THE HEALING CIRCLE: RESILIENCY IN NURSES

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The concept of resiliency has been explored extensively in the fields of developmental psychology as an adaptive life process. Increasingly nurses have begun to study resiliency in a wide variety of settings and client populations. This article explores the concept of resiliency in nurses. Resiliency was described through the use of personal exemplar, tracing the author’s odyssey of nursing homeless men in an emergency shelter. The author proposes that the traits of resiliency in nurses are widespread and largely unrecognized. There is a pressing need to cultivate and foster personal growth in nurses because we cannot give our patients what we do not possess ourselves.

His name, he told me with a broad grin was, Johnnie Jack Sullivan. He was a large bear of man, standing well over 6’3”, weighing in at close to 300 pounds, and yet his face belied his massive size and was oddly small and child-like. He was one of the first homeless men whom I met in the overflow shelter where I had come to work in the winter of 1989.

Unlike most of the other men, he came to the door of my make-shift clinic frequently during those first few nights of the clinic’s operation. He was like a great circling bird. He would walk around the confines of the National Guard Armory where the emergency shelter for homeless men was located, circle back to my door and poke his head in. “Hello nurse,” he would say, and then just as quickly disappear again and resume his pacing throughout the facility. His head bobbed as he walked, his eyes scanned up and down, only God knew what information he was...
gathering. The other gentlemen in the shelter were less inclined to come to my door, or to even acknowledge my existence, for that matter. The shelter had just opened and my tiny nurse’s clinic was off to a very slow start.

The emergency shelter had been established that winter in response to a desperate need for additional shelter beds in the city of Boston. There were thousands of homeless men and women in the city and the existing system was strained beyond capacity. With the existing shelter beds filled and hundreds of additional homeless people sleeping on plastic mats in shelter lobbies, hundreds more were sleeping in any one of the places where homeless people sought shelter from the cold in the city: public alley-ways, over the heating grates at the public library, ATM machine booths, anywhere that would keep them alive during the brutal Boston winter. A National Guard Armory had been opened for the purpose of providing 200 additional beds for the homeless during that frigid winter. The shelter was a primitive operation. In homeless shelter patois, it is often said that people receive “three hots and a cot,” meaning that they are fed three meals a day and receive a bed to sleep in. Not so in the Armory. This shelter provided one very skimpy bagged lunch and a hard army cot.

I wish I could say that my decision to become a community health nurse, specializing in vulnerable populations like the homeless, was the result of careful deliberation and research, but it was not. I entered the world of homeless nursing at a pivotal point in my life, both personally and professionally. I went to the job not entirely sure that I wanted to be a nurse any more; the flames of nursing burnout were licking at my feet. I had a tendency at the time toward rather rigid thinking and I felt that a decision was called for: I needed to decide “to be or not to be” a nurse. I was a modern day Hamlet of the nursing world. Fortunately, I was blessed with friends who saw beyond my rigidity of thinking to the deeper unfolding of my soul. A good friend had told me about a six month opportunity to work as a nurse manager in the emergency shelter clinic. I was desperate for a change from working in an ICU and my friend talked me into giving nursing one last try before abandoning my career. I decided to apply for the job.

Like many other nurses, I grew up in a family where addiction was rampant. One of the survival traits that have been explored in individuals coming out of families that have struggled with addictions is resiliency. I did not recognize it at the time, but when I walked into that shelter, I thought I was looking for a job. I now recognize that I was about to embark on my own journey of healing and that it would be my own resiliency skills that would sustain me through those first difficult months
There is an old saying that “water seeks its own level.” I might say that we seek the places where we need to be in order to find the healing we need. In this setting, I was to discover what it meant to be both healer and healed.

The concept of resiliency has been explored extensively in the domain of developmental psychology. Resilience has been described by these scholars as a life process where children of disturbed or incompetent parents learn to adapt to adverse circumstances through a variety of coping strategies and are able to flourish despite sometimes overwhelming obstacles (Dayton, 2000; Werner & Smith, 1992; Wolin & Wolin, 1993). The resilient person is one who is able to function psychologically at a level far greater than expected, given the person’s earlier developmental experiences (O’Connell-Higgins, 1994). Wolin and Wolin (1993) believed that, over time, children with resiliency developed in seven crucial areas that allow them to overcome their personal adversities. These areas include insight, independence, relationships, humor, morality, initiative, and creativity.

