Resilience: A Protector From Depression

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Short Report

Resilience: A Protector to Depression

Karen-leigh Edward

Personality type and resilient behaviors provide protection from the experience of depression, and resilience can increase the odds of not being depressed. Psychiatric–mental health nurses are well positioned to facilitate the development of resilience qualities in people who are depressed. Clinical strategies, which could be undertaken by the psychiatric–mental health nurse, include early intervention, promoting a positive social and familial climate, promoting self-esteem and support building, social and life skills / vocational education, and linking and brokering clients into extracurricular activities. ***J Am Psychiatr Nurses Assoc, 2005; 11(4), 1-3. DOI: 10.1177/1078390305281177***

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Depression is one of the most common mental illnesses encountered by the mental health professional (Antai-Otong, 2003). Fundamentally, depression is an emotional state marked by sadness; feelings of helplessness, worthlessness, and guilt; a withdrawal from others; and disturbances in appetite, sexual desire, and sleep. Depression exists on a continuum, and major depression is quite common (Australian Institute of Health and Welfare [AIHW], 2004). The incidence of depression has been increasing over the past 50 years; in Australia, mood disorders rank among the top 10 causes of disability (AIHW, 2004). Additionally, Australian well-being statistics suggest that by 2020 depression will be rated the second highest in incidence of disability, second to heart disease (AIHW, 2004). In terms of prevalence, women are twice as likely to develop depression as are men, and the prevalence of depression varies across cultures in relation to psychosocial supports and meanings attributed to the clinical manifestation of depression (Al-Issa & Tousignant, 1997; Gray, 1999). People who experience mental illness often experience a feeling of disconnectedness as a consequence of the symptomatology of the disorder. Resilience may offer the link for those with a mental illness to move from disconnectedness to connectedness.

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RESILIENCE

Resilience is defined as the ability to rise above difficult situations (Criss, Pettit, Bates, Dodge, & Lapp, 2002). The concept of resilience can be captured by the following:

> Having a sense of belonging and meaning in life is important to the development of resilience . . . but this connectedness and meaning in life can come in many different ways. We can draw resilience simply from a profound wonder at the beauty of life, and from the way in which everything is connected to everything else. (Deveson, 2003, p. 66)

RESILIENCE AND DEPRESSION

The resilience inquiry to date focuses on identifying personality characteristics associated with adaptive coping (Aroian & Norris, 2000; Edward, 2005; Flach, 1988; Garmezy, 1993; Schoon, Parsons, & Sacker, 2004; Smith, 2000; Werner, 1993). Smith (2000) suggested that vulnerability to depression may be attributed to the inability of the individual to develop positive self-perceptions. Smith suggested that a personality type characterized by self-perceptions tinged with a positive preconception and high levels of optimism provided resilience from the experience of depression.

Aroian and Norris (2000) reported on the relationships among resilience, demographic characteristics, immigration demands, and depression in a sample of 450 adult immigrants. The study did not support the relationship between resilience and psychological out-

comes, that is, no support was found for resilience modifying or mediating the relationship between the demands of immigration and depression. The investigators did find, however, that resilience increased the odds of not being depressed by about twofold.

Further studies related to resilience and depression/anxiety support that personality type and resilient behaviors provide protection from the experiences of depression and anxiety and that resilience increases the odds of not being depressed or stressed (Judd et al., 2003; Komiti et al., 2003; Ryden, Karlsson, Sullivan, Torgerson, & Taft, 2003). Additional research on the effects of psychological stress has focused on stress-related psychopathology (Charney, 2004). Charney (2004) developed psychobiological models of resilience to extreme stress. He proposed an integrative model of resilience and vulnerability that encompasses the neurochemical response patterns to acute stress and the neural mechanisms mediating reward, fear conditioning and extinction, and social behavior. The neural mechanisms of reward and motivation (hedonia, hopefulness, and learned helpfulness), fear responsiveness (effective behaviors despite intense emotion), and adaptive social behaviors were found to be relevant to the character traits associated with resilience. He concluded that an opportunity now exists to implement the advances in the neurobiological basis of behavior to facilitate the discoveries needed to predict, prevent, and treat stress-related psychopathology and suggests this may promote resilience.

Bachay and Cingel (1999) suggested three constitutional factors that enhance resilience—self-efficacy, well-defined faith lives, and the ability to reframe obstacles. The authors put forward that in conjunction with these emotional and cognitive factors, support networks and relational/psychosocial factors also play a role in enhancing the experience of resilience for individuals. Furthermore, Willemse, Smit, Cuijpers, and Tiemens (2004) examined the effects of minimal-contact psychotherapy in primary care patients with subthreshold depression on the onset of major depression, the reduction in depressive symptoms, and health-related quality of life. Participants (N = 216) were randomly assigned to minimal-contact psychotherapy (n = 107) or to usual care (n = 109). The investigators found that the incidence of major depressive disorder was significantly lower in the psychotherapy group than in those receiving usual care. Additionally, a small but significant effect was found on depressive symptoms and on aspects of health-related quality of life.

Studies undertaken looking at chronic illness in targeted samples of adults who have coped well with the illness (and in some cases, comorbid depression) include long-term survivors of AIDS (Rabkin, Remien, Katoff, & Williams, 1993) and those at risk for cervical carcinoma (Antoni & Goodkin, 1988). Personality characteristics associated with resilience in these studies included optimism, an active or adaptable coping style, and the ability to elicit social support (Antoni & Goodkin, 1988; Rabkin et al., 1993). In addition, Rabkin et al. (1993) mentioned higher levels of intelligence and education, wide-ranging interests, and an ability to articulate future goals as attributes of resilient individuals.

A study conducted in Australia (Maybery, Szakacs, Baker, & Ling, 2002) examined the needs of children whose parents had mental illness. This study found that the core features of resilience in this group involved the exposure to risk and successful adaptation. They concluded that the experience of resilience did not result from avoidance of risk; rather, it stemmed from exposure to risk and the consequent successful negotiation through successful problem-solving skills (Luthar, Cicchetti, & Becker, 2000, as cited in Maybery et al., 2002). This is supported by another Australian study undertaken by Edward (2005) examining resilience as experienced by crisis care mental health clinicians. The findings of her study suggest that resilience was experienced as a result of the caring environment in addition to having a sense of self, faith and hope, having insight, and self-care. These studies support that assisting people toward successful adaptation and negotiation of difficult life events has the potential to enhance resilience qualities.

IMPLICATIONS

The question then becomes: How can resilient behaviors relate to everyone experiencing depression? The following statement in Anne Deveson's (2003) book on resilience captures the accessibility of resilient behaviors, as follows:

> What begins as a quest to understand the extraordinary has revealed the power of the ordinary. Resilience does not come from rare and special qualities, but from the everyday magic of ordinary, normative human resources in minds, brains, and bodies. (Deveson, 2003, p. 38)

Resilient behaviors can be learned and interwoven with contextual life experiences as purported by Tusaie and Dyer (2004) and Edward and Warelow (2005), and

in this context, there is the potential to guide mental health clinical interventions.

Various social-psychological strategies can counterbalance the adversity experienced by people who have a depressed mood. These strategies include early intervention, positive social and familial climate, self-esteem and support building, social and life skills/vocational education, peer involvement, and extracurricular activities (Edward & Warelow, 2005; Flach, 1988; Wang, Haertel, & Walberg, 1997). Psychiatric–mental health nurses are well positioned to facilitate resilience strategies for clients. In clinical practice, supporting people who are depressed toward enhancement of resilience qualities can be achieved through core practices of the psychiatric–mental health nurse, such as counseling and psychosocial education.

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