Exceptional Outcomes:

Using Narratives and Family Observations to Understand Resilience

Stuart T. Hauser

Judge Baker Children's Center

Harvard Medical School

Department of Psychiatry

Joseph P. Allen

University of Virginia

Department of Psychology

and

Marc S. Schulz

Bryn Mawr College

Department of Psychology

> I know I could try ... I know if I try I will know how to go back….In between you can go up or you can go down. You go up and somebody pushes you down, you're gonna be bummed. And if you go down and nobody helps you back up, you're gonna be bummed. So you should just sit in the middle for now... see how things work out. And if I feel like I'm gonna talk, I'm gonna. If I don't feel like it, then I'm gonna sink down. And right now I'm sinking. But I think I might be able to work things out. (Eve, at age 15.)[1]

Eve, a 15 year old, thinks aloud about changing, a year after mutilating her face and arms. A decade later we found that she and several other young men and women, seriously troubled in their teenage years, were leading healthy and productive lives. The questions raised by such transformations are numerous. How did they occur? What characterized these individuals as adolescents? If we just listen to their stories, might it be possible to draw conclusions that speak to the fundamental nature of resilience? These are some of the topics we sought to address in this study, while seeking to develop and utilize a time-tested but often overlooked approach in psychological research: the study of individual narratives.

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[1] All names of participants in this chapter are not their actual names. In addition, we further protect confidentiality by changing any other possible identifying information such as hospital names, geographic locations, or type of work.

Our work draws from our long term study of young adults who, during their adolescence, were hospitalized as psychiatric patients. Whatever the stresses that led to their interlude in the hospital of months, and sometimes more than a year, the hospital itself was problematic for these teens. They were separated from their families and abruptly placed in unusual surroundings. At the hospital they had to respond to unfamiliar adults whom they never asked to be their caretakers, a new collection of peers, many of whom presented in frightening ways, and attend a special school program that most found repugnant.

Writing about her adolescent years in a psychiatric hospital, Kaysen (1993) characterizes this stage of her life as *Girl Interrupted.* Was this period also a major interruption in the lives of these former patients in our study who are now leading fulfilling, non-impaired lives? How do they perceive, and understand, their time in the hospital from the vantage point of young adulthood? Along with understanding the development and adaptation of a larger group of adolescents whom we continue to follow in their adult years we have been intensively studying the families and tracing the pathways of this special subgroup of former patients. Our goal has been quite simple: to see what we might learn about the paths that led them from their troubled teen years to young adult lives characterized by remarkable competencies and minimal evidence of major social and psychiatric problems.

Identifying and Studying Resilience

Fourteen years after they first participated in our project, we found *all* of the original participants we had first met as young adolescents, now spread across the country and world. Our original goal in following our participants through to young adulthood was to identify adolescent individual *and* family predictors of adaptation and experience in the early adult years. As we proceeded, a new and compelling question quickly surfaced: How could we account for

unexpectedly competent outcomes in the group of young men and women whose lives had been deflected during their adolescence? Often called *resilience,* similar discontinuities were recognized in early programs of research on schizophrenia (Garmezy, 1973) and are currently a focus of much scholarly and scientific activity (e.g., Davis, Luecken, & Chalfant, 2009, Luthar, 2006, Masten & Obradovic, 2006)

We approached the study of resilience using a person-centered approach (Bergman, Eye, & Magnusson, 2006) rather than a traditional variable-centered approach. We view resilience as a multi-dimensional construct; thus we assembled outcome profiles using multiple domains to identify resilient young adults. We then carefully examined data collected prospectively during adolescence to identify predictors of these unusually positive outcomes. In this chapter we focus primarily on data derived from yearly interviews first begun in the hospital then continued over the next two years. Through these interview texts we consider how the former patients gave meaning to the troubling circumstances leading to hospitalization, and to their experiences in the ensuing years. We also examine functioning in their families using systematic family observations obtained soon after our individual interviews.

