VIEWPOINT

Cultivating Deliberate Resilience During the Coronavirus Disease 2019 Pandemic

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Coronavirus disease 2019 (COVID-19) is affecting our health care community in unprecedented ways. As a pediatric oncologist who studies resilience in the context of illness, I started thinking about what this pandemic means for our professional resilience a few weeks ago, when the first US patient with fatal COVID-19 died in my home city of Seattle, Washington.

Promoting resilience among health care workers and organizations starts with understanding what resilience is (and what it is not). Historical psychology and social science suggested resilience was either a trait (eg, hardiness), a process (eg, adaptation), or an outcome (eg, the absence of posttraumatic stress or the presence of posttraumatic growth after a particular adversity).[1] The first and last conceptualizations are questionable. The potential for resilience is not a unique trait that one has or does not have; the capacity for resilience is inherent in all people. Resilience is not a single dichotomous outcome measured at a point; we can simultaneously experience posttraumatic stress and growth, and these (and other) outcomes dynamically evolve throughout our lives. Finally, both trait and outcome conceptualizations suggest resilience is something that happens to the fortunate and something we can hope for but not necessarily achieve. This is incorrect. Resilience is neither lucky nor passive. It takes deliberate effort. Indeed, while resilience researchers have quibbled over nuanced definitions and requirements for resilience, they agree that it can be strengthened with practice.[1]

Modern psychology and social science define resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress."[1,2] For years, I questioned the qualification of the word *well*. Who defines wellness, and what is well enough to meet the threshold of resilience? My questioning stemmed from a conversation I had years ago with a parent who was bereaved. They said they were resilient because they had gotten out of bed that day, because they were putting one foot in front of the other and continuing the hard work of living without their son. I thought, "Yeah. That seems pretty resilient. I'm not sure I would be able to do the same." I concluded that resilience was about adapting—the wellness part was optional.

Time and observation have forced me to reconsider that conclusion. Certainly, getting out of bed and putting one foot in front of the other is part of the resilience process. But it is not the whole story. If I were to learn that the same parent was still defining their resilience by getting out of bed without some additional forward progress, I would worry. Day-to-day subsisting without wellness is not resilience; it is a failure to thrive. I would wish more for them.

Most people do get to experience more. When they get far enough past an adversity to look back with perspective, they appraise it. They consider its effects on their lives and identities, and (sometimes only with prompting) they reflect on the skills they leveraged or developed, the actions they took, the lessons they learned, and the reasons they kept (or keep) going. The parent who was bereaved and got out of bed each day, for example, recently shared with me that they now endeavor to live their life to the fullest because their son cannot.

What does this mean for us as individuals and organizations in the era of COVID-19? It means we need to be deliberate about navigating the middle of the resilience process, the part between getting through and looking back. Communities and individuals facing adversities as diverse as war, famine, poverty, illness, or death do this by harnessing consistent categories of resilience resources.[1,3] Which resources work for whom is highly contextual and based on culture, community, and individual needs. Naming the categories and examples of their corresponding, specific resilience resources helps us identify and harness them.

Categories of resilience resources are individual (eg, personal characteristics and skills), community (eg, social supports and sense of connection), and existential (eg, sense of meaning and purpose; **Table**). In the context of COVID-19, these apply to both health care professionals and organizations. For example, an individual resilience resource is the ability to successfully set goals, often by identifying and mapping specific, measurable, and realistic steps toward their achievement. For professionals, this may involve the deliberate creation of short-term goals for working from home or for self-care after a stressful day on the hospital ward. For organizations, this may involve deliberately celebrating systems-level steps toward shared community goals, such as evidence that local social distancing practices are beginning to flatten the curve.

Community resilience resources for both professionals and whole organizations may involve deliberate efforts to maintain connections via frequent video conferences and communication of COVID-19 policies and their implications (Table). Finally, to cultivate an existential resilience resource, such as the sense of meaning and purpose, professionals and organizations might deliberately consider the value of their contributions; appreciate experiences, people, and things for which they are grateful; or ground themselves by recalling their missions to help vulnerable populations.

Table. Evidence-Based Categories of Resilience Resources and Possible Applications in the Era of Coronavirus Disease 2019

Resilience resource category	Individual	Community	Existential
How to consider the resilience resource category	What do I (or we) do when times get hard?	Who helps me (or us) when times get hard?	Who do I (or we) want to be when this is over? What will it have meant for me (or us)?
Classic examples of the resilience resource category	Reliance on personal or group characteristics (eg, grit, hardiness, optimism); development of personal or group skills (eg, stress management, mindfulness, goal setting).	Prioritization and leverage of existing relationships with empathic or understanding people (eg, friends, family, peer networks); development and cultivation of new individual and group relationships with people who are like-minded to validate feelings and identify shared purpose (eg, colleagues, faith communities, advocacy groups).	Reframing appraisal(s) of adversity with integration of ongoing lessons learned; iterative evaluation of personal or group identity, with focus on values, meaning, and purpose; identification of gratitude and what matters in personal or group worldview.
Possible person-level applications	Practice self-care (we cannot be resilient if we, too, are ill); prioritize rest and stress management techniques, such as mindfulness and exercise; celebrate successes and recognize forward momentum; be proactive; approach challenges, such as required work from home by creating manageable short-term goals and steps toward their achievement.	Cultivate community: dedicate several minutes of virtual meetings toward checking in and conversations about experiences in the hospital, how people's children are faring, or the new normal of working from home. (This helps us maintain a sense of connection to colleagues and friends.)	Reframe social distancing as (1) a deliberate activity to promote patient and community safety, (2) an opportunity to identify which meetings are truly necessary in our work, and/or (3) an opportunity to become skillful at video conferencing; build personal purpose by helping others. (This may include caring for patients with coronavirus disease 2019 or volunteering to help communities disproportionately affected by social distancing guidelines.)
Possible organization-level applications	Practice self-care; support staff by clearly communicating expectations, acknowledging uncertainty, expressing gratitude, and providing access for frequently asked questions; celebrate successes and recognize forward momentum; be proactive; anticipate systems challenges, such as low morale, stress, workforce and/or equipment shortages, childcare needs, and sick leave; consider novel approaches to meeting shared organizational goals.	Cultivate for opportunities for shared self-discovery; organizations and staff can come together to explore lessons learned, new perspectives, and strategies for managing the stress of uncertainty and/or fear of the viral pandemic. (This helps us maintain a sense of connection to our organizational culture.)	Deliberately consider the future narrative of our medical community; begin writing the story we hope to tell about how we handled this adversity; cultivate and champion shared purpose in health care missions to support patients, families, and communities.

The process of resilience requires these deliberate actions. It is complicated and contextual. It is promotable. The pandemic of COVID-19 has already shown us how dramatically and quickly our world can shift in its approach to population health and individual patient needs. Many of us, as individuals and organizations, are in the beginning phase—the getting-through phase, the one-foot-in-front-of-the-other phase. We can only imagine the end phase, the looking-back phase. We cannot guess exactly what we will have learned. We can only know that none of us will forget.

So, let us now be proactive. Let us imagine our future narrative and direct ourselves toward its end. Let us harness our individual, community, and existential resources so that we not only navigate this experience but also continue to thrive. Let us ensure that when we look back on this story, we will be able to say we adapted well.

ARTICLE INFORMATION

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