

Title: The symbiotic relationship of vulnerability and resilience in Nursing

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Abstract

Background: Whilst the terms vulnerability and resilience are commonly used within professional nursing discourses, they are often poorly understood. Vulnerability is often framed negatively and linked to being at risk of harm, whilst resilience is often perceived as the ability to withstand challenges.

Aim: The aim of this paper is to explore resilience and vulnerability; re-positioning them within the context of contemporary professional nursing practice.

Design: Discussion paper.

Method: Drawing upon historical and contemporary international literature, both concepts are de-constructed and then re-constructed, examining them from the position of patient care as well as from the perspective of nurses and the nursing profession.

Conclusion: Resilience and vulnerability have an interdependent relationship as resilience comes into play in situations of vulnerability. Yet, contrary to the popular discourse they are multi-faceted, complex phenomena based on factors such as individual circumstances, supports and resources.

Keywords: Vulnerable, vulnerability, nursing, healthcare, resilience, patient care

Impact Statement:

Understanding the integrated nature of vulnerability and resilience is vital to both patients and the nursing profession.

Introduction

Vulnerability is a nebulous and contested concept that has been used ambiguously within the nursing and healthcare literature. Predominate perspectives view vulnerability from a negative position, one associated with risk and adversity often associated with potential harm or detrimental outcome (Hurst, 2008; Purdy, 2004), and the inability to protect one's self (Sellman, 2005). The links between the notions of protection and vulnerability can be somewhat restrictive and negative. This can be explained using Butler's work on performativity. Butler (2014) argues there is a relationship between individuals and wider societal infrastructures; one's existence is both performative and relational. It is relational, in that individuals are dependent upon the societal infrastructures and discourses which influence their experiences leading to associated performative behaviours. Let us take the example of older people. Within Western societies discourses, ageing may be linked to negative decline and social productivity, focussing upon frailty and weakness rather than strength and vitality (Grenier et al. 2017). This labelling of older people influences nurses' performative behaviour such as using elderspeak (Kemper et al. 1998) infantilising older people as well as through further paternalistic actions, including acting for rather than with older people, thus disempowering them. These actions, we argue, are not undertaken consciously to harm the individual but represent unconscious behaviours arising from the wider societal discourses regarding ageing. These interactions result in an unconscious performative response from the older person leading to behaviours such as passivity and deferring to the decisions made by the nurse. It is this performative and relational aspect of vulnerability which leads to vulnerability being defined in terms of weakness, failure, inequality, inferiority, and dependence (Batchelor, 2006), which is not dissimilar to labelling theory (Parker & Ashencaen Crabtree 2018).

Broader perspectives have suggested that vulnerability can be the catalyst for positive consequences and outcomes, with being open and 'openness' being the central core of what it means to be vulnerable (Purdy, 2004). Purdy (2004) suggests that being open and therefore susceptible to some form of entity or risk can create the opportunity for either positive growth or negative consequences in relation to health outcomes. A contrasting philosophical discourse perceives vulnerability as neither negative nor positive rather both, as the innate

nature of being human equates to vulnerability (Sellman, 2005). Indeed, anthropological features of vulnerability identify that human beings are poorly equipped physically and socially and therefore vulnerable (Kottow, 2004). Thus, vulnerability is a “condition humana” which affects us all (Kottow, 2003 p. 461). Considering the discourse associated with vulnerability and for the purposes of this paper, we refer to vulnerability as being context bound, individually defined and determined, and influenced by internal and external factors including societal, spiritual environmental, physical and psychological constructs.

In this paper, we explore and discuss the elusive nature of vulnerability and the particular enigma of vulnerability within the nursing context. We argue that resilience and vulnerability have a symbiotic relationship, as managing and addressing vulnerability can lead to the development of resilience, conversely a lack of resilience can lead to increased levels of vulnerability. It is also important to note that both vulnerability and resilience are not homogenous; rather they are individually defined and contextually experienced.