The concept of resiliency has increasingly found its way into the nursing literature (Tusaie & Dyer, 2004). Nurses in all domains work with individuals and communities whose daily lives are defined by circumstances of extreme adversity and for whom resiliency is a way of life. In a concept analysis of resiliency, Dyer and McGuinness (1996) identified the following critical attributes of the concept: rebounding and carrying on, having a sense of self and determination, and being pro-social. The main antecedents to the concept of resiliency were identified as a sense of mastery and effective coping skills.

Polk (1997) attempted to develop a middle-range theory of resilience and to develop a nursing model of the concept. Polk described resilience as “the ability to transform disaster into a growth experience and move forward” (1997, p. 5). The defining characteristics of resilience were classified as four patterns that manifest a larger underlying pattern of resilience, with each pattern contributing both individually and energetically to the support of the person. The four patterns include: dispositional patterns, relational patterns, situational patterns, and philosophical patterns. The development of this theory was the result of a concept synthesis conducted by the author. Polk’s work was influenced by the work of nursing theorists Martha Rogers and Margaret Newman (Polk, 1997).

Nurses in practice settings have studied the concept of resiliency extensively in a variety of patient populations, from pediatric populations (Childs, Sepples, & Moody, 2003) to elders (Neary, 1997; Racher, 2002). Nurses have examined the concept of resiliency as applicable to
vulnerable populations such as battered women (Humphreys, 2003) and persons recovering from psychiatric disabilities and living with mental retardation (Lustig, 1999; Ridgway, 2001). Whole communities have been described as displaying characteristics of resiliency (Kulig, 2000). Resiliency is not merely the attitude of seeing the proverbial glass as “half-full,” rather it is a dynamic life process whereby the capacity for adaptation can mean the difference between a full and happy life versus a life of despair and dysfunction.

Resiliency is a primitive and powerful survival skill that is not the exclusive domain of human beings. Those who study resiliency have often turned to the world of animals to understand the concept. Resiliency has been noted in other primate species. In the Discovery Channel Film, Why Dogs Smile and Chimpanzees Cry (Fleisher, 1999) the traits of resiliency are brilliantly explored.

In a troop of chimpanzees, a male infant chimpanzee, Sashimi, was left orphaned. In the matriarchal world of chimpanzees, an orphaned chimp such as this would normally be expected to die. One of the traits of resiliency is the ability to attract parent surrogates, often through the use of intelligence and charm. Sashimi displayed unusually developed resiliency skills by charming his way into a pack of adult male chimpanzees, earning their care and protection. He did this through displaying advanced social skills, offering the males affection, and constant grooming. Such an adoption by males is extremely rare and it was Sashimi’s resiliency, manifested through these social skills and playful charm that won the group over and forged the bond (Dayton, 2000).

During one incident, Sashimi was injured by another young male during a fight and had his finger badly bitten. Rather than retreat to nurse his wound alone, Sashimi located himself in the middle of the troop and wailed in a pitiful manner. While normally it would be the mother of the chimp who would offer comfort for such an injury, Sashimi the orphan had none, yet his cries aroused the compassion of the troop. Slowly troop members came to where he was lying in a pitiful posture, upside-down on a tree branch, and offered tender gestures of comfort. This behavior exemplifies one of the traits of resiliency, the ability to seek alternative forms of nurturing and love, however limited the alternative resource might be; one resilient survivor described her life as a child as having the ability to “feast on crumbs” (Dayton, 2000, p. 291). Sashimi found, as many human beings do, that a person may not live on bread alone, but crumbs can keep one going for a long, long time.

Meanwhile, back at the emergency shelter, things were not going well. In the alien world of the homeless shelter, I found myself, like poor Sashimi, motherless and alone in a strange new troop, whose cultures,
norms and even grooming rituals were completely unknown to me. I needed to muster all of my survival skills and nerve just to walk through the door each day. Perhaps, because my life story is not entirely unlike poor Sashimi’s I had some pretty well-developed resiliency skills myself, so that I didn’t run shrieking out of the job interview, back to the safety of the well-ordered ICU when I had my first experience of the emergency shelter.

