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Resilience as Accusation:

A Critical Examination of Individual Resilience Training for Burnout Mitigation

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Abstract

Burnout, a syndrome of work-related exhaustion and cynicism, is prevalent among nurses and is associated with workplace stressors. Resilience training programs are a prevalent method of burnout mitigation employed by healthcare institutions that aim to improve or alter how individuals respond to chronic stressors. Through the lens of General Systems Theory, we describe resilience training as a method of individualizing a systemic problem by problematizing a response to chronic stress exposure. Resilience training may furthermore serve as a mechanism which allows subversion of institutional responsibility for nurses' well-being in the workplace. We describe several suggestions for nurses to resist being scapegoated for their responses to systemic problems. Sustainable change must include other disciplines and is likely to require multiple different avenues including individual (e.g., honoring meal breaks), institutional (e.g., increased leadership participation), legislative (e.g., mandatory staffing laws), collective (e.g., collective bargaining), and educational (e.g., emancipatory pedagogy) methods.

Key Words: Resilience, psychological; burnout, professional; leadership; systems theory; occupational stress

Introduction

Nurses are an essential part of our healthcare system who are tasked with providing both emotional and physical labor required to provide care to patients. Nurses often work in under-resourced settings and lack decision-making authority to increase resources available to complete work; even nursing leadership is often excluded from institutional or policy decisions that affect nurses (Kurtzman et al.,

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2011; Penconek et al., 2021; Salvage & White, 2019). Nonetheless, nurses are often asked to take responsibility for the shortcomings of the systems they work within (Richards & Borglin, 2019).

In this paper, we will use General Systems Theory (von Bertalanffy, 1972) as a framework to explore individual resilience training for nurse burnout mitigation. We will explore the context of individual resilience training in a hierarchical healthcare system which often disempowers nurses, discuss how resilience training may scapegoat nurses for their normal responses to structural, institutional, or systemic stressors, and outline how individual resilience programs may serve as a mechanism to subvert institutional responsibility for unhealthy work environments (Akoo et al., 2023; Christianson & Johnson, 2023). Finally, we will discuss actions that nurses may consider to both resist scapegoating for burnout, and sustainable, constructive ways to mitigate workplace stressors that contribute to burnout.

Burnout and Resilience

Burnout, a syndrome of exhaustion and cynicism regarding one's work, is prevalent in the nursing workforce (Ge et al., 2023). Rates of nurse burnout vary by workplace and have been reported to be as high as 70% (Bakhamis et al., 2019). Research has associated burnout with individual factors (e.g., years of experience in nursing), environmental factors (e.g., workloads), psychological factors (e.g., secondary traumatic stress), motivational factors (e.g., work engagement), and social factors (e.g., the quality of relationships with managers and peers) (Bakhamis et al., 2019; Dall'Ora et al., 2022; Kelly, 2020; Nabizadeh-Gharghozar et al., 2020). Burnout is associated with higher incidences of depression, anxiety, and stress among nurses, as well as greater morbidity/mortality among patients cared for by nurses who experience burnout (Chen & Meier, 2021; Mousavi et al., 2017; Schlak et al., 2021). Despite extensive scholarly description of burnout, evidence suggests that burnout was worsening prior to the Covid-19 pandemic and has continued to worsen post-pandemic (Bakhamis et al., 2019; Ge et al., 2023; Tan et al., 2024). Burnout-related intention to leave the nursing profession threatens the stability of healthcare delivery, with over 20% of nurses reporting intention to leave the profession (Christianson et al., 2024).

Promoting nurse resilience, the ability to adapt to or cope with adversity, is widely touted as an intervention to prevent and mitigate nurse burnout. In the United States, resilience training programs are recommended by organizations such as the Joint Commission and the Veterans Health Care Administration to combat burnout among nurses (The Joint Commission, 2019; U.S. Department of Veterans Affairs, 2021). However, despite the widespread implementation of resilience promotion programs, burnout has worsened. While resilience programs are undoubtedly helpful to some nurses, only 26% of nurses have low resilience, which raises a question of whether lack of individual resilience is truly a widespread cause of burnout (Cheng et al., 2022).