At the start of the study, we met with 146 middle adolescents and their families. Equal numbers were drawn from two groups: non-psychotic in-patient adolescents from a private teaching hospital and adolescents from the freshman class of a local high school. The patients included three major diagnostic groups: disruptive behavior disorders, mood disorders, and personality disorders. Patients with psychosis, evidence of mental retardation or medical conditions with psychiatric sequelae were excluded from the study. The samples were comparable in age, race, and family type, and were predominantly Caucasian middle and upper middle class.

Over the following two years, we continued to meet with 80% of these adolescents and their families. The adolescent participants responded to specific developmental and personality measures, and participated in annual clinical research interviews, usually with the same clinically trained interviewer (for more details, see Hauser, Allen, & Golden, 2006). The interviews were semi-structured and always included inquiries about past family and individual history, current peer and family experience, school life, the handling of intense feelings, and future visions. We have used the interviews to assess coping strategies, elements of self-image, and constructs related to affective communications. In this report and other related ones (e.g., Hauser, Allen, & Golden, 2006) we use the interviews as a source of narrative data.

The participants and their parents also engaged in a family discussion task, based on a revealed difference procedure (Strodtbeck, 1951) using Kohlberg moral dilemmas (Kohlberg, 1981). Our family analyses are based on these recorded discussions (described in greater detail in Hauser et al., 1984). We located 100% of the original participants when they were in their mid-twenties, and met with 98% of those still alive. Using conceptually relevant measures and diverse methods, we assessed dimensions of ego development, close relationships, attachment representations, and aspects of social competence.

This new direction in our work was sparked by several interviews calling our attention to former patients who appeared to be functioning exceptionally well. To systematically study these young adults with remarkable recoveries from their adolescent years we operationalized the definition of "exceptional functioning" by applying two thresholds to the full range of our new measures. First, we identified former patients with development and relationship scores above the 50th percentile for the entire sample (including both the high school and patient samples). We used friends of the participants to assess their ability to reflect, their adaptive functioning,

and their ego resilience (Kobok & Sceery, 1988). Relationship closeness was assessed by self-report (Berscheid et al., 1987), attachment coherence ratings derived from an age 25 interview (Main & Goldwyn, 1998), and a traditional sentence completion task was used to assess ego development (Loevinger, 1976). The second threshold involved indications of social deviance and psychopathology. To be identified as exceptional on these markers of *dysfunctional behaviors,* former patients needed to have scores below the 50th percentile for the entire sample on measures of dysfunctional behavior. Here we used three indices: hard drug use in the past six months (Elliot et aI.,1983); criminal behavior in the last six months (Elliot et aI, 1983); and global psychiatric symptomatology (Derogatis, 1983). Four men and five women, 13.4% of the 67 former patients, fit this definition of exceptional outcomes. This group of nine young men and women were demographically similar to the other 56 former patients in terms of age, percentage that were female, and diagnosis, although they were almost twice as likely to have experienced parental divorce prior to age 14.

Using Ward's cluster and transposed principal components analyses of the patients with these sources of data, we found these nine young men and women in the same cluster and loading on the same component. We then proceeded to compare the nine exceptional former patients with a group of former patients whose adult outcomes were neither outstanding nor unusually dysfunctional for individuals with similar histories (i.e., they had outcome scores between the 40th and 60th percentiles for the *entire* former patient group).

Studying Resilient Narratives

Many successive readings and re-readings of adolescent interviews obtained across multiple years led to the development of a Narrative Guide for their analysis as texts (for more detail, please see Table 1 in Hauser, Allen, & Golden 2006). The Narrative Guide highlights the

specific content and structural dimensions expressed in the individual interviews of the exceptional former patients.[2] We began by demarcating two stories: the patient's path to the hospital; and life within the hospital. We focused on the following questions: Were the stories told coherently? Was there evidence of self-interruptions, digressions, and overt refusals to continue and to disclose? Were multiple events included or was the story that was told woven around a single overriding episode? Embedded in these stories were representations of self, and interpersonal relationships. For representations of self, we considered coherence, ways of disclosure and privacy, self-reflection, self-efficacy, self-esteem, aspirations, mastery, helplessness, and long-term visions. Relational representation dimensions included the extent to which the adolescent spoke of relationships as inter-connected, the presence of seeking and eliciting relationships, and the discussion of sustaining and changing relationships.