On the day of my job interview for the position of nurse manager of the homeless shelter nurse’s clinic, I arrived nattily attired in my “get a job pantsuit,” with the requisite packet of crisp resume, nursing license, current CPR card, and letters of reference in hand. I was met by a young woman, Julie, wearing torn jeans and a baggy sweater and wild, long hair that she was forever pushing out of her eyes, who identified herself as the Assistant Director of the Shelter. She looked at me as if I had just blown in on a space shuttle from Mars. Most of my nursing career had been spent working for the Veteran’s Administration (VA) and now I felt like Dorothy in the Wizard of Oz. I clearly wasn’t in Kansas anymore. In fact, Julie did not feel it necessary to even interview me. “When can you start, tomorrow?” she asked hopefully. Most normal people would have taken that as a clue to run, but I did not, despite the red alarm warnings that sounded blaring horns in my head. “Wouldn’t you like to interview me first?” I inquired. “Oh no, Terri says you’re fine,” Julie responded. Terri was the friend who had told me about the job and was working as a nurse in a local alcohol rehabilitation program associated with the shelter.

That was it, “fine.” My entire nursing career summed up in one word, “fine.” There were no questions about my nursing assessment skills, my ability to respond to emergency situations, my work habits, my thoughts on working as a member of a team. Julie then went on to explain how this shelter was different from all others, how it was not oppressive or paternalistic. She further explained that most of the staff were artists and musicians who did this “gig” to support their art and because it was a good cause. She might as well have been speaking Mandarin Chinese; I understood nothing of what she talked about. There was not much talk of oppression and paternalism at the VA. Our talk ended without her asking me the mother of all interview questions, “Where do you want to be in five years?” I wanted to answer that question. I wanted to say, that in five years I wanted to be back in the crisp, khaki embrace of the United States government serving America’s veterans, anywhere but this strange, strange place. If I clicked my heels three times would I get back home, I wondered?

Julie went on to inform me that the label “nurse manager” was a bit of a misnomer, since I was going to be the only nurse hired. The management
aspect would primarily be of myself and overseeing the operation of the yet-to-be-developed nurse’s clinic for the 200 homeless men who would utilize the emergency shelter.

Julie then led me to a small, windowless concrete room that was dirty and bare except for a battered desk and a small equally battered exam table. “This is your clinic!” she exclaimed proudly. Terror gripped my heart. “Where are the supplies?” I asked. I was coming from a world of intra-aortic balloon pumps and cardiac output machines, where there were computers at the bedside, a world where a nurse could be drawn and quartered for not adequately re-stocking her bedside table with supplies. A clinic without a single supply was unimaginable. “Oh, I didn’t think of that,” she said. “I guess you’ll have to get some in the CVS.” Good God, this was like being Florence Nightingale in the Crimea and not a single window to open.

I was accustomed to the pseudo-military jargon of the VA. I knew, being the keen observer of human beings that I was, that with Julie there would be no talk of annual leave, sick leave, or the proper procedure for leaving the post, and I was quite sure that I would never be mandated to fill out a form in triplicate. I suddenly longed for the smell of hospital disinfectant, to wash my hands in Hibiclens soap and be done with this silly experiment. Julie, however, was oblivious to my reservations. “Well, what about it, can you start tomorrow?” she asked again. I then displayed another trait of a person who had grown up in a home with addictions and who was still in the early phases of healing, the inability to say no. “Sure, I guess,” I said, despite the fact that I was still working at my other job and despite the fact that I had profound reservations about the job. “I guess I can, yeah sure, I can start tomorrow,” I stammered, not believing the words that were coming out of my mouth. And so it was, a homeless nurse was born, albeit prematurely.