Vulnerability in healthcare

Early literature that posited vulnerability from a healthcare perspective, noted the need to move beyond determining vulnerability in terms of risk (etic perspective) and encapsulate the experiential nature of being vulnerable from individual perspectives (Spiers, 2000). Spiers (2000) postulated that vulnerability from an ‘emic’ perspective considers what it means to be vulnerable from lived experience and to be vulnerable is fluid, contextual and influenced by an individual’s perceptions of self, perceived risks, and coping abilities. More recently, this perspective has been further developed by Heaslip et al. (2016a) who argued that rather than a focus of either the etic or emic view, there needs to be a fusion which they term the ‘etemic’ in order to truly appreciate and understand an individual’s experience of vulnerability. This perspective embraces both the external scientific or professional perspectives of an individual’s vulnerability alongside the individual’s own personal lived experience. They argue that the fusion of both perspectives is essential in order to develop healthcare services which can truly address health vulnerability (Heaslip et al. 2016a).

Despite all individuals being vulnerable and susceptible to illness, certain groups and populations are perceived to have heightened risk of vulnerability due to some form of risk

or sub-optimal circumstance that may be environmental, social, psychological and/or physical. In order to explore this further and for consistency let's use the example of older people, for this group is often identified as vulnerable due to the conceptualisation of vulnerability in terms of risk. The labelling of older people as vulnerable can change the dynamic of the nursing relationship from one of partnership to one of power (nurse) and passivity (older person). This can occur particularly when the older person is perceived as weak or frail (Heaslip 2013), which can increase the likelihood of marginalisation and medicalisation (Thompson, 2011); and a focus on what the older person cannot do rather than what they can. This focus can then lead to negative outcomes for the health and care of the older person. Thus, although perspectives of vulnerability have broadened in scope, healthcare literature still focuses on vulnerability from a limited perspective conceptualised by risk and outcome, in addition to the seeming assumption that vulnerable groups are somewhat homogenous. By healthcare professionals conceptualising and perceiving vulnerability in a limited manner, it is possible to negate the fact that people by nature are precarious creatures and therefore all individuals are and can be vulnerable throughout and within the contexts of their lives (Herring, 2016).

Defining vulnerability through generalisations can also emphasise and enforce stigmatisation among groups who may be considered vulnerable and this can perpetuate generational vulnerability. Let's take experiences of marginalised cultural groups (such as Gypsy Roma Travellers, Australia's Aboriginal and Torres Strait Islander peoples and New Zealand Maori peoples as well as other colonised groups). A core determinant of health vulnerability at a population level is the social status of these groups in their respective countries. As social hierarchies promote intergenerational inheritance of social status resulting in a highly systemic and deterministic fashion (Furumoto-Dawson, Gehlert, Sohmer, Olopade, & Sacks, 2007), their health vulnerability is perpetuated year upon year as is evident in the health inequalities and experienced by these and other marginalised groups. For example the impact of colonisation and subsequent subjugation on marginalised cultural groups such as Australia's Aboriginal and Torres Strait Islander peoples, has led to multiple health disparities, which is further exacerbated by the lack of access to culturally appropriate services and the lack of trust in mainstream healthcare based on experience (Australian Institute of Health and Welfare, 2015; Wilson et al 2018; Wilson et al 2019).

Conversely, categorising groups as homogenous fails to recognise actual vulnerabilities (Sellman, 2005), the 'uniqueness' of subgroups and/or individuals and their experiences of vulnerability (Heaslip et al., 2016), which may encompass feelings of vulnerability associated with relationships and the self (Little, Paul, Jordens, & Sayers, 2000). Moreover, determining vulnerable groups through generalisations ignores the most vulnerable individuals and groups who are hidden within societies and communities, and who are often already overlooked and unheard from a societal and healthcare perspective such as people who are homeless. Creating defined vulnerable groups also ignores situational vulnerability (Rogers, 1997). Consider for a moment accessing healthcare, an individual enters a new relationship or environment, where there may be new terminology, new equipment, and new sounds (Heaslip, 2013). Heaslip (2013) highlights that in addition to this 'new world' is a restriction in one's social support (for example due to restricted visiting hours) as well as increased uncertainty (due to for example illness), all of which can create or perpetuate feelings of vulnerability. Yet this vulnerability may not be recognised if the patient does not fall into a traditionally perceived vulnerable group.