We did not intend our Narrative Guide to serve as a rigid template, imposing categories onto these rich texts. Its purpose was to sensitize the reader to important themes, while not interfering with awareness of unanticipated meanings. We analyzed each year's interview texts with the same basic Guide, now applied to new stories about the participants' current life and self-described changes. But when a participant's path returned to the hospital, we paid particular attention, since we believe that such successive accounts will illuminate how these adolescents were making sense of a most distressing time in their young lives.

Following each participant through adolescence, we tracked enduring themes, connections, and new meanings attributed to past events. Do some adolescents, for example,

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[2] The ideas for this Narrative Guide were strongly influenced by the work of Brown and Gilligan (1992) and Main and Goldwyn (1998.)

express a dominant voice in the very first interview; a voice that is elaborated with increased increasing complexity over time? Do the adolescents' relationships evolve over time on dimensions of trust, confidence, and closeness? Ideas about enduring themes led to thoughts about how pathways of development can be discerned in these narratives. Did the resilient patients show different pathways than comparison groups -- patients with average outcomes? outcomes or high functioning non-patients Findings, based on Year 1 interviews from the nine exceptional participants and from the seven participants whose outcome scores fell between the 40th and 60th percentile of the entire patient group point to intriguing differences between these two groups.

Four themes ultimately emerged that characterized the narratives of the exceptional adolescents: narrative coherence, self-reflection/self-complexity, sense of agency, and continual gravitational pull toward forming relationships, however problematic and challenging these might be at first. It was only through careful attunement to recurring patterns in individual narratives that these themes emerged. These themes were often buried in innumerable chaotic and emotion-charged events that swept up both our exceptional and our more typical patient groups.

For both the exceptional and the average former patients, cascading family and individual events that had gone awry, leaving the individual feeling helpless and overwhelmed, were central in *Paths to the Hospital* stories were cascading family and individual events that had gone awry, leaving the individual feeling helpless and overwhelmed.. Participants spoke of many losses, school failures, paralyzing fears about attending school, accelerating self-hatred, and pervasive social unease often linked with painful isolation. Their actions, which usually propelled others to recommend hospital admission, included serious overdose, self-mutilation, and violent outbursts.

Yet, for all but one of the exceptional adolescents, stories were easily elicited and coherent; they were not surprised that the course of events led to the hospital. This was not so for the average outcome patients. Their views of how they came to the hospital were vague and strongly colored by surprise, rage, and betrayal.

Exceptional patients' *Life in the Hospital* narratives showed great variation, ranging from disturbing nightmares and continuous angry actions to forceful verbal protests about not being taken seriously. They shared a complex view of a complex confusing and rapidly changing world, in which they took leading, and quite active, roles. Several described how they became more open with others during their hospitalization, often coupled with their positive psychotherapy experiences and feeling more secure about their growing self-restraint. Exceptional participants also spoke of the hospital as being a "terrible" and unacceptable place. One participant spoke of her terror as she watched a friend placed in restraints. In brief, these patients, who had displayed such successful adult adaptation, initially perceived and constructed many sides to this extraordinary time in their lives. In stark contrast, adolescent narratives of the patients with average outcomes were virtually unidimensional: the hospital was useless, an incredible waste of time; or it was extremely helpful, where everyone was "nice."