General Systems Theory

General systems theory refers to a theoretical framework credited to von Bertalanffy (1972) based upon the Aristotelian worldview that the whole is greater than the sum of its parts. The framework was described as a potential resolution to a problem present in the Galilean scientific theory: that the existence of self-maintaining units as a theoretical precondition is not satisfactorily explained (Gavin, 2011; von Bertalanffy, 1972). General Systems Theory responds with a framework in which both units within a system, a set of interacting groups or units, and the relationships between units are examined relative to one another.

General Systems Theory provides a theoretical and concrete way to understand how systems operate and illustrates flaws in viewing individual parts of a system as independent actors or entities (Ackoff, 1999; Ackoff, 1994; Sillitto et al., 2017; von Bertalanffy, 1972). Although notions of individuality and self-determination are frequently held up in other models, within General Systems Theory there is a focus on relationships between people and

processes to describe how systems operate (Clarkson et al., 2018). Fixation on self-determination often conceals that a system of relationships exists and that those systems of relationships affect the behavior of everyone in it. Even worse, ignoring the power of a system leads to the denigration and oppression of those with the least self-determination power within it (Bailey, 2020).

General Systems Theory is often criticized for providing an avenue for individuals in the system to escape taking responsibility and blame for their actions (Clarkson et al., 2018). However, an underacknowledged issue is that the actions of individuals are not fully comprehensible without seeing how the parts (the individuals and groups of individuals) are connected to the whole (the system). Although each person in the system is an individual with lived experiences and beliefs that influences their decisions, their abilities, responsibilities, actions, and behavior are largely determined by the system of which they are a part. Regulatory practices, incentive structures, and hierarchical structures may be underacknowledged if focus is limited to individual decision-making. The result of focusing solely on the individual parts of the system results in blaming individuals (Clarkson et al., 2018). For example, healthcare administrators are frequently blamed for being focused solely on profit, nurses are blamed for not being selfless enough, or physicians are blamed for poor patient outcomes (Brborovic et al., 2019; Yadava, 2023). Few analyses take into account that all these actors work in systems in which capital-generation, production of assets that confer benefits to others (like money), is an organizational priority (Raghupathi & Raghupathi, 2020).

Healthcare Institutions as Systems

To clearly define 'healthcare institutions' we will outline our application of General Systems Theory. A system is defined as a set of interacting groups or units within an organized relationship structure that exists between the groups or units (Sillitto et al., 2017). A social system is actualized through laws, rules (both formal and informal), the larger system of which it is a part (i.e., the national healthcare system), and the organizational culture (Weick et al., 2005). Our perspective as authors is based in the United States, which has an overtly capitalistic healthcare system in which healthcare is highly commodified and access to healthcare is stratified by an individual's access to economic resources (Hermann, 2021). While our analysis pertains particularly to the medical-industrial complex in the United States, elements of our analysis may be applicable in healthcare systems or institutions that are less overtly commodified but nonetheless are subject to capitalist economic structures.

For the purposes of this paper, we will simplify our description of the system by limiting discussion to the following groups: healthcare administrators, management, providers, nurses, and patients. 'Healthcare administrators' refers to personnel who are primarily tasked with health services regulation, such as compliance with standards of patient care or developing budgets for healthcare areas (Thompson et al., 2012). 'Managers' refers to personnel who are tasked with implementing regulations from healthcare administrators in a limited setting, like in a specific department or among professionals with a shared job title (Thompson et al., 2012). 'Providers' are professionals tasked with developing patient care orders and recommendations (such as physicians, advanced practice nurses, or physician assistants), 'nurses' are professionals tasked with implementing patient care, and 'patients' are the care recipients. Figure 1 depicts a diagram of our simplified conceptualization of the healthcare institution as a system.

One notable feature of the system is that different groups have different decision-making authority, which affects the relationships between groups. Physicians and managers, for example, have decision-making authority that affects the nurse's practice, but nurses have limited decision-making authority over physicians', administrators', or managers' decision-making practices (Essex et al., 2023). Hierarchical structures in which decision-making authority is unequal are prevalent in healthcare institutions, which leads to power

disparities between groups (Essex et al., 2023; O'Shea et al., 2019). While consolidated decision-making authority may have practical value with regards to streamlining decision-making, top-down structures may also lead to disparate treatment of groups with less decision-making authority.

