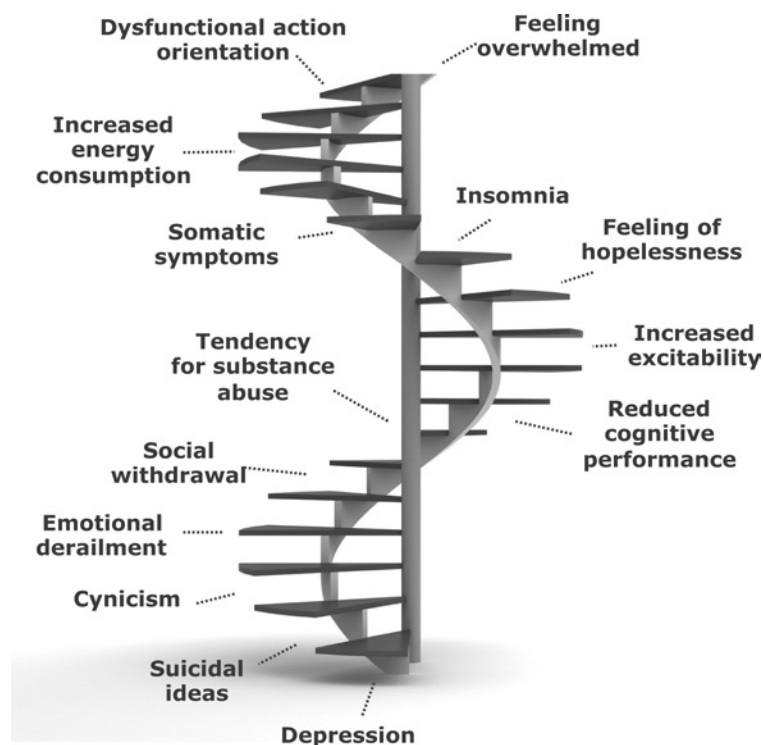


Figure 5.5 • The downward spiral into burnout

To begin with, there is an increasing feeling of being overloaded. What follows is an inner rebellion against the challenges, which frequently becomes noticeable in the form of hyperactivity. Consequently, the manager needs a lot more energy to

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

complete his tasks, since nothing seems to work of its own accord anymore. At about this time, the first non-specific physical signs usually start to appear, such as backache, cardiac arrhythmia and headaches. If things continue to get worse, then the person will usually suffer from sleeping disturbances, which again severely reduce the level of available energy, and the affected person is confronted even more with a feeling of hopelessness. Now the first changes of behaviour start to become apparent to the manager's environment. There is greater irritability, while the level of concentration declines. Having difficulties finding words and generally experiencing greater forgetfulness are symptomatic of this. Depending on the type of personality, the probability increases that the lost productivity and sleeping problems will be compensated by taking medication. Greater social withdrawal is the consequence, particularly in that person's private life. Emotional outbursts occur more frequently that are untypical for the person concerned. There is increasing cynicism and a feeling of hopelessness; suicidal thoughts may also arise. The spiral may end in depression, burnout, cardiovascular diseases and even suicide if the person doesn't pull the emergency brake beforehand. Every manager in a demanding position, working in a challenging environment, knows some individual steps of this process. Most of them, however, find possibilities for intervening and taking control and freeing themselves of this downward spiral.

FROM NEURASTHENIA TO BURNOUT

The American psychoanalyst Herbert Freudenberger coined the term 'burnout' in 1974 when describing the exhaustion phenomenon found among people in care jobs; this was seen to be linked with a loss of performance, negative emotions, higher irritability and physical symptoms, such as headaches and a reduced functioning of the immune system. In addition to his therapeutic work, Freudenberger taught at various universities of New York and was involved in social projects. The starting point for his interest in what he was later to call 'burnout' was his involvement in St. Marks, one of the many so-called free clinics. In these free drop-in clinics, doctors, nurses, psychologists and social workers, mostly working as volunteers alongside their actual jobs, gave people without health insurance at least some basic outpatient medical care. In the course of the years, he noticed in numerous colleagues and also twice in himself a specific process of change, which he named 'burnout' for the first time in an article published in the *Journal of Social Issues* in 1974. Indications of the phenomenon described by Freudenberger were the following characteristic changes and symptoms in the affected person: exhaustion, reluctance to do disciplined work, loss of efficacy, sleeping disorders and psychosomatic symptoms.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

The colleagues concerned developed a negative, pessimistic and even an underlying cynical attitude and behaved increasingly inflexibly and rigidly. The colleagues ended up taking a lot longer to complete standard tasks, which resulted in them spending more time at work at the expense of their private lives. In the end they had a total breakdown. Freudenberger found those persons to be particularly at risk of burnout who were especially idealistic and committed at the start of their employment. He also saw the type and amount of work as influential factors.

The fact that Freudenberger's term 'burnout syndrome' gained international recognition was largely due to his younger colleague, the American psychologist Christina Maslach. She refined the description of the symptoms and expanded the description of the risk group to include the factor 'people workers' – in other words those people who are very involved with other people in their jobs. She saw the reason for the rising number of cases of 'job burnout' to be rooted in the transition from an industrial to a service-based society. In this respect she drew a parallel to the diagnosis of neurasthenia, a general debility of the nerves, which had frequently arisen in the transition from an agrarian to an industrial society and which today is no longer diagnosed. Furthermore, she developed a scientifically sound questionnaire, the Maslach Burnout Inventory (MBI), which meanwhile has become an internationally recognised instrument for measuring burnout syndrome and has been translated into a number of languages.

DISPUTE ABOUT THE FIGURES

The public discussion on burnout is unfortunately often characterised by exaggeration and hysteria on behalf of the media, while many managers respond – just as unfortunately – with irony, shrugging off burnout as a trendy diagnosis. In order to be able to critically appreciate the statistics, a little background information in this field might be helpful.

If the policyholders of a health insurance fund were given sick leave in Germany, beginning in 1996 the diagnosis was provided voluntarily. It became mandatory in 2000 to provide a diagnosis according to a specific code. This code, which had its beginnings in the 1850s, is issued by the WHO database as the tenth version of the International Classification of Diseases, or ICD-10 for short. In order to get physicians' services acknowledged and covered by the statutory health insurances, certain diagnoses, such as 'depression', are viewed by physicians as being more likely to succeed than others, where there are still too few statistics and treatment methods available. The coding of certain clinical pictures has made it much more

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

transparent for the statutory health insurance funds to determine which diagnosis is more likely to be cured by means of which standard procedure. The diagnosis 'burnout' is not listed as an independent diagnosis in ICD-10, but only as a secondary diagnosis. This is partly for historical reasons and partly because a uniform set of symptoms has yet to be acknowledged, since the course of the disease differs greatly from one person to another. The corresponding key for burnout is that 'Z73 problems related to life-management difficulties'. By contrast, other psychological diseases are encoded under the letter F.

According to the AOK (one of the largest German statutory health insurance funds), in 2011, only 15% of all burnout diagnoses were exclusively made with this code. Most diagnoses are instead encoded with the keys F32 and F33, which describe spectrum disorders of severe depression. But physical diagnoses, such as 'M54 backache', are also frequently made to cover burnout symptoms. At first glance, the allegation of it being a 'trendy diagnosis' is therefore valid, since in the past there was no guarantee that the secondary diagnosis 'burnout' would be covered by the statutory health insurance funds, but they are now increasingly doing so. Hence, it follows that burnout did not appear in the overview of days of sick leave before 2004. On the other hand, this also means that the actual number of unrecorded cases has probably always been much higher, but probably been diagnosed instead as depression, for instance. In order to get an accurate picture of its development over the past few years, one needs to view burnout together with depression, although it should be noted that not every depression is a burnout, but nearly every burnout is also a form of depression. **Figure 5.6** depicts the total number of sick leave days per 100 policyholders resulting from psychological diseases occurring between 2004 and 2012. Burnout and depression are listed separately.

In the year 2012, the diagnosis 'burnout' made up less than 8% of all mental illnesses. Nevertheless, the trend is clearly on the rise, especially if the diagnosis 'depression' is also taken into account. Specific data on the group of managers is only fragmentary. According to a study conducted by the HR consulting company Kienbaum, around half of all managers work between 60 and 70 hours per week on an annual income of over EUR 200,000. We can assume that top performers, such as managers, are affected more than average by the diagnoses 'burnout' and 'depression'. According to a study conducted by the Robert Koch Institute, 5.8% of the managers in Germany suffered from burnout syndrome in 2012.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

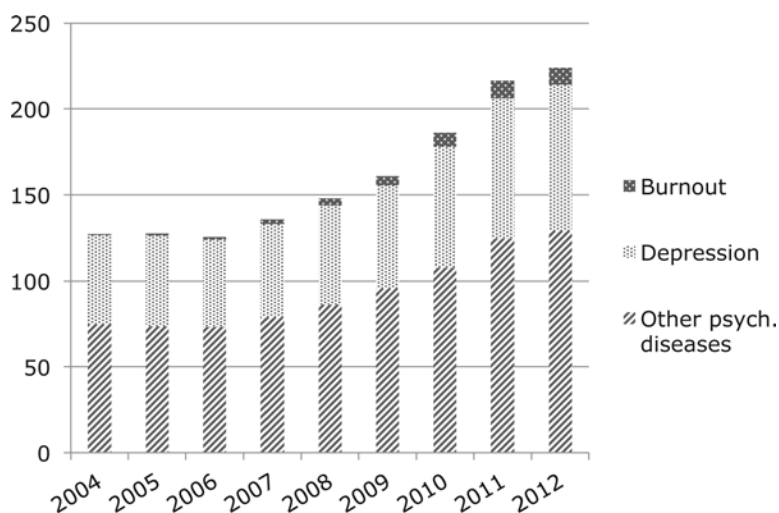


Figure 5.6 • Development of mental illnesses according to sick days per 100 policyholders. Source: DAK.

DOPING FOR THE JOB

Managers are frequently workaholics who identify themselves with their tasks and role. They are also pragmatic and will tend to make use of all available and seemingly justifiable options to achieve their goals. This unfortunately also includes the increasing use of psychotropic drugs to raise performance levels or to relax. According to a study conducted by DAK statutory health insurance in 2009, nearly 20% of employees, who were under immense pressure professionally, took pharmaceutical drugs, such as medically unnecessary mood enhancers, in order to raise their performance levels. In its 2012 absence from work report, the AOK estimates that around 5% of its employed policyholders use psychotropic drugs to make themselves fit for work. Another study carried out in 2012 by DAK showed that as many as 2 million employed people in Germany have had some experience with motivation-boosting or mood-enhancing drugs which were not prescribed by a doctor, even though they require prescriptions. These 'cognitive enhancers' are generally ordered from foreign dealers on the Internet. In Germany, around 800,000 employees, nearly 2% of the employed population, regularly take such pharmaceutical drugs. Even if the debate in the media on this topic, as with burnout, is carried out in an exaggerated way, the rising tendency towards performance-enhancing and stress-reducing brain doping is very alarming, particularly because the intake of such highly potent drugs is also accompanied by significant side effects and health risks associated with the drug intake.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

If we take a look at advertisements in magazines and in television, it is noticeable that over the past few years, the advertising of non-prescription drugs with a stress-reducing and performance-raising effect has significantly increased. This also includes products such as Lasea or Vitasprint. This would certainly not be the case if the pharmaceutical companies concerned did not see a potentially growing market for these products.

BIBLIOGRAPHY

- Bennett, Nathan; Lemoine, G. James, *What VUCA Really Means for You*, Harvard Business School, Boston, USA 2014.
- Borysenko, Joan, *Fried: Why You Burn Out and How to Revive*, Hay House, Carlsbad, USA 2011. Breuer, Jochen Peter; Oetzmann, Dorothee, *Gefühle sichtbar machen, Ausgebrannte Unternehmen*, Manager seminar, Bonn 2012.
- Casserley, Tim; Megginson, David, *Learning from Burnout: Developing Sustainable Leaders and Avoiding Career Derailment*, Butterworth-Heinemann, Oxford, UK 2009.
- Grabe, Martin, *Zeitkrankheit Burnout, Warum Menschen ausbrennen und was man dagegen tun kann*, Francke, Marburg 2005.
- Greve, Gustav, *Organizational Burnout, Das versteckte Phänomen ausgebrannter Organisationen*, Gabler, Wiesbaden 2010.
- Han, Byung-Chul, *Müdigkeitsgesellschaft*, Matthies & Seitz, Berlin 2010.
- Händeler, Erik, *Die Geschichte der Zukunft, Sozialverhalten heute und der Wohlstand von morgen*, Brendow, Moers 2005.
- Heinemann, Helen, *Warum Burnout nicht vom Job kommt, Die wahren Ursachen der Volkskrankheit Nr. 1*, Adeo, Asslar 2012.
- Illig, Tobias, *Jammern ist gut fürs Unternehmen, Resignative Reife*, Manager seminar, Bonn 2012.
- Johnson, Barry, *Polarity Management: Identifying and Managing Unsolvable Problems*, HRD Press, Amhurst, USA 1992.
- Kail, Eric G., *Leading in a VUCA Environment*, Harvard Business School, Boston, USA 2010.

WHAT JEOPARDISES RESILIENCE?

Excerpted from *Resilient Leadership*

Kwoh, Leslie, 'When the CEO Burns Out, Job Fatigue Catches Up to Some Executives amid Mounting Expectations; No More Forced Smiles', *Wall Street Journal* 2013.

