Resilience and Professional Chaplaincy: A Paradigm Shift in Focus

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Research into the area of resilience provides a challenge and a great opportunity for professional chaplaincy. In this article, we will consider the challenge that the research primarily of George Bonanno of Columbia University offers to the traditional, clinical perspectives and assessments of professional chaplains serving in health care. Secondly, we will propose the practical implications for a wider paradigm and an expanded focus on intentionality and interventions of chaplains. Resilience is seen as a positive response possibility for those facing potentially traumatic events. It is understood to be a predominant response to traumatic events more often than the grief recovery model usually presumed to be active. Resilience has heuristic value and merits being factored into professional chaplaincy as it relates to patient assessment, interventions, interdisciplinary care, staff and corporate support, and transcultural usefulness.

KEYWORDS chaplaincy, resilience, spiritual assessment

Professional chaplaincy in hospitals has historically focused on caring for those who, under stress, are experiencing injury or illness, chronic grief and/or recovery from grief due to the changes in health or other life events. Pastoral care, as it was called at the beginning of the movement, understood good care to be welcoming the patient’s expression of feelings of concern, grief, pain, fear, anger, and so forth, as pathways to recovery of spiritual, emotional, and physical health (Cadge, 2012). The founders of the Clinical Pastoral Education (CPE) movement “drew insights from theological liberalism, philosophic pragmatism, Freudian psychology and religious existentialism” (Cadge, 2012, p. 26). Disease, suffering, and sorrow were

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losses that needed to be "worked through" in order to move back to a place of normal work and love. Grounded in a developing medical model of care (Lee, 2002), professional chaplaincy devoted itself to the practice of providing a caring, nonjudgmental ministry of presence, giving sufferers support, the possibility of catharsis, the opportunity to work through their grief, and new ways to cope until their health returned to normal status.

The genius of CPE was to merge a model for the clinical training of ministers with a model for patient care. Classical CPE focused on the defenses of students in order to break through to a genuine experience of feelings, with the belief that there would follow a new capacity to understand and be connect with their patients and each other (Bruder, 1971, 1972). As the student became more capable of this authenticity, so—it was hoped—would the spiritual care of the patient deepen the patient's exploration and processing of his/her own grieving and healing experience. The patient was also assumed to be in denial if feelings of grief and stress were not expressed in a timely manner. There can surely be no doubt as to the power of presence to evoke healing experiences of acceptance, forgiveness, faith, and love. Clergy trained in this model of care became sensitive caregivers to those in distress (Jankowski, Vanderwerker, Murphy, Montonye, & Ross, 2008). And so it has remained to this day. Our care attends to the present needs, distresses, and hopes of the patient. As medical personnel care for wounded bodies, so chaplains care for wounded spirits.

PARADIGM SHIFT

Glenn A. Richardson (2002) at the University of Utah observes that a paradigm shift has been occurring away from a "reductionistic, problem-oriented approach [to grief].... Resiliency and resilience have emerged as intriguing areas of inquiry that explore personal and interpersonal gifts and strengths that can be accessed to grow through adversity" (p. 307). Hasui (2009) notes that a shift in research occurred in the 1970s from maladjustment to trauma to "personal attributes that protect people from developing such maladjustments when exposed to life's adversities" (p. 15). It is because of this adjustment that a significant new dynamic was opening.

A case in point is the research of George A. Bonanno (2001, 2004). His studies on grief and grief-work have challenged the conventional understanding of how humans respond to loss and other potentially traumatic events (PTEs). He has argued, first, that there is no clinical evidence for the received wisdom that grief is always traumatic to the extent of derailing persons from normal life pursuits, thereby requiring extensive mental and emotional effort to overcome. Second, he proposes that humans are actually endowed with natural capacities of resilience that enable them to adapt to
changes as part of the normal flow of life, such that they may not experience the need for grief work at all.

Bonanno's studies show that a significant percentage of persons experiencing major loss, as high as 63% (Bonanno, 2012), does not devolve into such a state that they are severely limited by grief. Some individuals who suffer a major loss feel overwhelmed by it and do not function normally for years, exhibiting a pattern of chronic dysfunction. Other individuals are distressed for months before eventually recovering to their previous levels of functioning. Others have moderate symptom levels and distress, before slowly worsening, exhibiting a pattern of delayed distress. Finally, there are other individuals who continue to function after the loss, suggesting they have some form of psychological resilience (Bonanno, 2004, 2012).