The relative lack of power held by nurses despite having multiple groups wielding power over them is of particular interest to us for this analysis. Other scholars have noted that the contributions of nurses are systemically undervalued and that nurses have relatively little decisional authority within healthcare institutions despite wielding substantial potential power as the largest group of healthcare professionals (Dillard-Wright & Shields-Haas, 2021; U.S. Bureau of Labor Statistics, 2022). Nurses are expected to be advocates for patients, yet they are often systemically disempowered from engaging in that same advocacy work (American Nurses Association, 2015; Cole et al., 2014; Dillard-Wright & Shields-Haas, 2021). Many nurses are reluctant to advocate, particularly when their advocacy involves advocating upstream against this power gradient (Lingel et al., 2022). While poor workplace autonomy itself is associated with burnout, there is a disconnect between the self-expectations nurses have been taught to carry, the expectations others put onto nurses, and reality of practicing as a nurse (Christianson, 2023). Nurses often join the profession because they want to act on altruistic ideals, are educated to champion patient needs above all else, are expected to advocate for patient well-being by both patients and their licensing boards and are then disempowered from the very advocacy work they are tasked with.

Resilience in the Nursing Literature

Burnout is characterized by emotional exhaustion related to one's work, but many burnout researchers have noted that not all individuals develop burnout uniformly. Individual responses to stressors are believed to be central to individual burnout; resilience training was developed to address those individual differences by modifying individual responses to stressors (Cooper et al., 2021). Not all individuals have the same resilience, but resilience is believed to be a cultivatable trait that is necessary to cope with the emotional labor inherent in nursing (Delgado et al., 2017; Prosser et al., 2017).

Definitions and theoretical frameworks describing resilience in the literature are inconsistent. Resilience is sometimes defined as an individual trait where other sources define resilience as an outcome of adversity (Etchin et al., 2020). Correlates of resilience are similarly inconsistent; individual characteristics such as age, outside support system, years of nursing experience, and educational attainment are inconsistently associated with resilience (Cooper et al., 2021). While neither the definition of resilience nor the relationships between individual traits and resilience have been clearly defined, resilience training programs are nonetheless popular as burnout mitigation interventions.

Resilience training programs described in the nursing literature include a variety of interventions aimed at emotional self-regulation including cognitive reframing techniques, promoting optimism and gratitude, self-care techniques, meditation and mindfulness exercises, and promoting awareness of one's emotional responses (Foster et al., 2018; Janzarik et al., 2022; Zhai et al., 2021). Promoting self-care and a positive attitude towards one's work is believed to protect against both burnout and its negative health effects (Cooper et al., 2021). Fostering resilience is also believed to promote intention to stay among nurses (Byun & Ha, 2019).

Failure to Retain: Shortcomings of Resilience Training for Burnout Mitigation

A shortcoming of resilience training programs is evident by examining the prevalence of such programs as compared to the prevalence of nurse burnout: Despite widespread resilience training program promotion and implementation, nurse burnout has failed to abate (Ge et al., 2023). One reason may be an unwritten theme in the literature: a presupposition of individual capacity and desire to partake in resilience training programs (Elwany et al., 2023). There is a dearth of

research examining the characteristics of nurses who opt in to resilience programs and the role of personal motivation and/or ability to participate in resilience training programs is an underacknowledged limitation of such programs. Nurses who do not take part in resilience training programs do not benefit from their implementation (Zhai et al., 2021). Additionally, evidence suggests that resilience training programs are effective in the short term but have limited long-term benefits for participants (Cleary et al., 2018; Janzarik et al., 2022). Not all nurses have the capacity or desire to participate in protracted (and often uncompensated) resilience training programs necessary to prolong the program's effects on resilience.

Another noted shortcoming is that some scholarship frames resilience without consideration to hierarchical or decision-making structures within a given system. Resilience-focused interventions often target individuals and/or groups with limited decision-making authority (Witter et al., 2023). Failure to acknowledge or address power disparities, lack of autonomy, or poor decision-making authority may limit resilience capabilities by restraining how much one may modify their workplace to create meaningful, sustainable change.

Resilience as Accusation: Shifting the Blame for Nurse Burnout

Nurse burnout may be framed through General Systems Theory as an (albeit undesired) 'output' of the healthcare institution system. Burnout is a chronic syndrome: While it is possible to point to any number of progenitors of burnout like excessive workload or empathetic stress, burnout could be prevented if such progenitors were temporary (Taylor, 2019). For example, excessive workload could be mitigated by providing additional instruments or staff to ease workloads, and empathetic stress could be improved through blame-free cultures or providing mental health leave days (Shin et al., 2018; Soosova, 2021). Nurses are willing to advocate for such changes; however, their efforts are often met with structural barriers that prevent them from effecting changes necessary to mitigate stress (Akoo et al., 2023; Conolly et al., 2022; Lee et al., 2022; Nsiah et al., 2020). Therefore, we posit that one of the key progenitors of burnout is disempowerment from effecting change.