Lawrence, Kirk, *Developing Leaders in a VUCA Environment*, UNC Executive Development, Chapel Hill, USA 2013.

Mahlmann, Regina, *Unternehmen in der Psychofalle, Wege hinein. Wege hinaus*, Business Village, Göttingen 2012.

Mitchell, Sandra, *Komplexitäten, Warum wir erst anfangen, die Welt zu verstehen*, Suhrkamp, Frankfurt 2008.

Nagel, Gerhard, *Chefs am Limit, 5 Coaching-Wege aus Burnout und Jobkrisen*, Hanser, Munich 2010.

Obholzer, Anton; Zagier, Roberts, *Vega: The Unconscious at Work: Individual and Organizational Stress in the Human Services*, Routledge, London 1994.

Oshry, Barry; Devane, Tom, *The Organization Workshop: Collaborating for Change, Power+Systems*, Boston, USA 1999.

Petrie, Nick, *Future Trends in Leadership Development: A White Paper*, Center for Creative Leadership, Colorado Springs, USA 2011.

Reeves, Martin; Love, Claire; Mathur, Nishant, *The Most Adaptive Companies 2012: Winning in an Age of Turbulence*, Boston Consulting Group, New York, USA 2012.

Sennett, Richard, *The Culture of the New Capitalism*, Yale University Press, New Haven, USA 2006.

Snowden, David J.; Boone, Mary E., *A Leader's Framework for Decision Making: Wise Executives Tailor Their Approach to Fit the Complexity of the Circumstances They Face*, Harvard Business School, Boston, USA 2007.

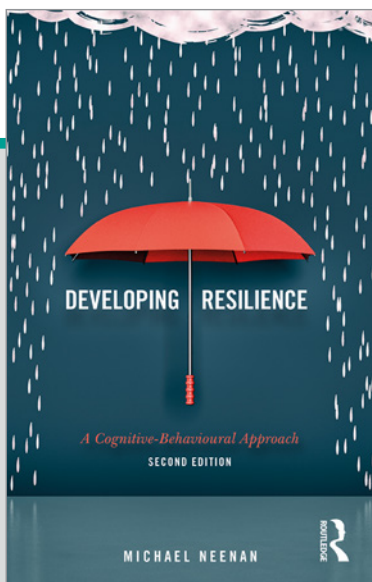
Taleb, Nassim Nicholas, *Der Schwarze Schwan, Die Macht höchst unwahrscheinlicher Ereignisse*, Deutscher Taschenbuch Verlag, Munich 2010.

Väth, Markus, *Struktureller Burnout ist der blinde Fleck von Unternehmen, Umgang mit Burnout*, Manager seminar, Bonn 2010.



CHAPTER
4

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING



This chapter is excerpted from
Developing Resilience: A Cognitive-Behavioural Approach
By Michael Neenan

©2017 Taylor & Francis Group. All rights reserved.

[LEARN MORE >](#)



ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

INTRODUCTION

Resilience is one of the subjects studied by positive psychologists. Positive psychology was launched in the late 1990s and focuses on identifying and building on your strengths and virtues (what's right with you), rather than looking at your deficits and weaknesses (what's wrong with you) which is the usual remit of traditional psychology. However, some psychologists argue (and I agree) that we don't need to separate psychology into types, as psychology 'spans the whole of the human condition, from disorder and distress to well-being and fulfilment' (Linley et al., 2006: 6).

If developing resilience can help you to overcome adversity and find ways of creating a better life for yourself, then we need to identify the blocks to its development and what can be done to remove them. What follows are some attitudes that keep people trapped in responding poorly to the difficulties they face; these attitudes are not the only ones that interfere with resilience building, just the common ones I encounter in my practice. These attitudes are not set in stone, so ways to change them are also presented. It's important to point out that some people, for whatever reason, don't reach out to learn resilience. They're overwhelmed and demoralized by their unsuccessful attempts to cope with adversity and happiness continually eludes them. A few will see suicide as the only option to end their suffering. Such individuals require a compassionate understanding of their plight, not condemnation because they fail to overcome the challenges they face. As I pointed out in Chapter 1, resilience is not about dividing people into winners or losers, quitters or fighters but offered as a capacity open to all to learn.

'IT'S NOT MY FAULT I'VE BEEN MADE A VICTIM'

This means feeling helpless and angry in the face of adverse events, continually blaming others for your misfortunes and seeing the world divided into victims and villains. Anyone who questions your victim status is accused of victim blaming. Leahy (2001) suggests that when a therapist attempts to help such clients by encouraging them to focus on problem solving, this too invites accusations of victim blaming and making light of their suffering: 'I see, I'm just supposed to get on with my life as if being viciously mugged is of no account whatsoever; in other words, I'm making too much of a fuss about it'.

The victim's story can become the only story in your life, forever ready to relate to others – if they're still listening to you – your tales of suffering and helplessness. Being a victim has become your identity; this often leads to a state of infantilization where you

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

can't be expected to take responsibility for dealing with your difficulties ('How can I? I'm still hurting'). If you mix with others who have similar stories to tell, you're likely to become involved in a competition to establish whose suffering is the worst. The longer you justify your victim status, the harder it will become to break free of it and develop other facets of your personality and life. Incidentally, this competition in suffering can also be seen in grief: 'Look how much I loved her/him and with these tears I prove it (and win the trophy)' (Barnes, 2014: 114). Competitive mourning has been called the narcissism of grief (Oates, 2011) where my loss is the most devastating, heart-rending and I remain utterly inconsolable (unlike my friend who'll get over her loss).

While you may have been treated unfairly at the hands of others and not received the redress you were seeking, it's still your inescapable responsibility to decide if you want to remain dependent upon your pain in order to attract sympathy or put boundaries around the pain and escape from the victim trap (Wolin and Wolin, 1993). For example, Peter was bullied by his boss and eventually took sick leave having been worn down by the experience: 'Nobody took my complaints seriously. They just said "it's a tough environment we work in and you've got to get on with it"'. He left his job but couldn't let go of how he'd been treated by his boss who, he later learned, had been promoted. He saw this promotion as his boss being rewarded for treating him badly.

In our sessions, he spent some time venting his understandable anger at his boss's mistreatment of him and the company culture that 'turned a blind eye' to such behaviour. But more importantly, we focused on how his continuing anger and sense of helplessness about correcting this injustice were having corrosive effects on his life; principally, his reluctance to find another job in case the bullying happened again.

I argued there were two forms of injustice: first, what his boss did to him and, second, the injustice he would do to himself if he didn't pursue his desired goals, forever blaming the bullying for holding him back in life. He considered the second one, the self-inflicted injustice, as the truly destructive one. He saw the sense in regarding the bullying as a time-limited event (it occurred over a six-month period) that would not adversely affect the rest of his life. I taught him some techniques for standing up to a bullying boss (see Chapter 8). Looking beyond the bullying, he felt he was beginning to regain control over his life.

Before I leave this section, I'd like to make some comments on helplessness which is a key feature of victimhood. When people say they 'feel helpless' they really mean 'I believe I'm helpless' (an assumption, not a feeling or a fact). Believing you're helpless is a choice you make. The late philosopher Isaiah Berlin observed:

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

Action is choice; choice is free commitment to this or that way of behaving, living, and so on; the possibilities are never fewer than two: to do or not to do; be or not to be ... it is always possible, though sometimes painful, to ask myself what it is that I really believe, want, value, what it is that I am doing, living for; and having answered as well as I am able, to continue to act in a given fashion or alter my behaviour. (2013: 96)

It may seem to you that it's equally painful if you stay the same or change, but the pain associated with change carries with it the possibility of a brighter future, whereas staying the same sees only a bleak one. Finally, a choice is a choice whether it's straightforward or hard to make, so don't become trapped by thinking that choices should only be easy and painless.

'I'LL NEVER GET OVER IT'

The 'it' may be a traumatic event, troubled childhood or any misfortune you believe has robbed you of any future happiness or irreparably damaged your life. Some clients describe the 'it' as having 'left me in pieces'. From this viewpoint, it's reasonable to ask: can a broken Humpty Dumpty be put together again? (Some writers use the nursery rhyme character to introduce this discussion.) Flach (2004) argues that falling apart in the face of significant stress is a normal – even necessary – part of the resilience response as, during this period of disruption, new ways of reacting to tough times can be developed so that the pieces of ourselves can be reassembled in sturdier ways. Our old ways of dealing with things have become obsolete, forcing us to find new ways to cope. However, this period of disruption is not without its risks. The pieces can be reassembled successfully or fail to cohere into a meaningful whole that leaves you 'forever more or less destabilized' (Flach, 2004: 13). Going through a period of severe stress can either be grasped as a valuable learning experience for both present and future benefit or thrown away because, for example, you refuse to accept that anything good can ever come from anything bad.

I saw an executive, Roger, who'd been overwhelmed by the relentless pressures placed upon him. He felt depressed ('I'm a failure, washed up at 42'), angry ('What were they trying to do, kill me?') and ashamed that he couldn't cope with the pressure ('I'm weak for the whole world to see'). He believed his life was in pieces. When he seemed receptive to the message, I pointed out to him that 'Humpty Dumpties' can be made whole again. He was intrigued that he could reconfigure the pieces of

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

himself and move his life in a different direction. However, despite this interest, he remained unyielding in his view that he should've been able to handle the pressure and that he would be 'stained with the mark of weakness for the rest of [his] life'. He dropped out of therapy after several sessions and I never saw him again.

Sometimes the process of self-repair can take a long time. In a famous long-term study (from youth to old age) of socially disadvantaged men (one of three groups studied), Professor George Vaillant and his team at Harvard University tracked their progress and came up with some surprising and welcome conclusions (as Vaillant (2012) says, to investigate adult development properly requires lifelong study). A poor start in life doesn't have to mean that a happy and fulfilling existence cannot eventually be achieved:

The disadvantaged youth becomes a loving and creative success; the child who 'did not have a chance' turns out to be a happy and healthy adult. We have much to learn from these once-fragmented Humpty Dumpties who ten – or even forty – years later become whole. (Vaillant, 1993: 284)

If you study someone's life at a particular point, you might see her struggling unsuccessfully against the odds and this snapshot might lead you to make gloomy predictions about how her life is going to turn out. Revisit her life in 5, 10 or 15 years' time and these predictions may have proved inaccurate. I worked in the National Health Service for 20 years and saw many clients who led chaotic, self-destructive lives. Some died, some seemed forever trapped in a cycle of despair, and some pulled through. If I was a betting man I would've lost a lot of money predicting who would and who wouldn't eventually make it.

'I CAN'T STAND IT!'

Also called low frustration tolerance (LFT; Ellis, 2001), this attitude refers to your perceived inability to endure frustration (e.g. delaying gratification), boredom, negative feelings, hard work (e.g. tackling your procrastination), inconvenience, setbacks – if something cannot be easily and quickly attained you give up. The cognitive core of LFT is 'I can't stand present discomfort in order to achieve future gain'. LFT is a key reason why some clients drop out of therapy or coaching when the hard work of change begins; that is, putting into daily practice the CBT skills they've learnt. LFT is a deceptive outlook because it encourages you to think that you're winning by avoiding difficulty, whereas your life is actually becoming much harder to

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

manage in the longer term as your unresolved problems pile up and opportunities for self-development aren't grasped because they seem like too much hard work.

Helen wanted to learn French but left the course after two sessions as she found it embarrassing having to practise in front of others and realized she wasn't going to become fluent in French *immediately*. She'd tried to learn Spanish and classical guitar the previous year but gave up for the same reasons. She kept vowing to get fit, seek a new job, find a relationship, make life more exciting, but all to no avail. Ironically, in avoiding the discomfort of persevering with change, she ended up suffering the greater discomfort of a dull and unfulfilled life. Which is more unendurable, the discomfort of maintaining the status quo in your life or the discomfort of changing it in order to arrive at a brighter future?

To make matters worse, she frequently became angry and depressed for giving up too easily ('What's wrong with me? Why can't I stick at things?'). She had a triple dose of discomfort – a dull life plus being angry and depressed for not persevering with her efforts to change. In therapy, she kept demanding instant answers to understand her problems and easy solutions to solve them.

When you make LFT statements such as 'I can't stand it when there's a long queue in the shops', what does 'I can't stand it' actually mean? Will you die as a result of having to put up with frustration or go into psychological meltdown because you have to stick with doing boring tasks? Or you may think that you can't be happy if you have to deal with disagreeable events. In fact, many people actually do stand what they believe they can't stand. The challenge is to find better ways of standing it; namely, choosing to seek out the avoided tasks and situations in order to prove to yourself that frustration is indeed tolerable, nothing terrible will happen to you while you're feeling frustrated and that future gain is worth fighting for. In Helen's case, the challenge was to persevere with her efforts, among other things, to learn French and classical guitar. Frustrations in life are inevitable; disturbing yourself about these frustrations doesn't have to be (Hauck, 1980).

'WHY ME?'

People often ask this question when they've experienced a traumatic event. The answer is usually implicit in the question: 'It shouldn't have happened to me. I've done nothing to deserve this.' (The word 'should', when used by clients throughout this book, is meant in the imperative sense of expressing commands and demands.) 'Why me?' suggests you believe in immunity justification; that is, offering reasons why

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

bad events shouldn't happen to you. Your assumption of a just and fair world has been shattered by a traumatic event (Janoff-Bulman, 1992). As de Botton observes: 'The continuing belief that the world is fundamentally just is implied in the very complaint that there has been an injustice' (2001: 93).