I was putting on my coat to leave when Julie stopped me, “Oh, don’t go yet,” she said, “the counseling staff are just getting out of their meeting and I thought that you could give them an in-service on seizure disorders.” I froze in my tracks and stared at her thinking, “Holy Mother of God, what now, an in-service? This woman really is insane!” My well-honed fight or flight response begged for flight, whispering loudly in my ear, “Get out now while you still have your other job, while you still have a nurse’s license, before this insane woman asks you to perform open heart surgery, dispense methadone without a license, do God only knows what else, before she locks you in that concrete room she’s calling a clinic and demands that you stay. Go now, go run fast!” I wish I could say that I had enough recovery to tell Julie that a request to give an in-service at a job interview is both inappropriate and insane, but I did
not; I gave the talk. Once again my survivor skills kicked in and using my resiliency traits, I relied on humor, my charm and my limited-on-the-spot knowledge of seizure disorders and medications, figuring correctly that whatever knowledge base I had was larger than the group’s. The talk was a big hit, the counseling staff loved the talk and seemed to accept me, despite my “member of the establishment” appearance. If we had been chimps we might have engaged in a little mutual grooming. Instead I went home and got on the phone with my friend Terri and requested a psychiatry consult. Was I as out of my mind as I perceived myself to be? She thought the job was a great idea and I began to question her sanity. I started the job next day, after a long shopping excursion to CVS drug store, where, to my dismay, they did not stock emergency carts.

I was informed that the homeless men who would use this over-flow shelter were outcasts, men who were barred from the regular shelters for rule violations, those who shunned the strict rules of the shelters, or those who were too impaired by their diseases of addiction and/or mental illness to negotiate the sometimes complicated world of the shelters. Some of the men came willingly, but some were reluctant participants in the shelter. They came after being rounded up by the police and shelter workers who patrolled the city streets trying to keep people from literally freezing to death. The shelter was a harsh and bleak place; basic sustenance was the order of business.

The following day the buses rolled in and the homeless men poured out like drunken, hungry, and forlorn sardines. I was there waiting for them. I was nervous and unsure of myself, but like a good VA nurse I was at my post, ready for duty. Because the men were not allowed to drink in the shelter and they were not allowed to leave the shelter once they arrived, the men would frequently guzzle large quantities of cheap and potent alcohol immediately before boarding the bus, in an attempt to ward off the horrors of alcohol withdrawal for the 12–14 hours it might be until they could find a drink again. The unfortunate result of this practice was frequent alcohol overdoses. My job was to stay close as the bus came in and to evaluate those who had a true alcohol overdose as opposed to the men who were just very, very drunk.

Those who were just very, very drunk were allowed to stay and those with an alcohol overdose were triaged to local hospitals. Drug overdoses of heroin and benzodiazepines were almost daily occurrences as well. The constant need to respond to emergency situations in the shelter felt familiar to me. In some ways I felt as if I had just moved to an ICU that had been stripped of equipment. I was constantly appalled and frightened by the lack of basic emergency equipment and the gravity of medical situations that presented themselves each night. I believe now
that it was not just my background as a nurse in an ICU that prepared me to deal with the nightly trauma by myself and in the most primitive of circumstances. My earlier life experiences also had taught me well to function highly in chaotic and dangerous situations.

Adrenalin had flowed in my veins for so long that emergency situations did not faze me. There had been a time in my life when I enjoyed the adrenalin rush of an emergency. In the ICU we used to vie for the role of first responder to emergency codes on the floors, but those days were gone forever. Those first nights in the shelter I experienced a rush of adrenalin responding to the drug and alcohol overdoses, but it was the type of rush that was needed to turn the feelings off to get the job done and it was followed by an equal and more powerful rush of devastating sorrow, unlike any I had known working in the ICU. My personal recovery was causing a type of global warming of my ice-bound soul and now I could feel the full force of the despair and sorrow I encountered when I looked into the eyes of these haunted men who seemed intent on annihilating themselves.

I knew nothing about what a nurse’s clinic for the homeless should look like, so I invented my own. I had equipped my little cement room with basic dressing supplies, blood pressure cuffs, stethoscopes, and primitive first aid equipment. Another trait of resiliency is the ability to adapt. During my childhood I moved seven times before the age of 12, leaving me with a life-long need to nest wherever I was, so before long my cement room began to look like me. I brought in books, small objects of art, and my personal favorite, a candy dish. If there had been a window, I would have hung curtains.

Each night after the men got off the bus and were handed their pitiful bag lunches, which consisted of one skimpy sandwich, an apple and a carton of milk, they would gather in a large room and sit on hard plastic chairs arranged around the perimeter of the room. The only alternative was to go to bed on the hard cots, which were equipped with one Army-issue grey woolen blanket in the huge dorm space beyond the sitting area, separated by partitions. The lighting was harsh fluorescent, and because smoking was still allowed in 1988, a steady haze of blue smoke filled the air. A more depressing atmosphere could not have been imagined, yet it kept these gentlemen from freezing to death.