Quale and Schanke (2010) defined the resilience outcome for those experiencing a physical injury as the ability "to maintain relatively state, healthy levels of psychological and social functioning and to maintain positive emotions and a positive perception of self and the future" (p. 13). In keeping with Bonanno’s (2004) findings, some persons who endure traumatic events may continue to function well and feel optimistic, rather than become deeply distressed and grief-stricken as a result.

As previously mentioned, Bonanno's research (2004) revealed four possible pathways in responding to PTE: chronic grief, delayed grief, the recovery trajectory, and resilience. Figure 1 illustrates prototypical trajectories of adjustment following a PTE. The vertical axis indicates the level of disruption in normally functioning. These four paths were examined in a study on depression and anxiety following spinal cord injury (Bonanno, 2012). Contrary to expectation, the largest percentage of patients over 50% were found to be

FIGURE 1 © American Psychological Association. Reproduced by permission of American Psychological Association. Permission to reuse must be obtained from the rightsholder (see Bonanno, 2004, p. 21).
on the *resilience* pathway (Bonanno and Mancini, 2008, p. 369). Persons with *chronic* and *delayed grief* continued to endure traumatic grief reactions because of a pre-existing orientation or later emergence of a grief response. Those in *recovery* suffered major disruption at first, followed by a lengthy period working through and adjusting to the trauma. Those persons with *resilience* returned to normal levels of function relatively soon. Individuals with resilience (Bonanno and Mancini, 2012) are able "to maintain relatively stable, healthy levels of psychological and physical function... as well as the capacity for generative experiences and positive emotions" (pp. 77-78). Rather than a major grief reaction being the predominating and typical response to trauma, many persons seemed to be endowed with a natural capacity of *resilience* that enabled them to adapt to change as part of the normal flow of life, such that they did not experience the need for grief work at all.

Note especially the lines for "recovery" and "resilience." The recovery cohort follows the traditionally expected process of grief work, which slowly progresses over time until individuals return to their normal level of functioning. The resilience cohort remains relatively stable with little disruption in normal functioning in response to a PTE. "Grief work" became the standard for understanding the reaction to loss (Zolli & Healy, 2012). Thus, "recovering" from loss through the grieving process became the norm. Bonanno’s studies challenge this standard model. While the members of the resilience group undoubtedly feel the effects of grief they are not immobilized by it. Rather, they are “capable of functioning with a sense of core purpose, meaning, and forward momentum in the face of trauma” (Zolli & Healy, p. 126). As Bonanno puts it, "Resilient individuals, by contrast, may experience transient perturbations in normal functioning (e.g., several weeks of sporadic preoccupation or restless sleep) but generally exhibit a stable trajectory of healthy functioning across time, as well as the capacity for generative experiences and positive emotions" (Bonanno, Papa, & O’Neill, 2001; Cf. Mancini, 2006).

NEW THESIS

If Bonanno and others are correct about a resilience pathway of responding to a PTE, professional chaplaincy needs to have a paradigm shift in focus that will enable us to recognize that there are indeed several pathways of responding to traumatic events—not just the normal grieving process or psychopathology. While health care chaplains are generally caring for persons in the early hours and days of crisis and trauma, chaplains need to be cognizant of resilience factors that might be emerging and could well be affirmed and supported early on in the patient’s experience. Indeed, active and empathic listening should well pick up the signs of resilience factors coming on-line to deal with the traumatic event. Our western spiritual, medical, psychological, and social science culture
TABLE 1 Perspectives and Behaviors Associated with Resilience