For example, John was involved in a multiple car crash and sustained some significant injuries. He was very angry about this happening to him. He kept on insisting that he was a 'very conscientious person'. The connection between this virtue and the car crash initially seemed puzzling. However, in teasing out John's sense of logic, it became clear that being a very conscientious person should have given him an exemption from 'anything horrible in life'. He said, 'I could understand it if I'd been a lazy, work-shy kind of person or someone who's a liar and a cheat, an unpleasant person, but I'm not that kind of person'. His idea of how the universe worked had been 'mocked and destroyed'. He now saw himself as the victim of cruel, uncontrollable forces and couldn't see how any constructive meaning or order could be restored to his life. He even wondered at times if he'd been deceiving himself and was, in fact, a bad person who deserved punishment (if a person believes prior to the trauma that she is bad, this view is likely to be confirmed when it happens).

'Why me?' introspection is unlikely to yield any useful answers that will help you in your time of distress (this is my experience in working with such clients). For what answers would satisfy you? That the world can be random and capricious; therefore, what happened to you is not actually about *you*. Goodness is no protection against experiencing adversity. What happened was completely unseen, a bolt out of the blue; the driver had a heart attack, his car swerved across the road and hit you. (Some clients will say or think, 'Why couldn't he have hit the car in front of or behind me instead of mine?' implying that they were singled out in some way by the driver or fate.) 'Why me?' is an unappeasable question. To keep on searching for answers that will only prove unsatisfactory prevents you from starting to process the trauma in a constructive way; accepting the grim reality of events and learning how to adapt to them in order to start getting your life back to some form of normality.

A very different perspective might provide an answer, 'Why not me?' This question states an unpalatable truth: that no one is exempt from experiencing the possibility of tragedy or trauma, no matter how well you lead your life. Obviously the timing of such a question is crucial. The therapist is likely to be seen as callous if he asks it before the client has been given the space to explore her reactions to the trauma. When the question is eventually asked, in a sensitive, non-accusatory way, it can take a

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

different form such as 'Have you ever considered that everyone is likely to experience some misfortune in their life?'

Mary had been mugged and listed her own immunity justification, 'Bad things shouldn't happen to good people', but came round to the idea of 'Why not me?' She said the idea made sense to her (unlike John) and began to break free from the restraints of 'why meism'. However, her new belief was 'Now that I've had my one [mugging], I'll be safe. It's someone else's turn.' The philosophy of 'Why not me?' also includes the possibility that it could happen again, which Mary hadn't considered. She was reinstating immunity justification into her new outlook. We discussed the trap she might be setting for herself and she removed the justification. Two years later Mary was robbed on the London Underground. She said that what stopped her 'from completely disintegrating' was her acceptance that horrible things could happen to her again.

'YOU CAN'T ESCAPE THE PAST'

The past maintains its unshakeable and malign grip on your present behaviour ('It's like being chained for ever to what happened earlier in my life'), depriving you of any real happiness or feeling of freedom. It's not the past itself that maintains this grip but the beliefs you've constructed about these past events which you still believe today. It's the beliefs that are the chains. The past is unalterable; your beliefs about it are not (breaking the chains). In his teenage years, Darren found out that he'd been adopted and jumped to the conclusion that he must be unloveable because his real parents had abandoned him. I met him when he was 30 and he still believed this:

MICHAEL: Before you found out you'd been adopted, how did you see yourself?

DARREN: I saw myself as okay, just normal.

MICHAEL: What was life like with your adoptive parents?

DARREN: It was happy. I liked it.

MICHAEL: Why did you think you were unloveable when you found out your biological parents put you up for adoption?

DARREN: It's obvious. Everybody would think like that if it happened to them.

MICHAEL: Could you explain the obvious to me?

DARREN: Well, if you're a loveable baby then your parents would want to keep you. That makes sense, doesn't it?



ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

MICHAEL: Could you be a loveable baby but still be put up for adoption?

DARREN: I suppose so.

MICHAEL: What reasons might there be for doing that?

DARREN: Well, I know about that. I've discussed that with my adoptive parents. My real parents had lots of problems, some of them psychiatric, and they couldn't really cope with their own lives let alone bring up a child, so they wanted the best for me because they couldn't provide it themselves.

MICHAEL: Presumably you don't find that a convincing explanation.

DARREN: No, I don't. What continues to anger me all these years later is that if they really wanted me then they would have found a way to keep me. They just would have found a way. It's as simple as that.

MICHAEL: And because they didn't find a way to keep you, the only answer can be that you were and remain unloveable. And you're stuck with that view of yourself.

DARREN: That's right. What else am I supposed to think then?

MICHAEL: Well, given what you know about your parents' struggles and their inability to cope with their problems, you expected them to somehow become superhuman, fight to keep you and win. In other words, to be the kind of people you wanted them to be. But they couldn't be anything other than the people they were at that time: individuals struggling unsuccessfully to overcome their problems.

DARREN: I suppose that's true. I never saw it that way. I suppose my parents couldn't be anything else other than how they were, though it's hard to get my mind round that.

MICHAEL: Another thing to try and get your mind around is that you keep labelling yourself as unloveable because you were adopted. Being adopted didn't make you unloveable, if you were truly unloveable then how could your adoptive parents love you to bits? Being adopted isn't the problem, maintaining this negative view of yourself is. Every day you can decide to keep it or begin to change it.

DARREN: How do I do that then?

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

MICHAEL: By what we've been doing today: stepping back from this belief that you're unloveable and starting to examine it critically. It's as if you've been brainwashing yourself for fifteen years that you can't be anything else other than unloveable.

Eventually, Darren was able to see and accept the following points: that he'd rejected himself when told he'd been adopted and, in consequence, had been perpetuating this self-rejection for fifteen years; that the quality of his life with his adoptive parents was probably far better than his real parents could've provided if they'd kept him; and that who his real parents are isn't determined biologically, but by the people who provided a loving environment for him to grow up within and who continue to stand by him through thick and thin.

'IT SHOULDN'T HAVE HAPPENED'

How many times have you said that? You were hoping for a different outcome to the one that occurred. For example:

- You're low on petrol and keep passing petrol stations. You're not prepared to queue in your eagerness to get home after a tiring day at the office. You eventually run out of petrol several miles from home and ask incredulously, 'How could this have happened?'
- You've no skills or interest in DIY but decide reluctantly, at the urging of your partner, to 'have a go' and end up with a host of problems which require the services of a professional to put right. You shake your head in disbelief at the large fees you have to pay for his services.
- Your car has faulty brakes and is going into the garage for repairs in several days' time, but you think you'll be safe if you continue to drive but only at night when there's less traffic on the road. You crash the car and are off work for several weeks. You can't believe how reckless and stupid you've been.

As Edelman observes: 'Everything that we say and do, including those things that turn out to have negative consequences, happens because all the factors that were necessary for them to occur were present at the time' (2006: 74). From this perspective, these events should have happened, not shouldn't have happened, based upon your wishful thinking which ignored inconvenient truths. Warburton defines wishful thinking as 'believing that because it would be nice if something were true, then it must actually be true' (2007: 160). In the first example, your overriding concern was to get home, not to get petrol, and you thought you could achieve it even though

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

the petrol gauge was indicating otherwise. In the second, you believed you would be able to do a reasonable job, not a badly botched one, without having any DIY skills. In the third, you took a chance that your faulty brakes wouldn't put you in danger if you were cautious by going out only at night, and that your brakes would 'be aware' of your caution and not let you down by failing (assuming the brakes have a mechanical intelligence that understands and responds to your apprehension).

So it's futile to keep telling yourself that 'it shouldn't have happened' (as if this will change the outcome of past events) when all the conditions were in place for it to have happened in the way it did. While we all engage in wishful thinking sometimes, it's important to subject such thinking to logical scrutiny to see if it really does make sense to you (conclusion: 'My brakes can fail at any time, so don't drive the car'). Or, to put it another way, such scrutiny is like throwing a bucket of cold water over yourself, waking you up to the possibility – likely probability – that you're deceiving yourself in some way. Acting on this probability should realistically lead to fewer instances of 'it shouldn't have happened' and head-shaking disbelief.

'I'M A FAILURE'

Such self-devaluation keeps you in a state of demoralized inertia as you act in accordance with your self-image; it's as if you've surrendered to the belief and declared 'This is how I am and this is how I'll stay'. Even though you probably see both of these statements as unchangeable facts, they're actually assumptions that you're making about yourself and your life which are open to examination and change. For example, if you're a genuine failure as a person then all you can ever do – past, present and future – is fail; even if you wanted to succeed, your essence or identity as a failure wouldn't allow it. A review of your life to this point will definitely not support the idea that you're a failure if you're open to finding disconfirming evidence, and your future is still to be revealed.

However, what's likely to stop you from seeing this disconfirming evidence is your negative belief functioning as a self-prejudice (Padesky, 1994); that is, your 'I'm a failure' belief rejects any evidence that might contradict it and seeks evidence only to confirm it. Think of a belief you don't agree with such as 'all women are bad drivers'. While listening to the person holding this belief, you might make yourself incensed: 'Why can't he see that women, just like men, are both good and bad drivers? Women have a better safety record than men, they're more careful. He's such a pig-headed git!' He won't be able to hear you because he has a fixed attitude and no amount of contrary evidence is going to shift it (at least not yet).

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

So, if we come back to your view that you're a failure, then you're doing exactly the same thing that he's doing; namely, discounting any evidence that doesn't fit in with your point of view. Some of my clients give this belief-as-self-prejudice a name such as 'ratbag', 'Bill' or 'the whisperer' (e.g. 'That ratbag is talking again but I'm listening to her less and less'). And the reason you're paying less attention is because you're looking at all the evidence about yourself and your life, not just focusing on examples of failure.

All self-devaluation beliefs are illogical because they are based on the part = whole error. An aspect of the self, such as a failed relationship, can never capture the complexity of the whole (you) or the totality of your life. There are other aspects of you that also contribute to making up the whole, but these are overlooked in your rush to self-condemnation. For example, when something goes right in your life does this make you a success? Can you be a failure yesterday and a success today? Neither label can do justice to the complexity of a person. Would you attach labels to your children and announce to the world that you've captured their essence as human beings? The inevitable failures and setbacks that we experience are part of the story of our life, but certainly not the whole story.

'I'M NOT ME ANYMORE. I FEEL LIKE A PHONY'

Clients sometimes complain, when tackling their problems, of feeling strange or unnatural as they start to think, feel and act in new and unfamiliar ways: 'This doesn't feel like me. I'm very uncomfortable with all this.' This dissonant state – the conflict or disharmony between old and new ways of doing things – can lead to some clients dropping out of therapy or coaching in order to feel natural again (i.e. returning to the status quo in their lives which they were keen to change a few weeks or months earlier). This dissonant state is a natural part of the change process and will need to be tolerated until it passes; old habits may now seem unfamiliar. Thinking, feeling and acting differently indicates newness, not phoniness. Hauck (1982) likens this dissonant state to wearing in a new pair of shoes.

'WHY CAN'T I FIND HAPPINESS?'

This plaintive enquiry is often heard in therapy with clients hoping that the therapist will come up with a happiness formula for them. No matter what the person tries, happiness continues to elude her, so each new activity undertaken (e.g. yoga) is interrogated, 'Will *this* make me happy?' Another person achieves the success he's

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

been chasing (e.g. gaining a much sought-after position in the company), but experiences post-success disillusionment as he believed all his discontents would disappear once his dream was realized. He sets himself and achieves another goal in his attempt to capture happiness but it remains out of reach. As Grayling remarks: 'It has wisely been said that the search for happiness is one of the main sources of unhappiness in the world' (2002: 71).

If the search for happiness does indeed end in unhappiness, then how are we to be happy? Auschwitz survivor Viktor Frankl explained thus: 'Happiness cannot be pursued; it must ensue. One must have a reason to "be happy". Once the reason is found, however, one becomes happy automatically' (1985: 162). What he meant by this is that happiness is a by-product or the result of an interesting and meaningful life (ensue), not the central goal of your life (pursue). I believe that Frankl's message is an eminently wise one and the 'formula' I teach my clients if they're receptive to it. Some of them say they're now seeking a more meaningful and interesting life, not pursuing happiness, but, alas, a few are still holding on to the old attitude (e.g. 'I've always wanted to do choir singing, so I joined a choir, but it's not making me happy!').

NOT FACING REALITY

In Chapter 1, I discussed the popular but unrealistic view that resilience is bouncing back from adversity. Such a view encourages what might be called resilience perfectionism; for instance, rising immediately to the challenge of adversity and overcoming it with faultless determination which elicits the admiration of others. Struggling to recover from misfortune departs from this ideal response and you angrily condemn yourself for failing to act 'in the right way'. Effort and struggle are to be despised as they point to deficiencies of character, 'It means I'm not in complete control of myself'. I once saw a senior manager who was a formidable problem solver, the more intractable the problem, the more he liked it – 'Bring it on' – until one day at work he experienced a panic attack and discovered, to his horror, that his problem-solving prowess was ineffective with panic (he thought some tough self-talk would do the trick). In fact, his panic attacks were getting worse and, in consequence, his performance and concentration were suffering. He was angry and dumbfounded by this state of affairs and kept asking incredulously, 'How could this happen to *me*?' He had a fixed view of his character and believed it would function in the way he told it to as if it was an obedient dog. I explained to him that he could deal with the panic attacks relatively quickly if he allowed me to show him how. His usual response was, 'You don't understand. This is not *me*.'