Resilience interventions are believed to modify how the individual contextualizes and responds to chronic stress. Rather than addressing the modifiable stressors directly, resilience-centric burnout mitigation plans problematize the individual response to chronic stress. However, if we examine the context in which chronic stress takes place, the disempowerment nurses experience when they try to modify the source of stress, the individual's response to chronic stress takes on a new meaning. Gaslighting refers to the act of intentionally or unintentionally manipulating others to provoke self-doubt or cause others to second-guess their experiences (Johnson et al., 2021). Problematizing nurses' responses to chronic stress while disempowering nurses from effecting change to relieve their stress may be an underacknowledged form of gaslighting that nurses endure.

Framing resilience as the preeminent problem is reminiscent of another context where the term 'resilience' is used: engineering. In engineering, 'resilience' refers to the examination of the functionality of a system while it is subjected to a given type of stress (Wied et al., 2019). A highly resilient system remains functional under the stressor(s); similarly, resilient nurses are similarly framed as able to function under extraordinary stressors. Engineers recognize the limitations of resilience because they examine resilience using a systems approach; engineers would not expect a building to be inherently earthquake-resilient but may instead employ additional resources or design elements to enable the building to endure this limited stressor. An earthquake is a transient but predictable stressor; an engineer can design a building that is likely to remain steady even in an earthquake-prone area and may even predict at what earthquake magnitude a structural failure is likely. Engineers also acknowledge that a resilience to earthquakes does not necessarily imply resilience to fires or high winds. In contrast to the engineering context, resilience when applied to nurse burnout is primarily

individualistic and therefore incomplete: Nurses are expected to be resilient under predictable stressors but are given few or no substantive resources to mitigate those stressors (Taylor, 2019). Individual resilience training as a primary mechanism for burnout management is problematic when viewed this way. The belief that individual resilience is a possible solution to burnout absent substantive resources to mitigate sources of stress is a belief in spontaneous generation (e.g., the belief that something may come from nothing).

The reason for incomplete implementation of resilience (with consideration to resource allocation) is clear: a goal is to reduce burnout for the lowest resource cost possible. The additional beam used to make a building more earthquake-resilient is not necessarily required for the building's day-to-day stability; similarly, the resources required to fully implement a resilience program within a healthcare institution could be considered redundant. One of the key concepts of General Systems Theory is that a system produces output, and that outputs act as mechanisms that feed back into the system (Sillitto et al., 2017). Capital is one output of a healthcare institution (Raghupathi & Raghupathi, 2020). Redundancies within a capital-generating system are undesirable because they reduce potential capital output, which reduces the capital that may be reinvested into the system (to generate more capital) (Akoo et al., 2023). In other words, the goal of a capital-generating system conflicts with the development of systemic resilience mechanisms because redundancies are undesirable to capital generation yet are necessary to developing systemic resilience.

One unfortunate – and detrimental – solution to address the conflict between the systemic goal of capital generation and the need to improve systemic resilience is to focus on individual resilience. This frequently invoked solution fails to recognize that the individuals (in this case nurses) in the system bear the brunt of the failure to address the underlying cause of stress. Thus, nurses are blamed for system failures that they do not have the power to rectify. In a classic 'blame the victim' routine, individual nurses are expected to respond with endless resilience to chronic and preventable stressors. Furthermore, this logical progression may enable attributing blame to victims of abuse or violence by providing a logical scaffold to pose the question "What could you (the nurse) have done differently?" when abuse or violence occur.

Individual failure to spontaneously generate resilience, even when guided through methods of actualizing chronic stress, effectively shifts the blame for burnout away from the system that is incentivized to deny resources necessary for stress mitigation and onto the nurses. While perhaps unintentional, individual resilience promotion programs that are implemented absent additional resources for stress mitigation send nurses an unfair but clear message: nurses are individually culpable for their own burnout. Such narratives effectively gaslight nurses for their natural response to the unhealthy environment they work in and simultaneously subvert healthcare institutional responsibility for the unhealthy work environment, which allows the root cause(s) to persist while avoiding spending capital on resource allocation.