| Positive emotions                          | Bonanno 2004; Bonanno and Diminich, 2013; Mancini and Bonanno, 2009 |
| Support of family, friends, and/or social resources | Bonanno, 2004, 2005, 2012; Mancini and Bonanno, 2009 |
| Awareness of one's own feelings and the ability to control one's emotions | Jackson, Firtko, and Edenborough 2007; Mancini and Bonanno, 2009; Bonanno, 2005; Bonanno and Diminich, 2013; Mancini and Bonanno, 2009 |
| Optimism                                   | Friedman, 2006 |
| Flexibility                                | Bonanno, 2005; Bonanno and Diminich, 2013; Mancini and Bonanno, 2009 |
| Spirituality                               | Jackson, Firtko, and Edenborough 2007 |
| Sense of humor                             | Bonanno, 2004 |
| Pragmatic, problem-solving approach        | Mancini and Bonanno, 2009; Bonanno, 2012 |
| Overly high self-assurance and self-confidence | Mancini and Bonanno, 2009 |
| High adaptability                          | McMurray, 2013; Mancini and Bonanno, 2009 |
| Sense of control of one's life, belief one can make a difference | Bonanno 2004, 2012 |
| Belief that life has meaning               | Bonanno 2004, 2010 |

has been tuned in to disease (brokenness), pathology (alienation), symptoms (sin), and treatment (redemption). Be that as it may, another mindset needs to emerge that recognizes a different healing trajectory. Resilience may indeed represent a non-dualistic, more life-affirming positive perspective that appreciates the complexity and the potentiality of life well lived.

As the analysis of various responses to traumatic events has progressed, a number of characteristics have been associated with a resilience outcome. Table 1 shows a list of perspectives or behaviors that have been connected to resilience.

One resilience study focused on highlighting general categories from which specific capabilities are drawn. These included “personal competence,” “tolerance of negative affect,” and “positive acceptance of chance” (Connor & Davidson, 2003, p. 80). The presence of positive attitudes, that is, optimism, positive emotions, and self-confidence, can be understood as existing resources that provide for an orientation toward change and adaptation. Flexibility and planning skills draw on capabilities useful to one needing to work toward a new, post-traumatic reality. In the field of research with cancer survivors and others, a number of themes have also been connected with a resilience outcome (Jacelon, 1997) (See Table 2).

A rich inventory of perspectives, behaviors, and styles is developing to catalog the resources that persons who have resilience may have. Richardson (2002) catalogues an extensive list of resilience-producing attributes from the school of positive psychology: happiness, subjective wellbeing, optimism, self-determination, creativity, morality, self-control, gratitude, forgiveness, dreams, and humility.
TABLE 2 Other Resilience Traits (Jachel, 1997)

<table>
<thead>
<tr>
<th>Trait</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Equanimity</td>
<td>Balanced perspective on one’s life</td>
</tr>
<tr>
<td>Self-reliance</td>
<td>Belief in oneself and capabilities</td>
</tr>
<tr>
<td>Independence</td>
<td>Ability to act on based own ideas and needs</td>
</tr>
<tr>
<td>Determination</td>
<td>Commitment to follow through on one’s own plans</td>
</tr>
<tr>
<td>Invincibility</td>
<td>Belief that one cannot be defeated</td>
</tr>
<tr>
<td>Mastery</td>
<td>Professional level of achievement</td>
</tr>
<tr>
<td>Resourcefulness</td>
<td>Creative access to assets and applications</td>
</tr>
<tr>
<td>Perseverance</td>
<td>Able to endure and continue on</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Ability to achievement goals</td>
</tr>
<tr>
<td>Superior cognitive skills</td>
<td>Intelligence and thinking skills</td>
</tr>
<tr>
<td>Positive responsiveness to</td>
<td>Open and accepting of others</td>
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</tbody>
</table>

It remains a mystery how the various factors of resilience actually come together to create such an outcome, according to Bonanno (2012). Simple one-to-one correspondence of cause-and-effect of qualities does not reflect the complexity and creative of the mind and spirit. As he observes, “Resilience, in other words, is not likely to result from one or even several factors but rather from multiple independent risk and protective factors, each contributing to or subtracting from the overall likelihood of a resilient outcome” (Bonanno & Mancini, 2008, p. 372).

IMPLICATIONS

Giving attention to resilience within the experience of patients has wide implications for professional chaplains and other professionals. First, this broader paradigm would allow the trained chaplain to note the emergence of the resilience factors and not see them as denial or defensiveness. Chaplains might well be able to identify for the patient or family member some of the perspectives, traits, and behaviors that the chaplain observes that might produce adaptation and new creativity. When resilience is at work one would not see the expected descent into grief from which recovery would be the necessary route. The ministry of the chaplain remains vital in being present, understanding, and responsive to these qualities exactly the same as one would be to the expression of sorrow, loss, anger, anxiety, and so forth.