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

His panic attacks undoubtedly belonged to him but, in his mind, they were the mark of a weak person; as he never saw himself as weak, they therefore couldn't be part of him. Why couldn't I understand that? He feared his character was beginning to unravel as he couldn't see a solution to a problem that he shouldn't have. After a few sessions, he left therapy none the wiser and berated himself for coming in the first place as this was another worrying sign of the weakness he was forbidden to have.

Needless to say, this is a self-defeating, self-deluding response to dealing with panic attacks or other problems because there will come a time when your expected (or in his case fixed) way of responding to events isn't working; new ways need to be explored if there's going to be a favourable outcome. Your way may have been the right way so far, but it doesn't have to remain the only way.

Another means of not dealing with the reality facing you is spending too much time daydreaming about or regretting not pursuing the un-lived life (i.e. the road not taken) – 'I should've married Mary all those years ago' – which you believe would have undoubtedly led to great happiness and fulfilment as opposed to the lived life of frequent struggle, intermittent happiness and unrealized potential. As Phillips observes: 'We discover these un-lived lives most obviously in our envy of other people, and in the conscious (and unconscious) demands we make on our children to become something that was beyond us. And, of course, in our daily frustrations' (2013: xii–iii).

While brooding about the road not taken, it's also worth remembering that it could have led to discontent and disillusionment if taken: 'I wish I'd never met and married Mary. It was a disaster.' While the un-lived life is part of the lived life, as our visits there demonstrate, too much mental wandering in the land of what could have been reduces the time, effort and concentration we require to improve the quality of the lived life.

'I NEED TO KNOW'

Intolerance of uncertainty is the core issue for most people who worry (Leahy, 2006). You believe you have to know *now* what's going to happen. Not knowing will leave you feeling on edge and you won't be able to focus on anything else. You can't enjoy life with this uncertainty hanging over you and you continually dwell on 'What if' imaginings (e.g. 'What if she's having an affair?'), which generate more 'What ifs' such as 'What if she leaves me?', 'What if I can't cope on my own?' and 'What if I can't pay the mortgage?' These proliferating 'What ifs' lead you to conclude that you've many more problems than you actually do and that you're losing control of your mind.

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

For example, Stanley had been suspended from work pending a disciplinary hearing and brooded endlessly on losing his job, the shame involved in being sacked, finding another job at 45, never being happy again – whatever could go wrong in his life would now go wrong. He kept on insisting in our sessions:

If they could just tell me today whether they're going to keep me or kick me out, then at least I would be put out of my misery. This disciplinary process is going to go on for another few months. It's mental torture. They should bloody well give me a decision instead of dragging it out! (Stanley)

The mental torture was largely self-inflicted as Stanley demanded that the disciplinary process run to his timetable, not the company's. He kept on assuming that the outcome of the hearing would mean the loss of his job, rather than the possibility he might keep it, and that he couldn't focus on anything else in his life until he had a decision.

Instead of demanding to know the unknowable before a decision was announced, Stanley focused on what he did know and could do, such as re-engaging in daily family activities. Additionally, Stanley flooded himself with uncertainty every day (Leahy, 2006) by saying to himself many times 'I could possibly lose my job'. In order to tolerate this thought without distress, he focused on developing contingency plans in case this did happen (he'd been avoiding doing this), and realized that any shame he may experience would be time-limited, not lifelong. By undertaking these activities, Stanley felt in control of himself in the face of uncertainty. He did lose his job, but the shock was moderate and he found another one within three months. Learning to tolerate uncertainty can bring forth some unexpected strengths, even if the results you were looking for from the situation don't materialize (i.e. keeping your job).

'I DON'T FEEL CONFIDENT'

How many times have you said this before trying anything new? Why should you feel confident if you haven't done it before? I see clients with performance anxiety (e.g. running a workshop or engaging in public speaking for the first time) who want to be articulate, witty, insightful, calm and cool, answer every question with impressive authority and get wonderful evaluations from the audience for their performance; in other words, they want to deliver a perfect performance. Yet their fear is falling well below this standard and being revealed as hopelessly incompetent, a laughing stock.

They always start in the wrong place in assessing their performance: they're beginners, not accomplished performers; so it's important to have beginner's

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

expectations, not those of a star performer. If they do want to become star performers, then they need to realize it could be a long road before they get there rather than, in their minds, achieving instant acclaim. Feeling confident before you do something new and potentially risky is putting the cart before the horse. Furthermore, courage usually comes before confidence; you're prepared to take the risk of putting yourself in your discomfort zone and staying there without knowing how the situation will turn out. Your legs shake, your heart pounds, your voice falters and your stomach churns, but you force yourself into the limelight. Talk of confidence at this stage is premature. Also, your view of confidence is one-sided as it only envisages a successful outcome. Being resilient means that real confidence embraces both success and defeat – neither is taken too seriously – and that learning from whatever happens is the true focus of self-development.

'I'M A PESSIMIST BY NATURE'

This usually means that when you've a setback you believe the consequences will be catastrophic, wiping out any present or future happiness. You're unlikely to persevere when the going gets tough ('What's the point?') and you slip back into a state of helplessness and self-blame, believing that you've no control over events in your life. Seligman (1991) states that this pessimistic outlook consists of three key elements when a negative event occurs:

- *permanence* – 'It's going to last for ever';
- *pervasiveness* – 'It's going to undermine everything I've tried to achieve in my life';
- *personalization* – 'It's my fault'.

When my clients say that pessimism is part of them, they usually mean it's inborn and therefore unchangeable. Some clients declare at the beginning of therapy that 'you won't be able to help me'. I see this as a hypothesis to be talked about and tested, not an accurate prediction of how therapy will unfold.

Optimists, by contrast, see negative events as temporary ('It will blow over soon'), specific ('It only affects one area of my life'), and place responsibility for the event on an external cause ('My boss was in a foul mood today'), or take personal responsibility without self-condemnation ('I was rather slow on this occasion in getting the report in on time'). Pessimists dwell on their problems whereas optimists seek constructive ways of dealing with them.

ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

How we explain events to ourselves is called explanatory style. As you can see, optimists and pessimists have very different explanatory styles. These two styles are habitual ways of thinking, but habits can be changed. You can learn to become more optimistic in your style of thinking. Martin Seligman, an eminent psychologist and author of *Learned Optimism* (1991), has to battle with his own pessimistic outlook:

I am not a default optimist. I am a dyed-in-the-wool pessimist; I believe that only pessimists can write sober and sensible books about optimism, and I use the techniques that I wrote about in *Learned Optimism* every day. I take my own medicine, and it works for me. (2003: 24)

One of the techniques he uses to start changing his pessimistic explanatory style is the ABC model that I discussed in the previous chapter.

- **A = activating event or adversity**
- **B = beliefs**
- **C = consequences** – emotional and behavioural.

For example, if you fail to successfully assemble a flat-pack bookcase (A) and feel despair and anger, and throw the pieces into the dustbin (C), you might believe (B) 'I can never do anything right. I'm completely useless.' This belief puts you in the dustbin along with the self-assembly pieces. In contrast, optimistic beliefs are balanced, flexible and realistic (not feel-good bromides), and point out the dangers of using words like 'never' and 'useless' in assessing yourself and/or your abilities as they create the dispiriting impression of unchangeability in your life.

Seligman (1991) made the case for flexible optimism because there might be specific situations where a pessimistic explanatory style might be more appropriate than an optimistic one, helping you to avoid the high risks you may be running. For example, if you've been drinking, you'd be wise to assume that you'll be stopped by the police and take a cab instead; if you're tempted to plagiarize material to put into your college assignment, you'd assume you'll be found out by your tutor; and if you lie about your achievements on your CV, you'd assume this will be discovered by your prospective employer. And, on a grimmer note, James Stockdale, the POW we met in Chapter 2, pointed out that those prisoners who didn't return from the camps were optimists. Year after year, their hopes that release was just around the corner, such as at Christmas or Easter, were continually dashed. 'I think they all died of broken hearts' (quoted in Coutu, 2003: 7).



ATTITUDES THAT UNDERMINE RESILIENCE BUILDING

Excerpted from *Developing Resilience*

UNDERMINED, BUT NOT FOR EVER

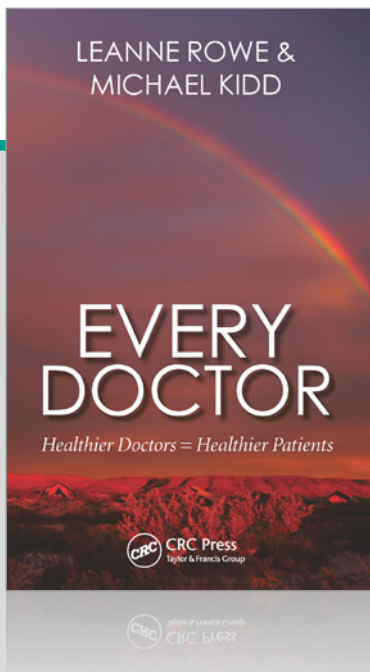
In this chapter, I've looked at some of the attitudes that undermine resilience building and suggested ways of replacing them with resilience-oriented attitudes. This transition can be slow and difficult and it's easy to give up and fall back into familiar, but self-defeating, attitudes and actions. Change is possible no matter how long you've been stuck in your ways, but the starting point is a willingness to be open to discussing new ideas and trying out some different behaviours if you want to develop a resilient outlook. This is the subject of the next chapter.



CHAPTER

5

STRENGTHENING OUR PERSONAL RESILIENCE



This chapter is excerpted from
Every Doctor: Healthier Doctors = Healthier Patients

By Leanne Rowe and Michael Kidd

©2018 Taylor & Francis Group. All rights reserved.

[LEARN MORE >](#)

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

'A table, a chair, a bowl of fruit and a violin; what else does a (person) need to be happy?'

Commonly attributed to Albert Einstein (1879-1955), regarded as the most influential physicist of the 20th century.

There are a number of practical ways we can strengthen our personal resilience through switching off after work, taking a break from being a driven doctor, communicating effectively, responding to criticism and conflict, and sleeping well.

SWITCHING OFF AFTER WORK

As discussed in Chapter 3, our time off work is very precious. It can be difficult to slow the brain after a long intense day. In an overstimulated brain, our negative mental filter can go into overdrive as we rehash the day's events, often thinking about what we forgot to do or what we must do tomorrow.

Unless we are seeking solutions, it is usually a fruitless exercise to let our minds dwell or brood on the same dysfunctional thoughts over and over again.

Here are some examples of common negative thinking patterns:

- Black and white thinking supposes that situations or events are either awful or perfect, which is rarely the case. For example, as recent medical graduates we may focus on one medical specialty as a goal, discounting all other options and predisposing ourselves to feeling like a failure if our 'only' choice does not eventuate. It can be more helpful to think about options, alternatives and shades of grey. Try to become aware of the more rational feelings and thoughts in between the extremes of black and white.
- Common negative over-generalisations are thoughts such as '*Things always go wrong*', '*Everyone at work is against me*', '*No-one understands how I feel*'. Extrapolating is rarely helpful. The evidence for these unhelpful generalisations can be challenged with constructive self talk like: '*I had a bad day, but tomorrow will be better*', '*Work has been stressful for everyone recently, but I'll try not to take things personally*', or '*Talking about how I feel to like-minded colleagues will help me feel better*'.
- Mind-reading involves making assumptions about what someone else thinks of us or believes about us. The evidence for such assumptions needs to be questioned, for example, '*How do I know this?*', '*How can I be sure?*', '*Could my colleague have something else on their mind?*'

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

- Making mountains out of molehills is a catastrophic way of thinking. For example, *'It will be awful/terrible/horrible'*, *'I can't stand it anymore'*. A more helpful inner voice may say: *'Yes, it will be difficult, but I have got through problems before and I will try to do my best'*.

Try this exercise:

Outside of work, try to seek simple pleasures. Identify enjoyable things in your day which bring you joy and do them every day – reading to your child, walking the dog, breathing clean air, feeling the sun on your skin, hugging your partner, laughing with a friend, talking to your parents, singing, listening to music, taking a bath, gardening, swimming, cooking healthy food, riding a bike, learning another language, dancing, smelling fragrant flowers, going to the theatre, taking photos, writing, reading poetry, watching a sunset, visiting an art gallery, tasting fresh fruit, growing something from seed or fresh herbs on your windowsill. What are the simple things you enjoy? Write them down and try to do more of them every day.

'Happiness is a habit - cultivate it.' – Elbert Hubbard (1856-1915)
was an American writer, publisher, artist, and philosopher.

CHALLENGING NEGATIVE THINKING

Sometimes it is difficult to stop intrusive thoughts and rumination about problems at work. We are trained to notice the negative. Whether we are pre-occupied with monotonous administrative tasks, overwhelmed with a never ending to do list or putting out bushfires at work and at home, we are trained to place ourselves on autopilot to get the job done.

Try this exercise:

Think about what you pay attention to when you are not working. Try to switch off your autopilot and consider a recurrent problem that comes to your mind frequently in your free time. Here are some helpful questions to try to understand and reduce unhelpful thoughts:

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

- *What is the evidence for this way of thinking about the problem?*
- *Is there another explanation for what I am feeling or what is happening?*
- *What is the worst that could happen in this situation?*
- *What is the best that could happen out of this?*
- *What is the most realistic way things could work out?*
- *What would I advise a colleague if he or she were facing the same situation?*

Challenging negative thinking can be more difficult if you have unconscious unrealistic belief systems. Are any of these inner beliefs underpinning your negative thinking patterns?