Vulnerability and nursing

Provision of care and advocacy for vulnerable people, are considered core principles of the nursing profession, as throughout history nurses have ministered to vulnerable populations (Drake, 1998). Yet how individuals perceive and experience being vulnerable is in contrast to how healthcare professionals may perceive their patient's vulnerability. For example, research has found that older persons' feelings of vulnerability were associated with emotional responses attached to situations and events, whereas healthcare professionals considered vulnerability in terms of the older persons' characteristics associated with risk such as physical and mental frailty (Abley, Bond, & Robinson, 2011). However, vulnerability among older people cannot only be perceived in terms of age and physical and mental decline but also by being perceived as a collective group equating to feeling devalued and at risk of societal exclusion. Furthermore, perceptions of vulnerability among older people are heightened through being sensitive to how they are treated by others, particularly in relation to the societal and stigmatising healthcare perceptions associated with the 'older person' (Sarvimäki & Stenbock-Hult, 2016).

The often negative and stereotypical views associated with vulnerable groups can be reinforced through nurses' own attitudes and perceptions (Wray, Walker, & Fell, 2008) creating further stigma and vulnerability and indeed reinforcing the potential felt vulnerability among groups. For example young women who have contracted a sexually transmitted infection (STI) have reported feeling judged and stereotyped by healthcare professionals, which can equate to perceived lack of effective healthcare (East, Jackson, O'Brien, & Peters, 2011). Yet these negative stereotypes can hinder nurses and healthcare professionals recognising individual circumstances for example how an STI was acquired that can identify personal vulnerabilities and may require attention such as within the context of abuse (East, Peters, & Jackson, 2017). In these circumstances, the vulnerability of the individual is seemingly forgotten and not given due care. This lack of care is not surprising considering people perceived to be responsible for their own health issues, for example an intravenous drug user (IVDU); an often stigmatised group, may not receive care compared to other groups who may be perceived as worthier of care due to not being responsible for their health situation, such as children (Mechanic & Tanner, 2007).

Nurses may not recognise the very nature of the vulnerability created by the nurse patient relationship. Illness creates vulnerability among patients and those who provide care (Carter, 2009). Nurses strive to provide person centred care, seek to respect and support all patients and to create a safe environment where vulnerabilities may be revealed. It is the very nature of the nurse patient relationship and the ability to provide person centred care that can recognise perceived vulnerabilities and provide individualised care that can assist in alleviating a sense of vulnerability. Moreover, a patient's vulnerability equates to a patient trusting nurses and the wider healthcare system to heal, restore and promote their wellbeing (Carter, 2009). Losing a patient's confidence and failing to establish the therapeutic relationship between the nurse and patient and indeed provide person centred care can detrimentally impact care and could exacerbate feelings of vulnerability (Carter, 2009). In addition, a patient's heightened perceived vulnerability can be further exacerbated by nurses' negative attitudes and perceptions exhibited toward patients (Angland, Dowling & Casey, 2014).

Contrary to the predominate perception that vulnerability is associated with weakness, feeling vulnerable can encourage behaviours of protection, which in some cases may equate to perceived difficult behaviours. Difficult behaviours such as aggression can result from one's ability and tendency to handle emotional situations (Anderson, 2002) and can be a reaction to feeling vulnerable. Furthermore, potential exacerbation of these behaviours can occur through patients feeling judged and nurses perceptions being based on patient characteristics (Hislop & Melby, 2003). In these circumstances, nurses often consider 'difficult' patients as burdensome, yet fail to elicit the vulnerable nature some of these patients may find themselves in and that these reactions and behaviours may be protective and actually stem from a sense of vulnerability. For example, an individual may have a lack of control within healthcare as both patients and families have limited control within the system and the physical environment, which largely lies within the power domain of the health care professional. Asserting oneself is a key facet in trying to regain control; however, assertive behaviour can be seen as challenging or difficult by nurses potentially compromising the professional relationship and the ability to provide person centred care.