Making accurate spiritual assessments would expand to note the presence of possible resilience qualities. It is oftentimes true that chaplains are present primarily in times of crisis when the loss or diagnosis is very painful. Being with the person through the experience of the moment is the task at hand. Should the chaplain have the opportunity to be with the patient further into their process, assessments of resilience might become possible. To facilitate the recognition of potential resilience factors, Mancini and Bonanno (2006) suggest that caregivers “do not recommend therapy for all bereaved persons” and should “beware of pathologizing resilient responses to loss or traumatic
events" (p. 978). In addition, they counsel caregivers to be attentive to iden-
tity issues, to express feelings that allow for positive feelings, and to encour-
gage emotional control and self-disclosure.

Second, when an assessment of potential resilience factors is possible,
the chaplain may note this to other team members. Resilience factors are
powerful resources for adaptation that could be useful in understanding and
encouraging the healing process of the patient. The presence of a weak-
ess of resilience factors could also be a negative indicator for recovery
experience. Expectation of grief denied or delayed is not the sole diagnostic
framework of chaplains, but is a common issue within traditionally trained
health care clinicians, doctors, nurses, social workers, among others. Many
caregivers search for problems, concerns, needs, and/or unexpressed issues
that are being avoided. The work of Bonanno strongly suggests that there
are a variety of potential dynamics going on in people who are undergoing
major life-altering events, including resilience. Mancini and Bonanno (2006)
suggest clinical practices that would be suitable for spiritual care and other
caregivers in the hospital setting, and should resonate with current standards
of care (see Table 3). These practices embody the spiritual care of profes-
sional chaplains.

Third, there are implications for interventions that could build up resil-
ience capacities. The phenomenon of neuroplasticity suggests that old path-
ways may be strengthened and new ones created. In other words, resilience
may be developed or learned. After disaster strikes, biochemical, genetic,
and behavioral factors act together to restore our emotional equilibrium (Stix,
2011). Adaptability with respect to emotions, memory, alternative selections
of behaviors, and enhanced narrative functioning indicate the viability of
fresh resources for encountering dramatic change (Mowbray, 2011; Siegel,
2006; Viamontes, 2006). Whereas such processes require time and invest-
ment on the part of the patient, chaplains may be in a position to suggest
hospital and community resources that can assist patients in pursuing resil-
ience enhancing treatments. Chaplains need to be careful not to expect or
anticipate resilience mobilization where it has not been in evidence before.

**Table 3** Caregiver Standards of Care (Mancini and Bonanno, 2006)

| Nonjudgmental listening and presence, creating a safe atmosphere |
| Demonstrate willingness to be empathic and accepting of self-disclosure |
| Avoid valuing only expressions of negative, painful emotions |
| Recognize indications of self-continuity with the patient’s experience |
| Note adaptive choices and behaviors |
| Support positive changes in emotions, perspectives, and the development |
| of creative meanings |
| Recognize expression and suppression of feelings |
| Support person’s process indicating resilience or recovery |
| Indicate resources that the person is drawing on to manage their lives |
Fourth, resilience is a capacity that is essential in persons who work under the demands and strains of health care (Hatler & Sturgeon, 2013; Pipe et al., 2012). The entire hospital staff is challenged to care for patients at the highest levels at all times. Resilience is an essential resource against high stress, compassion fatigue, and burnout. In-services and events that highlight resilience and provide training to notice and build up resilience factors could prove very beneficial. This would provide a different approach to risk detection, problem solving, and diagnostic approaches that are mainly problem-focused.

Fifth, the language of resilience has the extraordinary value of being user-friendly in a diverse, multidisciplinary, and multicultural environment. The variety and abundance of descriptive language is very illuminating. Religious, even spiritual, language carries baggage that might produce confusion and misunderstanding and thereby reduce the effectiveness of spiritual care providers. Words like optimism, self-reliance, flexibility, and resilience are positively neutral and communicate clearly.

The work of Bonanno and others who research resilience suggests both the challenge and the opportunity for a significant reimagining of the chaplaincy paradigm of care. Broadening our focus will open fresh possibilities for our patients, our hospital colleagues, and our ministry.

REFERENCES


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