- *I need other people's approval to make me happy.*
- *I should always have complete control over my feelings.*
- *It is weak to feel anxious or sad.*
- *I should never make mistakes and I should always be right.*
- *I must anticipate all risks.*
- *I must know everything and fix every problem.*

Try some more reassuring forms of 'self talk' such as:

- *I am human. I have feelings and it is sometimes helpful to express them.*
- *I do not need approval, but I would like support.*
- *I am dealing with many complex challenges and it is not possible to mitigate all clinical risks.*
- *All doctors make errors and mistakes, which we can try to prevent and learn from together.*
- *It is not possible to know everything but I know where and how to access relevant information.*

Practise prefacing your self-talk with words like, '*I would prefer*' or '*I will try*', rather than '*I shouldn't be thinking or feeling like this*', '*I am always negative*' or '*I must not feel like this*'.

Respond to your thoughts as you would to a radio station. Try to switch off the 'unpleasant music and voices' in your head and proactively focus on pleasurable thoughts that help you relax and feel better.

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

Many doctors say they do not have time for meditation or mindfulness and they do not relax easily. If this is the case, try to build mindfulness into your day, by shifting the focus of your attention to what you are doing when you are waiting on the telephone, in a queue, taking an elevator or walking from consulting room to waiting room, and at many other times when your mind is usually set to 'automatic'. Simple things like trying to slow your breathing at appropriate times throughout the day, eating nutritious food slowly when possible, and exercising opportunistically (for example using stairs not elevators), can all help you keep your stress levels in check during work hours and make it easier for you to unwind after work.

TAKING A BREAK FROM BEING A DRIVEN DOCTOR

'The reasonable man adapts himself to the world, the unreasonable one persists in trying to adapt the world to herself. Therefore, all progress depends on the unreasonable man'. – George Bernard Shaw (1856 – 1950) was an Irish playwright, awarded the Nobel Prize in Literature in 1925. Acknowledgement: The Society of Authors, on behalf of the Estate of Bernard Shaw.

Overwork is often regarded as the sign of a dedicated doctor. Doctors who have driven personalities are often rewarded professionally and financially. We receive few complaints, rarely make mistakes and are highly conscientious. We complete most of our tasks by the due date, constantly pre-empt problems, manage risks and work long hours to go beyond what is expected of us. Many of these personality traits are important to get the job done. But when we become task orientated and slaves to endless 'to-do lists' at the expense of our relationships, we stop enjoying our lives.

Try this exercise:

Are you:

1. Irritable when late?

Are you often late because of unexpected emergencies, long consultations or increasing patient demand?

2. Impatient while waiting?

Do you get frustrated that you will run even later if you have to wait for others?

3. A fast eater?

Have you been conditioned to eat quickly or risk not eating at all?

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

4. Interested in very little outside of home and work?

Do you find you have very little personal social time because when you are not at work you are making up for lost time with your family responsibilities?

5. Competitive and ambitious?

Were you encouraged to compete during student years for rankings and later for postgraduate training positions?

6. Frequently anticipating what others are going to say, sometimes finishing their sentences?

Are you sometimes frustrated with how long it takes for others to express their thoughts?

7. Always in a rush?

Do you find it a challenge accommodating patients who present with urgent medical problems, but at the same time feel pressured to make adequate time available for review of your current patients?

8. Trying to do too many things at once, and at the same time thinking about what you will do next?

Do you find it a challenge constantly pre-empting problems, assessing risks and managing multiple problems, and having to make complex decisions?

9. Seeking to be recognised by others?

Do you find you rarely receive recognition because patients, family and friends expect you to maintain your caring role at all times and rarely give you positive feedback because they assume you know you are appreciated?

10. Feeling guilty when idle?

Do you experience unease when you have nothing to do?

11. Never really happy?

Do you have a perfectionist, self-critical personality? Do you have a harsh inner voice? Have you set the bar too high? Do you think in terms of 'I must', 'I should' or 'I always'?

Are you being weighed down by other people's expectations, or do you have unrealistic, harsh expectations of yourself – or both?

If you recognise any of these personality traits, try to slow down and practice being kinder to yourself. Give yourself a break from your harsh inner voice and you may find you are more focused and content.

How do you switch off during your time off? Are you doing this proactively?

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

COMMUNICATING EFFECTIVELY

'Mindful practice in medicine is more than meditation and personal growth. Being mindful is when I know to stop briefly, look at patient in the eye, and ask, 'have I got it all, or is there more?' – And a patient, whose previously well-controlled diabetes is now uncontrolled, then tells me he hasn't been taking care of himself since his wife died six months ago. It's when I inject an inflamed shoulder joint - with focused attention, visualising the bones, tendons and muscles - and the needle slides in easily and painlessly. I'm being mindful when I notice that a patient doesn't look quite right, not her usual self, and then I notice the fatigued expression and the faint rash that are clues to her new diagnosis of lupus. Attending to each patient means that I remember that, although the last patient I saw only has days to live, the next patient - with a stubbed toe - needs the same focused attention.' – Dr Ronald Epstein is a Professor of Family Medicine, Psychiatry, Oncology and Medicine (Palliative Care) at the University of Rochester School of Medicine and Dentistry in New York. He is a family physician and palliative care physician, writer, researcher and teacher of communication and mindful practice in medicine, as well as author of 'Attending: Medicine, Mindfulness and Humanity'. www.ronaldepstein.com

From early in medical school, we are taught that good communication skills are critical to quality patient care, preventing patient complaints and avoiding medico-legal action. Communication skills training usually emphasises the value of active listening where we try to understand what a patient is really trying to say by fully listening and then restating what we have heard from the patient in our own words, beginning with something like: *'Let's see if I understand what you're saying ...'*

Unfortunately, the reality of medicine is such that there is limited time to do this. Instead, it is common to see many doctors avoiding eye contact, interrupting, dismissing and ignoring patients and colleagues. If we take short cuts with listening we are prone to mistakes, which are likely to be time consuming when other consequences emerge.

What is required is a willingness to value the voices of patients and their carers, particularly those who are frequently unheard - a child with a disability, a woman with poor literacy or an elderly man with morbid obesity. We save time if we take time to listen and communicate effectively because we are more likely to make the right diagnosis and work with our patients to make optimal decisions about management.



STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

YOU TALK AND I WILL LISTEN

We give patients as little as 12 seconds to tell their story before we start interrupting them. And then we keep on interrupting them.... You can understand why patients feel they can't get a word in edgewise. This can lead to all sorts of problems for doctors and patients alike: our hurriedness contributes, no doubt, to some of the dissatisfaction with modern medical care. What observations can be made about medical training that might counter this?

I canvassed the views of 50 colleagues: from family docs and surgeons, psychiatrists and critical care docs, to internists and pediatricians. I was, frankly, surprised by how quickly and enthusiastically most responded. Despite the negative things you may have heard about healthcare, a positive view of medicine is still alive and well. I received many excellent responses.

A family doctor suggested: 'If there is one thing to learn, to do really well as a physician, it is to listen. In the midst of the intensity of medicine, the crises, the sadness and the everyday, and the wall of computer screens, always listen to your patient. The patient will give you a better history if they see you are listening'.

An internist observed: 'Think of that patient as the only person you are seeing today, and you can achieve a connection that each patient will appreciate. Every patient is a person, an individual, and giving them each your full attention offers them the respect and connection they deserve'.

Another family physician had this to say: 'I used to draw inspiration from the heroes I met in literature and on the screen. Now, as a doctor, I have the great privilege of being in the presence of heroes. Regularly, in my office, at the bedside, and in living rooms across my community I am amazed by the courage, compassion, and tenacity shown to me by my patients who allow me to journey with them as we walk together on a path towards healing. They continue to be my greatest inspiration'.

A psychiatrist wrote: 'Most of us go into medicine because we want to help people - it is an honour and a privilege to be able to help people as their physician - if this remains your primary focus you will be happy in your work while making a positive difference in the lives of your patients. There is nothing more satisfying'.

A geriatrician wrote of the 'gratitude you feel that you have joined a long line historically of people like yourselves who have dedicated themselves often in many small ways to the betterment of their fellow beings'.

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

An intensive care unit doctor wrote: 'As a doctor, you will have the privilege to be present for ALL of the key moments in human life, far more than you would experience in one lifetime. Be humble. Be grateful. Be mindful. Art and science don't have to be in opposition. Let them be informed by AWE'.

An anaesthetist wrote: 'Be grateful for the opportunity and enjoy every day!'

A paediatric endocrinologist simply said: 'You're in for the most exciting time of your life! Buckle up!'

A critical care physician observed: 'This is the start of a journey. On this journey, you will be part of wonderful and terrible stories. You will have the power to effect positive change. You will also be powerless to prevent dreadful outcomes. You are more than just a witness, or a storyteller on this journey, you are an integral part of it, a player in the stories of the people you care for. Bring your best self. And always remember that although their stories become part of your own story, first and foremost you are there for them'.

An emergency medicine doctor observed: 'You are human. Do not think of yourself as bad or incompetent for making mistakes. Errors are the fountain of wisdom.' He emphasized: 'Every good thing I have done in my entire life has come from a mistake'.

A clinician scientist said: 'It's okay to say, 'I don't know' and 'I'm not sure'. Your patients and colleagues will respect you more, and the job of being a doctor will be easier. This is where the resilience of the doctor-patient relationship comes in if you are honest and open with patients'. Professor Emeritus Philip C Hébert is a Canadian family doctor, bioethicist and author of 'Doing Right: A Practical Guide to Ethics for Physicians and Medical Trainees', and 'Good Medicine: The Art of Ethical Care in Canada'.

RESPONDING TO INEVITABLE CONFLICT AND CRITICISM

'Our medical practice is a deeply dysfunctional, unhappy place, where most doctors don't say good morning and avoid contact in the staff room. Some of us disagree about patient care. Others about practice management and money. But the real problem is that we avoid debates and disagreements, and tension festers.' – Anonymous doctor.

We often work intense hours, deal with angry patients and exhausted colleagues, and make critical decisions in emergency situations. Our clinical judgement may be unfairly (or fairly) questioned. In this challenging environment, it may feel easier to disappear into our consulting rooms and avoid conflict and clashes of egos with colleagues, but this is rarely constructive.

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

Peer review, differences of opinion and debate are healthy in medical practice. This is how we learn. This is how we continue to provide the highest standard of care to our patients. How can we respond to inevitable conflict constructively?

Try this exercise:

Next time you are involved in a conflict, try to:

- Leave your ego at the door.
- Regard it as an opportunity to build a stronger relationship with your colleagues, rather than avoiding conflict.
- Remain calm and appropriately assertive. Ask if it's possible to have healthy differences of opinion and express them respectfully.
- Begin the conversation with statements like: *'I hope we can create a trusting relationship where we can give each other constructive feedback'*.
- Statements like: *'Thank you for the feedback', 'I can see we both want what is best in this situation.'* or *'I appreciate that you have high standards'*.
- Objectively establish the facts of the situation to ensure there is no misunderstanding. Try to understand if the conflict has arisen as a result of misinformation, poor communication or personal differences.
- Listen to understand, without interrupting. Understand the other person's intentions. Are they being constructive? What is really behind the conflict? What are they really trying to say?
- Reassure your colleague you understand why the conflict has arisen by saying: *'I can see why you would be concerned/upset over this. I'll bear that in mind in the future to prevent any misunderstanding'*.
- On the other hand, if the issue in a dispute seems vague, ask for specific examples so that you can better understand the issue. Try: *'Thanks for raising these issues so we can talk about some solutions'*.
- List all the possible solutions to a conflict or problem together and then weigh up the advantages and disadvantages of each solution objectively. Choose the best solution together – if it does not work, try negotiating again.
- Agree on finding an outcome that you can both support. This may require mutual compromise.
- Be clear on the issues that you cannot compromise on. Be open to changing your opinion as more facts emerge.

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

- Implement the agreed solution, and agree to review it later to determine if it is working.

Ask later: *'Is everything OK now? How can we work together to prevent any misunderstanding happening again?'* If the conflict becomes heated or personal despite these strategies:

- Acknowledge any strong feelings on either side.
- If you are being interrupted, ask if you may finish your sentences.
- Refer back to the issue at hand if there is any personal attack.
- Take responsibility for your own feelings by using 'I' statements like *'I feel hurt...'* *'I feel distressed...'* rather than *'You make me...'*
- Also try: *'I do not agree with your assessment'*, *'I am not used to being personally attacked'*, and *'I'll discuss this with you when you are ready to communicate calmly'*.
- If the conflict becomes destructive, it may be best to engage professional mediation.

Think about a recent difficult conversation and your reaction. Did you cut it short? Did you acquiesce to a show of authority, an attack on your integrity or yelling? Did the encounter trigger something from your past? Did you back down?

Try experimenting with your next conflict by remaining professional, listening fully and stating your rationale without emotion. Persevere with your point of view even if others behave inappropriately. Try reviewing your response using the points above. What did you find helpful?

'Honest differences are often a healthy sign of progress.'

– Mahatma Gandhi (1869 – 1948) was the leader of the Indian independence movement against British rule employing nonviolent civil disobedience.



STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

SLEEPING WELL NATURALLY

General sleep hygiene advice often includes avoiding:

- daytime or evening naps,
- lying in bed ruminating or worrying,
- work or stressful phone calls or emails immediately before bedtime,
- rethinking about today or tomorrow's stressful events,
- drinks containing caffeine or alcohol, and
- exercise near sleep time.

Other common advice to break the sleep/wake/insomnia cycle, includes only going to bed when sleepy, getting up every time we cannot sleep after about 30 minutes and doing something soothing (not watching TV or using a computer), trying to set ourselves a routine time for getting up in the morning, and scheduling relaxation and physical exercise throughout the day.

However, generic sleep hygiene strategies often do not work for doctors. We frequently do not have time to relax, meditate, or exercise during the day. We work after hours, night shifts and may be woken from sleep with emergencies. We may have to take phone calls at all hours, and often need to attend to our administrative work late in the day on a brightly lit computer. All of this can wreak havoc with our sleep patterns and cause chronic insomnia. This is significant because lack of sleep results in day time fatigue and irritability, and may predispose us to depression.

Unfortunately, a number of surveys of doctors suggest that many of us self-medicate with addictive benzodiazepines or consume alcohol to sleep, which is counterproductive and harmful.

The first step is to recognise the special challenges doctors may encounter with sleep, and from early in our careers, condition ourselves to sleep well, and if we wake, to get back to sleep easily. Brief relaxation exercises work well if we do them regularly as we condition our brains to let go. If we do not have time to do them during the day, we can use them at night when we cannot sleep.

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

Try these exercises regularly:

MUSCLE RELAXATION

While seated comfortably or lying down flat on your back, become aware of the muscle groups in your body: your hands, arms, shoulders, jaw, face and nose, stomach, and legs and feet. Tense each of your muscle groups for a few seconds and then let them go as follows.

Hands: Make a fist with each hand and let go and relax.

Arms: Stretch your arms out in front of you, raise them high up over your head and stretch higher. Let your arms drop back to your side and feel them go floppy.

Shoulders: Pull your shoulders up to your ears. Hold in tight and then relax.

Jaw: Clench your teeth together really hard. Then let your jaw hang loose.

Face and nose: Make lots of wrinkles on your forehead, and crinkle up your nose, then let your face go smooth.

Stomach: Pull your abdominal muscles in. Try to make them touch your spine. Make yourself as skinny as you can, then release your abdomen.

Legs and feet: Push your feet and toes down on the floor. Let your feet and toes go loose and floppy.

Take time to let each muscle group relax.

MINDFULNESS

Mindfulness has many definitions. Basically, it is an awareness of the present moment and an acceptance of thoughts, feelings and bodily sensations. To achieve this state of mind, try to watch your thoughts as an observer without reacting to them as 'good' or 'bad'. Try to shift your attention to what you are paying attention to. Sometimes the statement, 'just relax', can make things worse because your active mind can feel stressed about feeling stressed. Instead, accept your active mind as natural, and try to step aside from your thoughts. Try to get some distance from your thoughts by visualising placing your thoughts in boxes on conveyor belts or imagining your thoughts floating

STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

through the sky on clouds. Try not to stop stressful thoughts but let your thoughts flow through your mind and observe them from a distance, without judging them.

VISUALISATION

Imagining pleasant images is a powerful way to relax. Think of one of your favourite people or one of your favorite places, like the beach, a bush walk, a garden or a park. Imagine the smells, sounds, touch and scenery. Bring yourself back to the state of your mind when you were last at this place. Revisit a state of quietness and peace in this place in your mind. Take a deep breath in and out.

BREATHING

Count your normal breathing rate for 60 seconds. Then breathe in on the slow count of three (one...two...three...) and out for the slow count of three, for a full minute. Try counting your normal breathing rate over 60 seconds again and compare it to what it was before the exercise. The breathing rate often slows down, which in turn helps the heart slow down and makes it easier to relax.

Notice sensations that you do not usually pay attention to. For example, notice that the air you inhale is colder than that air you exhale (unsurprisingly).

'In the midst of winter, I found there was, within me, an invincible summer. And that makes me happy. For it says that no matter how hard the world pushes against me, within me, there's something stronger – something better, pushing right back.' – Albert Camus (1913-1960) was a French philosopher, author, and journalist, awarded the Nobel Prize in Literature in 1957.

IN SUMMARY

There are many ways to strengthen personal resilience and effective mechanisms to switch off after work, by identifying particular traits that predispose us to burnout. We can challenge common our negative thinking patterns such as black and white thinking, negative over-generalisations, and catastrophizing by questioning the evidence for unhelpful thoughts and being kinder to ourselves.



STRENGTHENING OUR PERSONAL RESILIENCE

Excerpted from *Every Doctor*

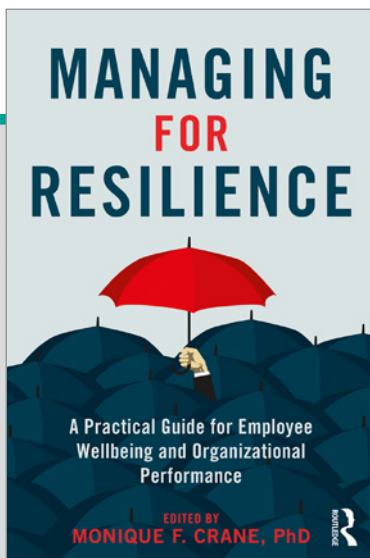
Effective communication skills are essential when facing criticism or responding to inevitable conflicts with colleagues.

Establishing healthy sleep hygiene early in a medical career is important, along with using simple and versatile tools for muscle relaxation, mindfulness, visualisation and breathing. These tools can be utilised in brief breaks during a working day, when trying to fall asleep, or when struggling to fall back asleep.



CHAPTER
6

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT



This chapter is excerpted from

Managing for Resilience: A Practical Guide for Employee Wellbeing and Organizational Performance

By Monique F. Crane

©2017 Taylor & Francis Group. All rights reserved.

[LEARN MORE >](#)

MONIQUE F. CRANE, PhD
EDITED BY



ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

Organisational scholars recognised the importance of support and demonstrating concern for employees as a responsibility of good leaders in some of the earliest research on leadership. Some of the initial (and still supported) conceptualisations of leadership came down to two over-arching components of helping employees stay on task and providing support for them (Fleishman, 1953; Fleishman, Harris & Burt, 1955; Judge, Piccolo & Ilies, 2004). Social support can be a particularly useful tool for a manager to use to help employees be resilient in the face of job stress. Yet, social support comes with several caveats on when it is most useful and how it should be implemented. How managers provide support to employees can impact their ability to demonstrate resilience under difficult work conditions. Although the overwhelming majority of studies have reported positive associations between social support at work and measures of health and wellbeing, this is not always the case. Other studies have failed to find a positive relationship, or even found a negative relationship. This may be a result of several factors, such as providing support that amplifies the stressful nature of the situation or not providing the supportive behaviour an individual really needs. Researchers from various fields are still working to understand the complexities of support and how it may be best used as a resource to enhance employee wellbeing. However, without doubt, it can be troubling when an employee lacks support in the context of stressful work and non-work lives.

Many jobs today involve a high level of employee stress, whether it be balancing a large number of complex tasks, enduring intense physical environments, or making high-stakes decisions involving large financial costs or even human lives. In these situations, it is important that employees be resilient to the obstacles that may impact their health, wellbeing and ability to perform their jobs. In most cases, it is hard for an individual to do this without the help of others in some form. Support from an employee's manager and workgroup can be critical resources in helping employees to thrive amidst these challenging circumstances. Although providing support seems like a basic concept that is relatively obvious to enact, researchers have found that social support is much more complicated and can have a wide range of effects on employees.

Take this example. A researcher at a private firm has a helpful and outgoing supervisor, with whom he works on a regular basis. He enjoys working with her and acknowledges that she is exceptionally helpful, competent and an overall great leader. Oftentimes he experiences some difficulty completing more complex statistical analyses and goes to his supervisor for help on this. She quickly volunteers to do the tasks for him, to help him out. While he is relieved to have the help, he often

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

feels discouraged and incompetent that she has to take over. So while his supervisor has positive intentions to help him, this type of support may undermine his confidence and efforts to learn.

As another example, consider a construction worker who loves his job and his manager, who has become a close friend and helpful resource for getting his work done. One day, the worker injured his back while lifting some heavy materials. He experienced a lot of pain that lasted several days. Instead of reporting the incident and taking time to visit a doctor, he decided to work through the injury because the job had to get done and he did not want to disappoint his manager. In this case, not wanting to let the manager down led the employee to act in ways that could limit his performance and harm his health.

In both of these cases the leader or manager had good intentions to support his or her employee; however, this support had some unintended negative consequences. Situations such as these may arise in the workplace more often than one would expect, where managers have good intentions, but need more information on how to best support their employees in various circumstances. Managers and co-workers alike should be informed on how to best support a variety of employee needs, whether that is offering an ear to listen to a problem or more tangible resources to help solve a problem. Knowing the most appropriate steps is critical in ensuring that the support offered is effective in helping employees build resilience and thrive in these complex work environments.

In this chapter, we provide a brief overview of the research that has been conducted in the area of social support. We focus on definitional aspects of support, including types of supportive behaviours and sources of support, how support can be helpful in stressful conditions, and when support can actually result in negative outcomes. Importantly, the second part of the chapter will shift to a practical focus on what managers can do to provide support to their employees.

WHAT IS SOCIAL SUPPORT?

Social support has long been an interest of social researchers, who conducted an extensive amount of research in a relatively short amount of time (Barrera & Ainlay, 1983). However, the surge in this research led to some very different conceptualizations of social support, making a single, clear definition difficult. Social support has been defined in broad terms as an individual providing resources to another to enhance his or her wellbeing, or the perception that assistance would be available if it was needed

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

(Langford *et al.*, 1997; Shumaker & Brownell, 1984). The resources provided can include tangible assistance, like helping complete a task or giving someone money, or can be more emotionally oriented, like offering an ear to listen to a concern about a work task or providing advice.

Researchers have made several distinctions in social support, including: (1) whether the support is specified as perceived or enacted, (2) the different behaviours that constitute support, and (3) the different sources of support in a person's social network. Recognising these distinctions can be important to gaining a greater awareness of effective ways managers can support their employees.

1. Perceived or enacted support.

The first distinction is that social support can be perceived or enacted. Perceived support means that an individual acknowledges that support would be available if needed, which may or may not accurately reflect the availability of resources. Enacted support is when someone actually performs a supportive behaviour (Haber *et al.*, 2007). While enacted support seems to better capture the reality of supportive behaviours, researchers have actually found evidence that perceived support is more consistently related to health outcomes (Haber *et al.*, 2007). Further, some would argue that actual supportive behaviours may only be helpful if they are perceived by the person receiving support as satisfactory or necessary (Dunkel-Schetter & Bennett, 1990; Sarason, Sarason & Pierce, 1990).

These distinctions between perceived and enacted support may be important for managers to consider. Even if managers do not necessarily feel they have the capacity to tangibly provide assistance to all employees, making it known that they can be available to help employees as needed may be a more important foundation. In addition, the behaviours managers engage in to support their employees may not be beneficial if employees do not actually perceive those behaviours as supportive, either because the behaviour is not obvious or the intent is unclear. Managers may therefore need to evaluate whether the supportive behaviours they engage in match the employee's perceived support needs by seeking regular feedback from employees.

2. The different functions of support.

A second distinction is in the types of supportive behaviours, which can serve very different functions. Most researchers distinguish four major categories of supportive behaviours: (1) emotional, (2) instrumental, (3) informational, and (4) appraisal (e.g., Cutrona & Russel, 1990; House, 1981; Langford *et al.*, 1997). Emotional support is what typically comes to mind when thinking of social support. That is, providing

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

emotional care for someone, such as by listening to a concern or conveying that the individual is valued and cared for (House, 1981). Perceiving emotional support has been associated with positive health and wellbeing outcomes in a broad range of stressful conditions (Cutrona & Russel, 1990). A major concern about emotional support, however, is that it depends heavily on the perception of the individual receiving support (House, 1981). For example, a boss may demonstrate care for an employee under high demands through offering words of encouragement, but the employee may not acknowledge the encouragement or misinterpret it as unhelpful or insincere. Thus, it may be harder for managers to gauge whether or not an employee feels emotionally supported in his or her job role.

Instrumental support is provided when someone engages in a behaviour that directly addresses the recipient's need, such as providing tangible goods or services (House, 1981). Broadly, this may be giving someone money, food or a ride when a person is in need. In a workplace, this may include actually performing work duties for another person or providing supplies needed to perform a task. Instrumental support can be very useful and has been related to positive health outcomes under stressful circumstances (Cutrona & Russell, 1990). Many readers can probably think of specific examples where a co-worker, boss, or other individual provided encouraging words when they were stressed about a task, but what they really needed was someone to help get the work done. Using instrumental support speaks to the idea that actions can sometimes speak louder than words, especially in stressful work environments.

The provision of instrumental support can be problematic if it is not perceived in a positive manner. For example, an employee may interpret his or her manager jumping in to help complete a project as a signal that the individual is not competent to do the job alone. Another common example of the slippery slope of providing instrumental support is with providing money to someone, which could signal that they are in need of money and dependent on other people to help them. Practically speaking in these examples, being too quick to offer instrumental support could also prevent employees from gaining job-relevant skills that could be acquired through further training or instruction. Overall, however, when applied appropriately, instrumental support can be helpful and results in positive outcomes under stressful conditions.