Resisting Scapegoating: Demanding Resources to Mitigate Stressors

Resilience is believed to be related to self-efficacy and agency, but nurses are often denied self-efficacy within healthcare systems (Conolly et al., 2022; Essex et al., 2023; Foster et al., 2019). Therefore, it is imperative that nurses demand greater decision-making authority and agency. Such demands may take place through individual, institutional, regulatory, legislative, collective, and educational avenues; multiple avenues are likely to be required to effect lasting change. Additionally, while we have chosen to focus on nursing for this manuscript, it should be noted that use of the concept of resilience to individualize a systemic problem may not be unique to nurses. To ensure that systemic change is equitable and does not simply shift burdens to a different (and more disempowered) group, it is vital to consider and include other stakeholders in decision-making.

On an individual level, nurses may resist accepting additional job duties or stressors by taking personal actions like honoring their meal break times, resisting pressure to accept overtime shifts, and reporting nursing care that was missed due to insufficient resources (Eder & Meyer, 2023). Nurses may also consider their right and ability to refuse to provide care under circumstances that may lead to patient harm, called conscientious objection (Grace et al., 2023). Nursing education must include discussion on duty of care, particularly the limitations around a nurse's duty and/or obligations. Nurses often engage in self-sacrificing behaviors because they are motivated toward helping patients and feel they must skip meal breaks or accept extra shifts to provide patient care due to chronic under-resourcing in the healthcare institution (Christianson et al., 2022; Eder & Meyer, 2023). Empowering nurses to feel comfortable saying 'no' to self-sacrificing behaviors begins with education on the responsibilities and contextual limitations of a nurse's duty to provide patient care.

We believe that solutions to nurse burnout must necessarily include increasing nurses' decision-making agency within healthcare institutions. Nurses are underrepresented in healthcare leadership and administration, particularly outside of nursing-specific leadership or unit management roles that are typically reserved for businesspeople or physicians (Akoo et al., 2023). Nurses, specifically nurses working in direct patient care, must demand inclusion in healthcare leadership structures, in both nursing-specific and institutional leadership roles. Some institutional programs, like shared governance models or the Magnet program through the American Nurses Credentialing Center, include structural nurse empowerment (American Nurses Credentialing Center, 2023; Duru & Hammoud, 2022). While these types of programs may be a good starting point, such implementations do not guarantee nurses decision-making capacity and have proven to be insufficient (Jaber et al., 2022).

Additionally, programs like shared governance or Magnet accreditation are too often limited to nursing. One of the key issues that nurses face is an increasing number of duties with fewer resources to draw upon, but resources provided to non-nursing areas may nonetheless benefit nurses. For example, nurses would not need to become de-facto housekeepers if there were enough housekeepers. Systemic problems are not limited to nursing in scope or impact; solutions must therefore be inclusive of all within the healthcare system. In addition to self-empowerment, nurses must also consider how they can be allies for the empowerment of other members of the healthcare team. Many of the cultural problems in nursing described in this manuscript are not solely perpetuated by externalities; nurses in management and leadership positions are central to perpetuating inequity. Nurses in leadership positions must consider how their leadership could be emancipatory rather than simply modifying pre-existing, hierarchical structures.

Nurses and their advocacy organizations may also consider the power of politics to effect change, such as lobbying hospital accreditation bodies like The Joint Commission to include standards for worker well-being in healthcare facility accreditation standards. Legislative actions like mandatory nurse-patient ratios, such as those in California and Oregon and the one proposed in Pennsylvania, might be an important part of a solution (AB-394 (Cal. 1999); HB 2697 (Ore. 2023); HB No. 2021 (Pen. 2021)). Such laws have the potential to change healthcare institutions through regulatory requirements.

Unionization may be a tool for workers to use existing labor laws to demand the right to bargain over their working conditions (Hagedorn et al., 2016). Several nursing unions have won concessions for their work environments in their collective bargaining contracts including minimum nurse staffing ratios, limitations around time spent on-call, prevention of mandatory overtime, and additional pay for shifts worked understaffed (Esposito et al., 2020; Massachusetts Nurses Association, 2024; New York State Nursing Association, 2023). Labor unions are particularly powerful because they provide a specific, legally defined method for empowerment that is not contingent upon institutional support (Christianson et al., 2025). Collective action may be taken a step further

through transitioning to alternative business structures like worker-owned cooperatives. A worker-owned cooperative refers to a business that is both owned and operated by its employees; such systems may better promote shared decision-making capacity among all workers as well as allow for the equitable distribution of the resources generated by the business. While such a structure has (to the writers' knowledge) never been attempted in a United States hospital system, there are many examples of successful worker-owned cooperative businesses including home health care agencies, electricians, manufacturing, and retail (Democracy at Work Institute, n.d.).