The exceptional patients also expressed a spectrum of self-representations: self-hatred; failed self-restraint; and feeling overwhelmed. They frequently reflected about their experiences, how they elicited certain events, and how they were reacting to people and activities over which they seemed to have no control. Several described dramatic swings in their confidence and self-esteem within a single day, and then over the course of their hospital stay. Accompanying these fluctuations in self-esteem were changing self-images of their bodies, which they initially found repulsive; love of being the center of attention; and feeling "boxed up." The average patients

communicated fewer self-images, and the ones they did describe were usually characterized by low self-esteem, helplessness, and resentment over their unbearable plight.

The exceptional patients described many relationships, especially troubling ones that erupted before arriving at the hospital. For all but one exceptional patient, these pre-existing relationships were angry, frightening, and often confusing. As adolescents, all brought up their near-constant loneliness and haunting rejections from past relationships that had gone sour. Yet, at the same time, these boys and girls were constantly seeking, and finding, new individuals they might trust --a parent, sibling, peer, hospital staff member, or psychotherapist. The average patients portrayed more consistent isolation and chaos in past and present relationships.

The narratives of one exceptional patient, Sandy, illustrate and elaborate many of these themes. Sandy was 14 years old when we first met her, arriving at the hospital soon after her serious and unexpected suicide attempt. Clear about being desperately unhappy for many hours immediately before trying to kill herself with an overdose, she erupted angrily when the interviewer asked too many questions about her sadness: "I just get depressed ...I don't talk to no one. If anyone talks to me, I get really mad at them. I can't describe it ... " And Sandy doesn't want to dwell on this state:

> I don't want to think about it, but people keep bringing it back up. I don't know the answers to the questions. I don't even want to think about it. I don't even ask myself why I tried to kill myself because I'm not going to think about it.
>
> *I(nterviewer):* You want to keep it out of your mind?
>
> *S(andy):* Yup. Just like when I get out of this place, I'm gonna keep this place out of my mind...I don't like being locked up here. I don't like people

> telling me what to do, when to do it, why to do it, how to do it, where to do it and things like that. I don't like being locked up.

Other than taking occasional pleasure in drawing, Sandy's two months in the hospital were filled with unhappy, angry, resentful and discouraged moments. She reported that: "This place depresses me. It's screwing me up. It hasn't been any help to me...I just hate everything about this place." Sandy wasn't doing well, but she was exquisitely coherent in describing her difficulties, and mentally active in her attempts (sometimes functional and sometimes not so) to cope with the problems she faced.

Sandy and her family kept her hospitalization a secret to all but one or two close friends. Others were told that Sandy had gone away for a couple of months. In the weeks and years leading up to her hospitalization, many people had died or otherwise left her --a favorite grandfather, then a grandmother, an aunt, and an uncle. Her boyfriend's sister was killed in a car accident. Two days before her suicide attempt, her steady boyfriend withdrew from her, without warning, after recovering from a flare up of his chronic illness. One further stirring loss was her mother. Because Sandy and her mother were having so many fights, Sandy's mother moved out of the house two months before Sandy's overdose. A and her father moved in.

In the hospital, Sandy was troubled by her volatile relationships with other girls in her hospital unit. Relationships mattered to her. Feeling controlled by the staff, and sometimes by other patients, Sandy also wrestled with how to regulate her own emotions and impulses:

> I feel controlled in here and there's nothing I can do about it. . .I keep my anger in .. .I have it all boxed up inside of me. I'm not gonna get mad because I don't feel like getting put in four comers [restraints] ...Maybe

> I'll let it out when I get out of here. But I don't feel like getting locked up and tied down.

Again, we see Sandy's strong efforts to be *in control*. Agency was her recurring meme. Sandy described typical adolescent yearnings for independence alongside her confusion: "I don't ask anybody for advice. I figure things out for myself. I don't know what to ask people for advice right now." Sandy was uneasy and annoyed with the possibility of being sent against her will, following discharge, to a restrictive residential school that the hospital was recommending. She hated the plan, seeing it as confirming the hospital's belief that: "I can't cope with the problems myself and shit like that." Sandy was flailing, but she knew she ultimately wanted to be in charge of her own life and destiny.