Informational support is when an individual provides information or advice that helps to solve a problem (Cutrona & Russel, 1990). Providing information to "help someone help themselves" can sometimes be a better alternative than providing emotional or instrumental support. Informational support means helping an employee to better

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

handle a situation, without risking reduced efficacy or feelings of inadequacy that may result from directly intervening. Informational support provided in stressful situations has been associated with outcomes such as higher positive affect and lower levels of depression symptoms (Cutrona & Russell, 1990). In the workplace, examples might include providing information about organisational resources that are available, providing training opportunities for an employee, or giving contact information for technical support. Some of these informational support behaviours may take more time than a brief word of encouragement or just doing a task oneself, but could have long-term benefits for the employee and organisation, particularly in the case of developing more resilient employees.

Lastly, appraisal support is similar to informational support, where information is provided in regards to self-evaluation (House, 1981). Appraisal support is typically shown through statements or behaviours that affirm that an individual is doing a good job or engaging in an appropriate behaviour in the given context (Langford *et al.*, 1997). In the workplace, this may include feedback or recognition from a supervisor that the employee performed a task well, or even telling a new employee that it is ok to feel overwhelmed at first and to validate concerns he/she may be experiencing. These forms of support can be very important in boosting an employee's self-worth, and especially for new employees, letting them know that they are on the right track.

Recognising the different types of supportive behaviours can be valuable in determining the best ways to support employees. In particular, understanding any unintended consequences of presumably supportive behaviours can help to identify the optimal ways to support employees to be more resilient. These considerations will be examined in more detail in the later discussion of ways support may actually be associated with negative outcomes in the workplace.

3. Sources of support.

The third feature of support is who is providing the support. The source of the support may also impact individual and organisational outcomes. While this chapter is intended to focus on the manager's role as a source of support, other individuals can serve a vital role in supporting employee needs. There are several other important sources of support, such as co-workers or family and friends outside of work, who may be more impactful in helping employees to cope with different job demands. Considering a more holistic view of support from a variety of sources may not only provide more useful information for making employees more resilient, but may also allow more realistic recommendations. Most managers must balance a wide range of

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

responsibilities, and trying to support every employee in specific ways may not always be feasible. However, promoting an overall culture of support, such as through supportive co-workers, can create more resources for employees to turn to when managers are unable to fulfill all of the needed support roles.

Specific in relation to employee stress, support from managers and co-workers has been found to have unique influences on employee outcomes. At times, support from a manager may be more critical for employees because of the control a manager has over factors like the tasks an employee performs or the resources that are available. For example, studies have found that supervisor support, but not co-worker support, was associated with lower levels of psychological distress and symptoms of depression (Akerboom & Maes, 2006; Dormann & Zaph, 1999). As another example, Halbesleben (2006) found that employee feelings of being burned out were differentially impacted by support from people in and outside the workplace. Support from those at work was associated with less experience of exhaustion, likely because exhaustion is closely tied to the particular work demands. However, support from those outside of work was more closely related to an employee's feelings of depersonalisation (i.e., feeling detached from or cynical toward work and/or work-related relationships) or personal accomplishment. Thus, those outside of work may contribute to these more personal, emotional experiences associated with work stress.

As a final example, some sources of support may not only matter for an employee's wellbeing, but could contribute to important behaviours in organisations. In a study of Taiwanese employees, Chiu, Yeh, and Huang (2015) found that co-worker support, but not supervisor support, was associated with a lower likelihood of engaging in deviant behaviours toward other employees. Interestingly, when employees rated co-worker support as high, they were less likely to engage in deviant behaviours, even as their stress from balancing multiple roles increased. These examples highlight that managers are important sources of support, but are not the only important source of support.

Seeking to promote an organisational climate with high co-worker support could be valuable for a number of reasons. First, employees may feel more comfortable accepting support from co-workers. Many times, individuals can feel uneasy when they receive support, but feel they have nothing they can give in return. Buunk and colleagues (1993) found that employees reported they could more equally reciprocate help received from colleagues compared to help received from supervisors. Further, employees may feel it reflects poorly on them to go to a supervisor for help, while the costs are much less intimidating to ask a peer. As a second consideration, co-workers

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

may simply spend more time with one another as compared to the time the manager gets to spend with employees. Therefore, a co-worker may better be able to perceive when an employee has a need for support or may be more familiar with what resources are most needed in specific work situations.

Leaders should not, however, use supportive co-workers as an opportunity to step out of their support role, but as an invaluable supplement to the unique ways a leader can support his or her employees. Leaders may also need to initiate efforts to encourage employees to support one another. Research from the field of occupational health has demonstrated that leaders play a major role in creating the overall climate within a workgroup. For example, research on safety at work has noted leadership as a primary influence on the climate related to safe practices in a workplace (Zohar, 2010). Therefore, the leader may be highly influential in setting the precedent for supporting fellow employees. As an applied example, having high task demands and individualised incentives may move employees to be very independent of one another in their work (and potentially even promote competition). However, encouraging collaboration and making schedules with some room to back-up or support a co-worker in need creates a more optimal foundation for supportive co-worker relationships to form.

SUPPORT IS *NOT* ALWAYS HELPFUL: AVOIDING HARMFUL FORMS OF SUPPORT

Although most researchers and anecdotal experiences would suggest that support from others is helpful, not all research has had the same promising findings. Some studies find either no effect of social support on improving employee health, or even an opposite relationship where support was associated with harm to an employee's wellbeing. Under certain conditions social support has been related to negative outcomes. For example, Ray and Miller (1994) found that nursing home employees experiencing high amounts of stress reported more exhaustion and burnout as co-worker support increased. Others have found that social support was associated with increased mental health symptoms such as psychosomatic complaints, anxiety and depression under some stressful situations (Frese, 1999). Even in the case of traumatic stress, some forms of support may not reduce the impact of experiencing trauma on physical and mental health outcomes (e.g., Stephens & Long, 2000). Lastly, studies have found that support may not always serve as a buffer to stressful circumstances. For example, support did not buffer the negative effects of stress on job satisfaction in a study by Ducharme and Martin (2000).

Empirically speaking, many of the inconsistent relationships may be due to issues with the study design or the way support was actually measured. Many researchers

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

use the term “social support” for a measure that may or may not be capturing support well. For instance, some researchers measure support as the number of close relationships possessed by the individual, while some better capture the quality of relationships, and others focus on specific aspects of support, such as the content of conversations in a supportive relationship (e.g., Stephens & Long, 2000). Some researchers have also argued that plausible explanations for correlations between negative outcomes and support are that those with a higher need seek out more support to begin with or that individuals receiving support when they do not want it, experience negative reactions (e.g., Barrera, 1986; Deelstra *et al.*, 2003). The claim that those with higher needs seek more support has not been clearly tested in empirical studies. However, Deelstra and colleagues (2003) did consider the relationships between need for support and responses to support in a lab study, finding that having a high need was not associated with more positive reactions to receiving support.

Cohen and Wills (1985) argued that the type of stress and support offered must adequately match in order to find an effect where support reduces the impact of stress on relevant outcomes. Therefore, support may not be helpful if it does not adequately fit the demand or the problem the employee is experiencing. For instance, employees experiencing a stressor of a social nature (e.g., an interpersonal conflict) may benefit from more emotional support. If the demand is a practical need (e.g., help completing a task), the employee may need instrumental support to reduce the demand and the impact on his or her health.

As briefly noted in the provision of instrumental support, sometimes supervisors or co-workers can have good intentions to help an individual that have unintended consequences. Therefore, it is important that managers are aware of the most appropriate forms of support to fit an employee’s need, and recognise how some supportive behaviours could potentially harm a person or situation. Beehr, Bowling, and Bennett (2010) provided three specific examples where support could actually be harmful.

1. Increasing one’s focus on the stressor.

The first example is when the type of support brings more attention to the stressful circumstance than would normally occur. As an example, Kaufmann and Beehr (1989) argued that this potentially accounted for a reverse-buffering effect they found in a sample of police officers. These authors found that high perceptions of instrumental support, specifically that others were available to help with work as needed, was

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

associated with experiences of increased strain when under high stress. They argued that in this case, the instrumental support may have re-affirmed the stressful nature of the officer's job, rather than reducing strain responses. Most readers can probably personally recall an instance of this phenomenon where the more they discussed a stressful event with others, the more stressful the experience became. The employee may normally just face these circumstances, with little or no stress, but the additional attention unnecessarily highlights aspects that unsettle them. Optimally, providing support should never make a worker feel worse than they did before an encounter.

Bringing additional attention to work-related problems may have also been a factor in the unexpected findings of Hahn (2000). These researchers found that emotion-focused social support was associated with higher reports of anger when employees experienced interpersonal conflict. In this case, confiding in others and seeking emotional support could unintentionally cause an employee venting about a problem to dwell on it and see it as more stressful. Similarly, Iwata and Suzuki (1997) found that the relationship between role stress and mental health symptoms was stronger for Japanese bank workers who reported high emotional support from co-workers. Thus, these employees may all have been more likely to dwell on their stressful experiences when receiving support, exacerbating the negative effects.

2. Support as a threat to competence.

The second example provided by Beehr *et al.*, (2010) is when helping poses a threat to the employee's perceived ability or self-image. The manager who takes on the "let me do it for you" attitude when a task seems complicated, rather than helping someone to help themselves, typifies this example. Such behaviour can make an employee feel inferior and incapable of completing their job, and could even be embarrassing if it is a task he/she should be able to do. Peeters, Buunk, and Schaufeli (1995) found evidence of this dynamic in their study of correctional officers. Officers who received instrumental support at work reported higher negative affect at the end of the day. The authors proposed, as other researchers have as well, that this type of support in this context may have been associated with feelings of inferiority.

3. "If I want your support I will ask for it".

The third and final example is trying to support someone who does not want support. Employees may feel frustrated when a co-worker or supervisor intervenes when help is unwanted. Therefore, it is important to gauge the extent to which support is needed before being too eager to help someone who may not actually need help. In a sample of university employees, Beehr and colleagues (2010) found evidence that some of these

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

types of attempted social support can be associated with higher levels of emotional exhaustion and even physical health symptoms, particularly when those behaviours are coming from supervisors. Deelstra and colleagues (2003) also found that getting unwanted support for a clear task was associated with higher negative affect.

APPLICATION: WHAT SHOULD I DO?

As a manager, you are in an optimal position to support employees in a variety of different situations. Based on the research evidence, we provide several recommendations for being a supportive supervisor that promotes resilience in employees. These include understanding the employee's demands, matching their demands with appropriate forms of support, and forming a supportive climate within the workgroup you supervise. These recommendations are discussed in more detail in the final section of this chapter, and are also summarised in a self-assessment format in Appendix 6.1.

Making it clear that support is available.

A problematic assumption that can be made by supportive managers is that the employees know that support is available if they need it. Ensuring routinely that employees know where and how they can access support is important, particularly for newer team members who might not be aware of various avenues for accessing support. Thus, it may be helpful to clearly convey that managers are available to help employees with different problems (e.g., getting the resources they need, talking about any difficulties in completing work), rather than making the assumption that the employees know he/she can come to them when needed.

Building an awareness of employee needs.

As with most duties of a manager, being supportive will most likely begin with coming to a better understanding of the employee's needs. It is hard to know how to be appropriately supportive without knowing what the employee's demands look like. Building an awareness of employee needs may come from prior experience in the role of the employee, if the manager was promoted from the same job. Alternatively, a manager may have to invest more time in observing employees or talking with them about their job. This can be difficult within the constraints of a manager's busy schedule, but even talking with employees about specific tasks that are difficult, time-consuming or in general stressful, can provide some useful information in knowing what to do to support them. Free programmes are also available where a manager could create an anonymous survey to administer to his or her workgroup to

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

get feedback on where employees could use more support (e.g., Google forms; Survey Monkey).

Anticipating and mitigating stressor.

A good manager may be able to prevent some stressful experiences altogether by providing resources needed or altering job duties. For example, if a company was introducing new software for tracking sales, the manager could provide step-by-step training on how to use the software to avoid the stressful situation of not knowing what to do (and not to mention adding learning the programme to their normal job duties). Managers should not underestimate the amount of stress that can be caused to employees with the introduction of new systems and software. Poor support to complement such changes can create not only harm to the employees, but also lowers morale and productivity. Prevention is better than trying to cure a problem after it occurs. Therefore, an important role of a manager in maintaining employee resilience is to anticipate the stress that can be created by change or other stressors and to develop strategies to prevent it.

Changing the way employees think about stressors.

When stressful events are inevitable, as is the case in most jobs, a manager can help the employee to adjust their perspective on the event as a whole. For example, a nursing supervisor can emphasise that though a patient is difficult, the nurse is able to serve a vital role in helping his or her health improve or potentially saving a life. Such reframing can help employees to take a new perspective on the stressful event to make it less threatening.

Considering how to best provide support.

After understanding the demands an employee experiences, a manager should consider how to best support that employee. In the opening of the chapter, some examples were provided on when a manager may have good intentions of supporting an employee, but the supportive behaviour does not match the employee's actual need. Some common issues that employees may find frustrating might be managers who always provide encouragement through conversation and communicating concern, but do not provide tangible resources or information that an employee actually needs to solve a problem. Another concern that has not received much research attention, and is likely hard to detect, could be if a manager is very supportive and the employees form a loyalty to them that can result in negative outcomes. This is likely a higher concern in jobs with high physical (or psychological) demands that could result in workplace injuries that warrant professional help. If an

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

employee does not seek treatment because he or she does not want to disappoint their manager, it could have negative long-term outcomes.