Nurses' vulnerability

It also has to be acknowledged that like patients, nurses can also experience vulnerability. The very nature of nursing work can create a feeling of vulnerability in nurses themselves (Carel, 2009; Heaslip & Board, 2012). Nurses bear witness to life and death and are at the forefront to the stressors faced by patients; the very nature of being empathetic can create vulnerability. The provision of care in times of illness place nurses in a space, which requires negotiating emotions of the self, patient and family; a difficult space to navigate and a space of vulnerability (Carel, 2009). Nursing work can also highlight to nurses their own morbidity, and mortality, which in turn may increase feelings of vulnerability (Heaslip & Board 2012; Angel & Vatne 2016). Yet these feelings of vulnerability can have positive dimensions as a nurse's sense of being vulnerable can assist them in recognising patient emotions and the importance of empathy, however if not managed it can become burdensome and lead to emotional burnout (Stenbock-Hult & Sarvimäki, 2011). Emotional labour and burnout can lead to task orientated care and nurses being on 'pilot mode' that may negate person centred care, the therapeutic nurse patient relationship and can increase vulnerabilities among both nurses and patients.

Nurses are also vulnerable to harm in the form of violence and bullying (Hutchinson et al 2013), and considerable work has been done to try to understand workplace violence nurses are exposed to (Luck et al 2006). It has been postulated that the workplace violence inclusive of bullying is felt, witnessed and experienced among the majority of nurses, with workplace violence being a common and continuing concern for the nursing profession (Hutchinson et al 2013). Nurses are more vulnerable in certain environments such as the emergency department (Gacki-Smith et al., 2009) or whilst working with certain patient groups such as older people (Scott et al. 2011; Jackson et al 2014). Research among nurses working in emergency departments in the USA (n=3465) found that approximately 20-25% of nurses frequently experienced verbal and physical abuse respectively (Gacki-Smith et al., 2009). Whilst research conducted in Ireland with nurses and care assistants working in care homes (n=112), identified that in the preceding year 68.8% (n=77) of the staff had been involved in an incident where they feared for their personal safety and a further 71.4% (n=80) of staff had witnessed an incident where they feared for the safety of a colleague. (Scott et al. 2011). As previously highlighted, nurses vulnerability to abuse can be a result of a number of factors including patient perceptions associated with nurse behaviours and attitudes such as perceiving a nurse to be uncaring (Gacki-Smith et al., 2009), the nurses themselves exhibiting negative attitudes toward patients due to stress and their own perceptions associated with patients (England, Dowling & Casey, 2014), as well as the unpredictable nature of how illness affects patients such as delirium (Somes et al 2011). However, Scott et al, (2011) identified that avoidance, being wary of the individual and withdrawing from them were common nurses' responses and this has implications for patient care.

Vulnerability and resilience

As we have noted vulnerability is not a static concept, rather it is multidimensional and dynamic (Adger, 2006; Mechanic & Tanner, 2007). Circumstances, situations and multiple factors can influence vulnerability, making vulnerability a fluid concept which can be transient, chronic and even cumulative across the lifespan (Adger, 2006; Mechanic & Tanner, 2007). Like vulnerability, resilience is a dynamic concept and multidimensional, being influenced by psychosocial, personal and physical circumstances (Rutter, 2012). In addition,

an individual or groups resilience can vary over time and across the lifespan (Rutter, 2006). Therefore, both vulnerability and resilience are variable and contextual in nature.

Within the literature, there is no universal definition of resilience (Herrman et al., 2011), rather, resilience is generally defined and associated with the ability to adapt or overcome some form of adversity (Herrman et al., 2011; Rutter, 2006). Within the nursing literature, resilience has been described as an 'active process' pertaining to the ability to positively adjust and move forward in the face of adversity (Jackson, Firtko, & Edenborough, 2007); a term used to describe personal capabilities to maintain balance in negative circumstances (McDonald et al 2013); an essential element of human nature needed for survival, promotes empowerment and is fostered by support, spirituality (Babatunde-Sowele et al, 2016), having one's voice and story heard (East, et al., 2010), resisting oppression (Jackson et al., 2011) and mitigating the impact of adversity (Jackson et al., 2012). In relation to the provision of nursing care, a partnership approach which includes patient involvement can foster resilience and recovery (Lee, et al., 2018) Traynor (2017) also suggests that "critical resilience is about understanding ourselves and our experiences in relation to our society" (p. 29), and that nurses need to be informed to become critically resilient.