I filled my candy dish and sat in my now cheery little clinic and waited for patients, or guests, as I had been told homeless gentlemen were called, to come to me. They did not. I was not stupid and quickly figured that Mohammad was not coming to this mountain, so I ventured out tentatively, like Sashimi, into the pack of males in the lobby. Slowly I made my way around the perimeter of the lobby, sticking out my hand
and saying, “Hi, I’m Eileen, I’m the nurse here. If you need anything come and see me in the clinic over there,” pointing to my concrete clinic. Several of the men slept through my introductions, one asked me if I was married and told me that I had a “nice, but large ass,” still another grunted, “ah, go fuck yourself.” If there had been a tree branch handy, I would have laid upside down like poor Sashimi and howled. Instead, I beat a hasty retreat to my clinic and ate some Tootsie Rolls.

Feeling like a lousy nurse, I sat there contemplating my utter incompetence when Johnnie Jack appeared at my door again. “Tootsie Roll?” I offered. “Sure,” he said with a wide grin and came in and sat down. It seems Johnnie Jack lived on the streets, shuttling between programs for the mentally ill and programs for alcoholics. He was caught in dual diagnosis hell, substance abuse and mental illness, and these were compounded exponentially by his inability to negotiate life in a shelter. Johnnie Jack became a frequent visitor during those first few weeks of operation. He would always leave by saying, “I like you nurse, you’re nice.” I would repeatedly tell him my name, but he would always say, “I know, I know, but you’re my nurse, I like you, nurse.”

Very gradually other men began to trickle into the clinic. Some conditions I knew how to treat, others revealed my total ignorance of just how complicated it was to provide health care to homeless individuals. I quickly became adept at treating simple wounds with very limited supplies, infestations with scabies, and lice, and a condition that is endemic among homeless populations, known as immersion foot. Yet when a gentleman came in one right and wanted help with the wombat infestation that he said was plaguing the Armory, I was at a complete loss. He sat at my desk and drew intricate diagrams of where the wombat lairs were and how he thought I could best attack the problem. This was years before I became a frequent watcher of Animal Planet and even knew of the actual existence of wombats. My glaring lack of psychiatric nursing experience was evident in my limited ability to do more than provide respectful listening and appropriate referrals for this tormented soul.

Resilient children are able to find parental substitutes and to take in whatever meager clues on healthy living that their environments might offer to them. One blessed day, the mother of all homeless nurses shuffled into my floundering clinic and threw me a life line. The now late Barbara McLnnis arrived, stuck a tuberculin syringe in my arm and poured hope into my soul. Barbara was a public health nurse who had worked with homeless individuals for more than 25 years. Her gentle spirit and total loving acceptance of homeless people had earned her uncanonized sainthood on the mean streets of Boston. She had come to my shelter to
do TB screening, but she really came to teach me how to be a nurse to homeless people.

“I don’t know what I’m doing,” I confessed to her. “You look like you’re doing okay,” Barbara responded in her flat, non-committetal way of speaking, helping herself to a candy from my dish. “The men like you and you’re doing your first TB screening, that’s not too bad of a start,” she added, taking another candy. “But hardly anyone comes into the clinic, and just today a guy called me a red-headed demon from hell,” I protested. Barbara reassured me that many nurses had been called worse and suggested that I try giving foot soaks as a way of luring people into the clinics and to keep working on getting to know the men through listening to their stories and offering them unconditional acceptance. The rest, she said, would fall into place. Barbara taught indirectly, through the telling of stories. “There was a homeless guy,” she would begin. On her way out the door she paused and looked back at me and said, “The candy is a nice touch, keep that up,” she said as she filled her pockets with a few extra pieces as she left.

Barbara was right, the foot soaks were a great hit and soon my cement clinic was filled with foot sore homeless men soaking their feet and sharing their often drunken and sometimes delusional stories. Some of the stories were flirtatious macho posturing, some were rag-time, semi-coherent murmurings fueled by Cossack vodka, heroin, cocaine, and sometimes even gasoline soaked rags. Some stories had me doubled over in laughter and others had me wanting to run into the bathroom and sob. While feet soaked, hearts opened and bled. Souls touched.