In determining the optimal form of support, managers may want to think through a few questions, such as: (1) "What is the source of this stressor?" (2) "Do I have any power to change if the employee experiences the stressor?" and (3) "Do I have any power to change how the employee perceives the stressor?" In reference to the first question, the manager may consider if the stressor is something that is more social or practical in nature. If it is an interpersonal or social issue, emotional support may be critical, while instrumental or informational support may be more helpful in addressing practical concerns. In reference to the second and third questions, managers should consider if they could change aspects of the job or work environment as a practical way to provide support instrumentally. If they cannot, they may still be able to provide emotional support or informational support to help the employee overcome the demand or perceive it in a more positive manner.

As a final consideration, a manager should think about any unintended consequences of the type of support that is provided. This is highlighted in the checklist and many of the examples throughout the chapter. Anytime a manager is seeking to help an employee they should consider factors like, whether they are jumping in too soon to offer help, if the help might make the employee feel incompetent, if the employee is missing out on learning a new skill because of their support, or if the help is over-emphasising an event as stressful. This issue may also be uncovered through seeking feedback from employees as to whether or not they feel supported appropriately.

Build a workplace environment that emphasises support.

While managers are in an optimal position to support employees in many ways, they simply cannot do it all. Even good managers with good intentions have a lot of tasks that they must get done and will not always be able to know everything that is going on for their employees. With these limitations, an important tool is to build up a work-group environment that emphasises support. Co-worker support has been demonstrated to uniquely relate to positive occupational health and organisational outcomes (e.g., Biron, 2013; Chiu *et al.*, 2015), and may benefit employees in ways that support from a manager cannot (i.e., because the manager cannot offer the same behaviours or they are less impactful coming from the manager). Other benefits of a supportive unit climate are that employees may actually get enjoyment out of helping one another! A study by Brown and colleagues (2003) found that providing support may be more beneficial than receiving support.

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

In order to achieve this, managers can consider how they can proactively set up supportive networks among work units before stressful events ever occur. Examples could include mentoring programmes between experienced and novice employees so new employees can learn more about what to expect on their job or even strategies that have been successful (or perhaps more importantly, unsuccessful) for the more experienced employees. Other examples may be training programmes on how to manage stress, information on how to receive help if experiencing a mental or physical health problem, or even how to detect when a co-worker is experiencing a problem and how to support them in that circumstance.

Practical steps may be necessary in the work context to allow enough time and resources for employees to help one another. For example, managers should be aware if an employee's job is so demanding that they simply do not have time to help their co-workers or form supportive relationships in general. They could also improve on resources available to provide help, such as potential training programmes discussed, on how to recognise and help a co-worker who may be experiencing a problem. This might also mean adjusting some of the structure of the work environment and job tasks with more flexibility and/or interdependent tasks to make it a natural and easy behaviour for co-workers to help one another as needed. Rigid schedules with little autonomy will allow less freedom for employees to foster such relationships where they can meaningfully provide support.

Reacting in a supportive way.

While recognising employee needs for support and creating a unit climate of support are more proactive measures, managers may also want to consider how to react in a supportive way after employees experience a stressful situation. In helping employees cope after a stressor has occurred, it may be important to talk about resources available or even discuss the event as a group. For example, Sattler, Boyd, and Kirsch (2014) found that participating in debriefings after critical incidents was associated with lower levels of post-traumatic stress and higher levels of post-traumatic growth for firefighters who had been exposed to trauma. This may also be an opportune time to notice signs that a co-worker may be experiencing a problem, and how to help the co-worker cope with any mental health symptoms that may result. While this may be especially important in high-risk jobs that involve traumatic events, debriefing could also be a useful practice during busy or stressful seasons in less risky work environments.

Encouraging employees to proactively seek the support they need.

Lastly, it may also be important to encourage employees to be proactive in seeking

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

support for work problems themselves. Again, supervisors cannot feasibly be aware of all employee needs at all times, so it is important that employees are aware and encouraged to seek out the resources they need, whether it be from the manager, from a co-worker, or from an outside source. One study found that employees who had emotional resources available and who were likely to seek out emotional support when needed were less likely to experience emotional exhaustion from their work (van de Ven, van den Tooren & Vlerick, 2013). Therefore, making employees aware of resources and how to access them may be a vital tool in promoting employee resilience.

FINAL THOUGHTS

There is a long history of research in social support and its impacts on wellbeing. However, it seems that not all support can yield good outcomes. Thus for managers wishing to provide good support to employees the landscape is extremely complex and it may be very difficult for them to provide support to employees in their job. Managers should be informed on how to best support a variety of employee needs, whether that is offering an ear to listen to a problem or more tangible resources to help solve a problem. This insight can come from spending the time to identify what employees would find most useful when it comes to support. Moreover, while managers are central to supporting their employees they cannot do it all. Thus, it is important to invest time in developing a supportive culture within the team or organisation. At another level, employees should be actively encouraged to proactively seek and access the support they need whether that be from managers, colleagues or professional support (e.g. mental health providers; counselors). Understanding the importance and nature of support required in your workplace and having appropriate support resources in place is critical in ensuring that the support offered is effective in helping employees build resilience and thrive in complex work environments.

KEY MESSAGES FROM THIS CHAPTER

- Not all forms of support are helpful and a manager needs to carefully consider the type of support provided to staff members.
- Inappropriate support that undermines an employee's worth, is unwanted, or that brings unnecessary attention to the stressful nature of a work situation may have some unintended consequences.
- Seeking to promote an organisational climate with high co-worker support is valuable for supporting the mental health and resilience of staff. Managers have an important role in influencing the culture of co-worker support.

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

- Managers can seek to build an awareness of employee support needs and offer support that matches these needs, encourage a supportive atmosphere among co-workers, anticipate stressor events and proactively initiate support and make efforts to ensure that employees know how to seek out resources when needed.

REFERENCES

- Akerboom, S. & Maes, S. (2006). Beyond demand and control: The contribution of organizational risk factors in assessing the psychological well-being of health care employees. *Work and Stress*, 20, 21–26.
- Barrera, M. (1986). Distinctions between social support concepts, measures, and models. *American Journal of Community Psychology*, 14, 413–445.
- Barrera, M. & Ainlay, S. L. (1983). The structure of social support: A conceptual and empirical analysis. *Journal of Community Psychology*, 11, 133–143.
- Beehr, T. A., Bowling, N. A. & Bennett, M. M. (2010). Occupational stress and failures of social support: When helping hurts. *Journal of Occupational Health Psychology*, 15, 45–59.
- Biron, M. (2013). Effective and ineffective support: How different sources of support buffer the short- and long-term effects of a working day. *European Journal of Work and Organizational Psychology*, 22, 150–164.
- Brown, S. L., Nesse, R. M., Vinokur, A. D. & Smith, D. M. (2003). Providing social support may be more beneficial than receiving it: Results from a prospective study of mortality. *Psychological Science*, 14, 320–327.
- Buunk, B. P., Doosje, B. J., Jans, L. G. J. M. & Hopstaken, L. E. M. (1993). Perceived reciprocity, social support, and stress at work: The role of exchange and communal orientation. *Journal of Personality and Social Psychology*, 65(4), 801–811.
- Chiu, S., Yeh, S. & Huang, T. (2015). Role stressors and employee deviance: the moderating effect of social support. *Personnel Review*, 44, 308–324.
- Cohen, S. & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 9, 310–357.
- Cutrona, C. E. & Russel, D. W. (1990). Type of social support and specific stress: Toward a theory of optimal matching. In B. R. Sarason, I.G. Sarason & G. R. Pierce (eds), *Social Support: An interactional view* (pp.319–366). New York: Wiley.

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

Deelstra, J. T., Peeters, M. W., Schaufeli, W. B., Stroebe, W., Zijlstra, F. H. & van Doornen, L. P. (2003). Receiving instrumental support at work: When help is not welcome. *Journal of Applied Psychology, 88*, 324–331.

Dormann, C. & Zapf, D. (1999). Social support, social stressors at work, and depressive symptoms: Testing for main and moderating effects with structural equations in a three- wave longitudinal study. *Journal of Applied Psychology, 84*, 874–884.

Ducharme, L. J. & Martin, J. K. (2000). Unrewarding work, coworker support, and job satisfaction a test of the Buffering Hypothesis. *Work and Occupations, 27*, 223–243.

Dunkel-Schetter, C. & Bennett, T. L. (1990). Differentiating the cognitive and behavioral aspects of social support. In B. R. Sarason, I.G. Sarason & G. R. Pierce (eds), *Social Support: An Interactional View*, pp. 267–296. New York: Wiley.

Fleishman, E. A. (1953). The description of supervisory behavior. *Journal of Applied Psychology, 37*, 1–6.

Fleishman, E. A., Harris, E. F. & Burt, H. E. (1955). Leadership and supervision in industry; an evaluation of a supervisory training program. Ohio State University. *Bureau of Educational Research Monograph, 33*.

Frese, M. (1999). Social support as a moderator of the relationship between work stressors and psychological dysfunction: A longitudinal study with objective measures. *Journal of Occupational Health Psychology, 4*, 179–192.

Haber, M. G., Cohen, J. L., Lucas, T. & Baltes, B. B. (2007). The relationship between self- reported received and perceived social support: A meta-analytic review. *American Journal of Community Psychology, 39*, 133–144.

Hahn, S. E. (2000). The effects of locus of control on daily exposure, coping and reactivity to work interpersonal stressors: A diary study. *Personality and Individual Differences, 29*, 729–748.

Halbesleben, J. R. (2006). Sources of social support and burnout: a meta-analytic test of the conservation of resources model. *Journal of Applied Psychology, 91*(5), 1134.

House, J. S. (1981). *Work stress and social support*. Reading, Massachusetts. Addison-Wesley Publishing Company.

Iwata, N. & Suzuki, K. (1997). Role stress-mental health relations in Japanese bank workers: A moderating effect of social support. *Applied Psychology: An International Review, 46*, 207–218.

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

- Judge, T. A., Piccolo, R. F. & Ilies, R. (2004). The forgotten ones? The validity of consideration and initiating structure in leadership research. *Journal of Applied Psychology, 89*, 36–51.
- Kaufmann, G. M. & Beehr, T. A. (1989). Occupational stressors, individual strains, and social supports among police officers. *Human Relations, 42*, 185–197.
- Langford, C., Bowsher, J., Maloney, J. & Lillis, P. (1997). Social support: a conceptual analysis. *Journal of Advanced Nursing, 25*, 95–100.
- Peeters, M. C., Buunk, B. P. & Schaufeli, W. B. (1995). Social interactions and feelings of inferiority. *Journal of Applied Social Psychology, 25*, 1073–1089.
- Ray, E. B. & Miller, K. I. (1994). Social support, home/work stress, and burnout: Who can help? *The Journal of Applied Behavioral Science, 30*, 357–373.
- Sarason, B. R., Sarason, I. G. & Pierce, G. R. (1990). Traditional views of social support and their impact on assessment. In B. R. Sarason, I.G. Sarason & G. R. Pierce (eds), *Social Support: An interactional view*, pp. 9–25. New York: Wiley.
- Sattler, D. N., Boyd, B. & Kirsch, J. (2014). Trauma-exposed firefighters: relationships among posttraumatic growth, posttraumatic stress, resource availability, coping and critical incident stress debriefing experience. *Stress and Health, 30*, 356–365.
- Shumaker, S. A. & Brownell, A. (1984). Toward a theory of social support: closing conceptual gaps. *Journal of Social Issues, 40*(4), 11–36.
- Stephens, C. & Long, N. (2000). Communication with police supervisors and peers as a buffer of work-related traumatic stress. *Journal of Organizational Behavior, 21*, 407–424.
- van de Ven, B., van den Tooren, M. & Vlerick, P. (2013). Emotional job resources and emotional support seeking as moderators of the relation between emotional job demands and emotional exhaustion: A two-wave panel study. *Journal of Occupational Health Psychology, 18*, 1–8.
- Zohar, D. (2010). Thirty years of safety climate research: Reflections and future directions. *Accident Analysis and Prevention, 42*, 1517–1522.

ENHANCING THE RESILIENCE OF EMPLOYEES THROUGH THE PROVISION OF EMOTIONAL, INFORMATIONAL AND INSTRUMENTAL SUPPORT

Kristen S. Jennings and Professor Thomas W. Britt

Excerpted from *Managing for Resilience*

APPENDIX 6.1: CONSIDERATIONS FOR MANAGERS PROVIDING SUPPORT

1. Do I engage in supportive behaviours toward my employees?
2. Do my employees actually perceive my behaviours as supportive?
 - a. Do they comment on whether they do or do not feel supported?
 - b. Do I have enough information on this? If not, consider an anonymous employee survey or conversations about how you can support them during performance appraisals or other interactions.
3. What types of behaviours do I use to support my employees?
 - a. Emotional
 - b. Instrumental
 - c. Informational
 - d. Appraisal
4. Do these behaviours match their greatest needs?
 - a. Do I know what their greatest needs are? If not, try to find out.
 - b. Are there any unintended outcomes that could come from the type of supportive behaviour I provide?
5. Am I the right person to be providing this support?
 - a. Can I feasibly help with this problem?
 - b. Could I train co-workers to support this need?
 - c. Is this something that I should bring up to upper management to initiate broader organisational changes?