Other literature postulates that resilience is the ability to maintain physical and psychological balance when experiencing traumatic circumstances and is individually determined as people will respond to adversity in differing ways (Bonanno, 2004). Some will cope with little disruption in their lives whilst others may be overcome by personal adversity and unable to find a way to move forward (Bonanno, 2004). Therefore, like vulnerability, resilient individuals and groups are not homogenous. Both individuals and groups exposed to the same adversity will have various levels of adaption and outcomes (Rutter, 2006, 2012). More recently there has been an increased focus on the role of resilience in the context of public health (Seaman et al, 2014), recognising the role that organisations and institutions have in creating and managing vulnerability as well as shaping individuals' capacity to react to societal challenges. We suggest resilience, like vulnerability is context bound, associated with personal circumstances and attributes and is influenced by both internal and external factors.

Resilience and vulnerability are similar contextually as both concepts resonate with adversity (Scholz, Blumer, & Brand, 2012). An individual's experience of the level of vulnerability can be influenced by their ability to manage and mitigate risk. Having known and perceived risks that potentiate vulnerability can establish safeguards and protective mechanisms that can foster resilience (Scholz et al., 2012). On the other hand, as being vulnerable or being exposed to adversity can increase resilience, exposure to adversity can also potentiate vulnerabilities (Rutter, 2006). Vulnerability and resilience are also based on self-perceptions, circumstances and constructs. For example research has found that religion, gender and social constructs, in addition to personal and social relationships influences both perceived vulnerability and resilience to HIV/AIDS (Saddiq, Tolhurst, Laloo, & Theobald, 2010). Likewise, other literature has asserted that social circumstances, networks, culture and both the sense of self and typical stereotypical views can influence perceived vulnerability and/or resilience to HIV infection (Glenn & Wilson, 2008).

Despite the vulnerable or resilient nature of individuals and groups both concepts need to be considered in relation to the self, perceptions, attributes, adversity, risk and circumstances, in addition to the social and individual context of one's life (Herrman et al., 2011). Thus, conceptually, resilience and vulnerability are concepts that are interwoven and not independent from one another, with both being reliant on individual circumstances and temporality. As previously identified nurses can experience vulnerability, due to incidents of violence, facing one's own mortality and emotional labour associated with their role. Yet despite this vulnerability, nurses have to also be resilient, to ensure that these felt vulnerabilities are not overwhelming, as such they need to adapt accordingly. Research with nurses by Benadé et al, (2017) identified that nurses managed this by utilising different strengths (personal, professional, contextual and spiritual) in managing their vulnerability, all of which increased their resilience. These strengths reflected a balance of personal attributes such as personal values (caring), attitudes (being positive), beliefs (religion) alongside their professional skills (communication) within the contexts they were working (work environment, support available). A focus on resilience within the nursing workforce is essential as resilient nurses are more likely to remain in the workforce (Turner 2014), which is of vital concern due to the international nursing shortage crisis.

Ultimately vulnerability can never be eradicated; as it is a human experience within a given context and although it may be perceived as negative, individuals can grow from vulnerability and in that growth, can be resilient. However, the multi-faceted nature of vulnerability and resilience has to be recognised as they are dependent on individual circumstances, supports and resources, because of this they are not static but fluid due to their contextual nature which varies across the lifespan.

Impact Statement:

Vulnerability and resilience are key concepts for nurses. Nurses work with individuals experiencing vulnerability, and seek to promote resilience in those living with illness. These concepts are also vital from a professional perspective in both understanding the vulnerability experienced by the nursing profession as well as promoting resilience in the professional workforce. This paper has taken a critical exploration of these concepts and how they manifest within the clinical community, as understanding the integrated nature of these two distinct concepts is vital to both patients and the nursing profession.

Conclusion

Vulnerability and resilience are context bound and individually determined. Both patients and nurses can experience vulnerability within the same shared experience, which can be exacerbated by the self, the influence of others, and impacted by environmental and societal factors and discourses. It is vital that nurses recognise how their own perceptions, attitudes and behaviours can perpetrate experiences of vulnerability among patients for who they provide care. Of equal importance is the recognition of how the nurse patient relationship and the provision of person centred care can foster resilience through minimising felt vulnerabilities as well as critical reflection of one's personal beliefs and practices, becoming consciously aware that vulnerability and resilience are contextual and have a symbiotic relationship.

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