One gentleman, Kevin, would come into the clinic in various stages of intoxications to soak his feet. Kevin was a paradox. In his drunken states he would be loud, abrasive, and sexually inappropriate, but when less intoxicated he would sit and read for hours and then come to the clinic to discuss what he had read. One night he sat in the clinic nervously scratching at the patches of psoriasis that covered his arms and hands. One night while we were alone in the clinic he asked me, “Did you know that when I was a kid and went to bed I used to scratch these itchy patches on my skin in my sleep, they would bleed and when I woke up my old man would beat the shit out of me for scratching them, can you believe that shit? Now how the hell was I supposed to not do that when I was asleep?” he asked looking very much like the little boy who had woken up to a brutal beating. As he spoke I thought of the little boy Kevin, with his bleeding sores and cruel father, and I also thought about the violence and addiction in the home where I was raised and wondered why it was that I was a nurse in a homeless shelter and not a guest. Suddenly the expression, “there but for the grace of God go I” took on new meaning.
I told Kevin that what his father had done to him was awful and that I was sorry that it had happened to him. I offered to help him to find a dermatologist to treat his psoriasis now and he accepted the referral.

Kevin developed a habit of asking me to read to him while he soaked his feet. Because so many of the men struggled with addictions, I kept recovery literature in the clinic. The basic bible of Alcoholics Anonymous (AA) is known as *The Big Book* (1976). In a loud voice Kevin would demand, “McGee, read me *The Big Book*, Chapter Five.” Chapter Five of *The Big Book* is the chapter that details how AA works for the individual who is trying to get sober. The chapter begins,

Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates, they are not at fault; they seem to have been born that way. They are naturally grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average (p. 53).

In a perverse fashion Kevin would use the words of AA to rationalize his drinking. He would soak his feet and rail in a drunken stupor, “You see, McGee, I am such an unfortunate. I am constitutionally incapable of grasping and developing a manner of living that demands rigorous honesty. Read it to me again.” He would slosh some water on the floor and demand another reading. Kevin and I had a good relationship; where he had once frightened me, I was able to stand up to him after awhile. One night he was particularly insistent on proving his point about his constitutional incapacity to become sober and I had decided that I had had enough of his self-fulfilling prophecy. “No, Kevin, I won’t read Chapter Five again. How about now I read you the promises of AA, the ones that talk about how if you put down the drink your life will get better?” I received a heavy sigh and a big slosh of the feet from Kevin, “They’re a load of shit, but okay read ‘em to me anyway.” I pulled my chair next to his and I began to read.

If we are painstaking about this phase of our development, we will be amazed before we are halfway through. We are going to know a new freedom and a new happiness, we will not regret the past, nor wish to shut the door upon it (Alcoholics Anonymous, 1976, p. 63).

Johnnie Jack continued to be a frequent visitor to the clinic during the six months of operation, sometimes stopping by several times a night. He had grown rather fond of me. I tried without a lot of success to get him into detoxification centers and back onto his psychiatric medications.
He appreciated any and all efforts that anyone made on his behalf. I had learned the value of a nurse acting as an advocate. One night he sat at my desk and said to me, “I really like you, I like you so much, will you be my imaginary mother?” I struggled for a moment, not wanting to damage our bond of trust, or to hurt him. I looked at him for a moment and said, “Johnnie, I can’t be your imaginary mother, but I can be your nurse? How about that?” He smiled that huge grin and said, “Oh, I like that, I like you nurse, that would be great.” It suddenly occurred to me when I said that to him that I no longer asked myself whether or not I wanted to be a nurse. The question had been asked and answered in my lived experience of the previous six months.

The six months had flown by and before I knew it Barbara McInnis was back recruiting me for a permanent job as a real nurse manager job at the Pine Street Inn shelter. Resume and references would be required this time and in this position I would actually have staff to supervise. I told Barbara all of the nasty things that the free-spirited staff had told me about the oppressive and paternalistic practices of Pine Street, testing out my new vocabulary, and Barbara suggested that I try a new spiritual practice of open-mindedness. My six month tenure at the emergency shelter had taught me enough lessons to fill a book, but primarily it reminded me that I loved nursing and that was where my path in life lay. So I took the “get a job pantsuit” out of the closet and went off to Pine Street for a somewhat more formal interview and was hired. I worked at Pine Street for 12 years and the lessons garnered from those years would fill an encyclopedia.