Finally, nurses must be educated in leadership and advocacy methods at all or hierarchical organizational levels. The American Association of Colleges of Nursing Essentials (2024) for nursing education denotes a focus on systems-based practice. While this entry-level competency outlined in the Essentials provides a basic outline, the competencies within the Essentials highlight working within an existing system. We posit that working within an existing system alone is insufficient given that nurse disempowerment is common. Nursing education institutions must choose to educate nurses to self-empower within systems that do not have pre-existing structures for empowerment. Advocacy education must include considerations for interrogating the utility, purposes, beneficiaries, and costs of systems. Use of emancipatory pedagogies, such as *Pedagogy of the Oppressed* by Freire (1970), or systems-oriented theoretical frameworks like General Systems Theory may be practical starting points both to teach nurses to recognize systems of disempowerment and to prevent the perpetuation of such systems.

Finally, nurses must be open and receptive to the ideas of other disciplines, particularly disciplines with similar – or lower – decision-making authority. Our representation of the healthcare institution as a system is not intended to communicate that nurses are the most disempowered within healthcare institutions. All healthcare systems differ, and our perspectives are oriented from the United States. While we believe that the core concepts described in this paper may apply to other healthcare systems, the specifics may differ in other types of healthcare systems.

Conclusion

When healthcare institutions rely upon individual resilience training to mitigate nurse burnout, they send a clear but inaccurate message: nurses are individually responsible for their responses to the work environment. Systemic changes are needed, including a reduction in the hierarchical nature of decision-making in healthcare particularly with regards to resource allocation and acknowledgement of work. Nurses can resist the gaslighting and scapegoating effects of resilience-centric narratives that elevate individual responsibility by demanding adequate resources to alleviate stress and excessive work duties. Acts of resistance must begin with a critical analysis of working conditions and systems that exist to effect change and must not be limited to the nursing discipline. Lasting change that benefits nurses is unlikely to come from a hierarchical, top-down system in which nurse well-being is not prioritized. Nurses must demand equitable institutional decision-making models and must be prepared to step outside of the traditionally accepted domain of nursing to effect beneficial change.

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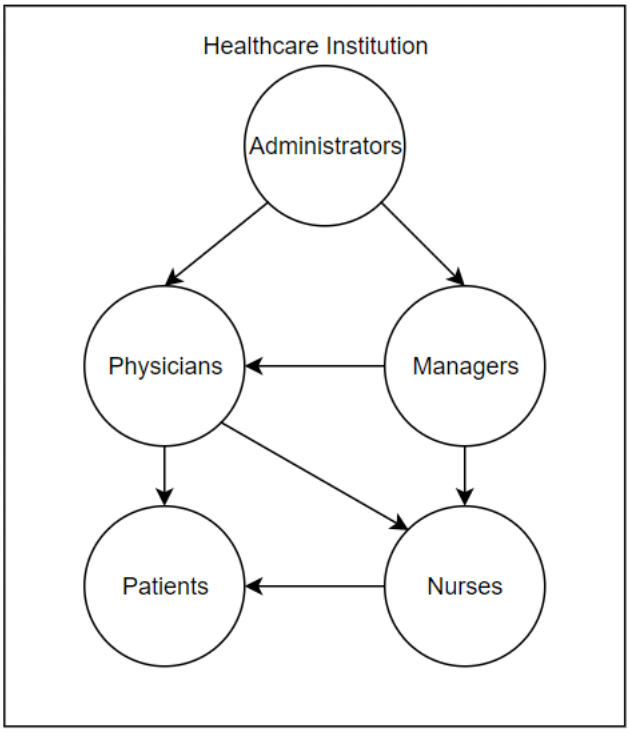
Figures

Figure 1



Notes: Each circle denotes a group, with the healthcare institution representing a system. Arrows indicate a dynamic of decision-making authority in which the goes from the decision-maker and points to a recipient of their decisions.