I write this now from the vantage point of history. Seventeen years and three degrees later, I now teach community health nursing and bring my students to work with homeless individuals, a few of whom I have known since my first bumbling attempts in the emergency shelter clinic at the Armory. Barbara McInnis died last summer and the homeless world still grieves for her. I still grieve for her.

Resilient nurses abound in nursing, of that I am sure. I can close my eyes and see their faces and hear their stories of hope, courage, and healing. Over the years I have come to know countless nurses, resilient children who have grown to be healers. When I worked at Pine Street, one nurse would glibly comment about the reality that we are all in need of healing. She quipped, “We all come with baggage, but some people come with steamer trunks. Those are the people who don’t do so well.” Unfortunately, too often in nursing each nurse is given the sole responsibility for sorting through her or his own baggage. Too often nurses either individually or collectively do not offer a gentle guiding hand to the soul doing the sorting and this is wrong. Caring is the moral
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imperative of nursing and caring begins at home. We need to find ways to nurture the traits of resiliency we find in ourselves, our students and our-coworkers; we need to breathe life onto the sparks of life that grow from small embers in our collective hearts.

The idea that nurses are wounded healers is hardly new, yet there is a paucity of information about the concept of resiliency as it pertains to nurses in practice. Theologian Henri Nouwen described a wounded healer as one who must attend to one’s own personal wounds while at the same time having the ability to heal others. “Making one’s own wounds a source of healing therefore does not call for a sharing of superficial personal pains, but a constant willingness to see one’s own pain and suffering as rising from the depth of the human condition which all men share” (Nouwen, 1972, p. 88). Nursing theorist Jean Watson (2003) spoke to this idea also when she wrote that:

When working with others during times of great despair, vulnerability, and unknowns, we are challenged to learn again, to reexamine our own meaning of life and death. As we do so, we engage in a more authentic process to cultivate and sustain caring healing practices for self and others. Such care and practice elicit and call upon profound wisdom and understanding, beyond knowledge, that touch and draw upon the human heart and soul (pp. 197–198).

While Watson (2003) suggested that nurses honor the reality that we are all on our own journey toward healing, there are precious few concrete ways that this actually happens in nursing practice. We can begin by owning our own woundedness and resiliency and by sharing these stories with each other. The sharing of stories requires a willingness to be human, to be vulnerable, and to do as Watson (1999) suggested and suspend roles and status and simply be another struggling human being sharing life’s journey. The sharing of woundedness and resiliency is not, as Nouwen suggested, a gratuitous sharing of personal information, but rather the deliberate and careful sharing of one’s humanity for the purpose of making a human to human connection, for the purpose of the promotion of healing. Nursing scholar Carol Kirby (2003) resonated with Watson’s suppositions, stating that:

Love is the only sane and satisfactory answer to the problem of human existence and that to speak of love is to speak of the ultimate and real need in every human being. We have discovered an understanding significant to rediscovering and reconnecting nursing spirit (p. 9).

In my own life and practice I am taking small steps to work toward encouraging my students’ resiliency and growth. The community health
course that I am now co-teaching was designed by another faculty member who used a caring curriculum. In my clinical groups we use reflective journaling techniques and clinical post-conferences to provide opportunities for growth and sharing of struggles. I tell a lot of stories and I often think of Barbara McIlnis when I do; some of them begin with, “I knew a homeless guy once . . . .”

It has been a long road from the days of the Armory Clinic. As the journey continues to unfold, I hope to share with my students and colleagues much of what I have learned from being Sashimi, a resilient survivor of my life and to listen to my fellow journeyers’ tales of resiliency and healing as well. I am looking for healing, I long to heal, the journey continues. Each semester I share with my students the words of Jean Watson (2003) who begged us to remember “That it is our humanity that both wounds us and heals us, and those whom we serve; and in the end, it is only love that matters” (p. 99). Amen to that.

REFERENCES