One year later, Sandy was in a profoundly different relationship with a new institution. Sandy's new step-father, an alumnus of a nearby liberal co-ed private secondary school, suggested she apply there. To her surprise, she was accepted. Interviewed while she was living at this new school, Sandy's mood and connection to the interviewer was markedly different from the previous year. Sandy attributed the positive changes to her new school:

> …I was made more aware of things….It's made me more mature than I was last year...A lot of positive things. I'm more confident in myself. Last year I was not confident in myself. I was self-conscious...and if someone looked at me, I'd think they were thinking something bad about me and I'm not that way anymore. I've changed that way.

For the first time, Sandy speaks at length about her depression:

> I was getting depressed...very, very depressed and having trouble with my mother, we weren't even speaking to each other... and the fact my parents had gotten divorced. Things like that.

Sandy was able to provide a more complex account of her relationship with her mother. She noted that there were many ongoing strains connected with their struggles and felt that her mother kept belittling her, treating her like a little girl. She blamed her mother for her parents' divorce, having for years heard her "daily bitching" at her father, who was always away. Sandy's descriptions of her relationship with her mother were quite different from those of the more typical adolescent patients—who often either minimized the painful aspects of those relationships or angrily and quickly wrote them off. In her interview, Sandy indicated that she now regretted hurting her mother's feelings by accusing her mother of causing the divorce. But life with her mother continued to be volatile. Sandy exploded when her step-father, concerned about his own biological child, announced Sandy was "screwing up his daughter's mind." Feeling unprotected by her mother, who took her new husband's side, Sandy stopped talking to her mother for the next six months. Sandy's intense focus on relationships and her desire to take an agentic role were both vying for central roles in the emerging play of her life.

Sandy's relationship with her psychiatrist was also changing in notable ways. No longer disdainful and distant, she referred appreciatively to Dr. Thompson. Sandy reported that after she spoke with Dr. Thompson about both her parents, Dr. Thompson told her, "...you should look at it from both sides. And I tried it out and it worked." At the same time, Sandy's yearnings for greater independence sprung back. Immediately after praising her psychiatrist's help, Sandy announced she was ending therapy.

Sandy remained acutely aware of her strong fears of being open and exposed, of being fragile, and of being over-controlled. After first leaving the hospital, she was frightened that "... if I talked about myself and my feelings and what was going on in my head, that they'd think I needed to come back. And I was really scared about that. .. After a while I figured out... they're not going to send me back, if they let me out. Why would they send me back?" Then Sandy became more engaged in her therapy, thinking more about who she was, struggling to bring order to what she sometimes thought of as her personal chaos. Gradually, Sandy was carving out the mental space in her life to allow herself to turn to taking on some of the normative tasks of adolescent psychosocial development, tasks which had been put on hold previously.

Sandy continued to experience dramatic swings in mood, her actions, and close relationships. Soon after we met with her, one year after leaving the hospital, school authorities found her smoking marijuana in the dormitory. The school responded by restricting Sandy's activities and giving her extra work details. Her father and his new wife became enraged, adding additional punishments. Offended by what she saw as their unfairness, Sandy ceased visiting them, deciding to live only with her mother during school vacations. In the midst of describing these new quarrels with her father, Sandy remembered her life-long troubles with him over his severe and arbitrary use of power with her and her brothers. Importantly, Sandy's stories indicated that she *cared* about these relationships, and wasn't afraid to express this caring, via a desire for connection when relationships went well, or clear anger and frustration when they did not.

A few months after our interview, Sandy admitted herself to the psychiatric ward of a local hospital because she was "doing a lot of drugs" and crying all of the time. After "doing downers" every day for 15 days, she suddenly stopped. "I got totally crashed… I was like

floating for two weeks." Two weeks later, she discharged herself. "I sort of straightened myself out by myself, because they really didn't do anything for me. I mean it was more like I had to help myself and I couldn't have done it at home because I really have a lot of trouble living at home…I couldn't have handled it." Sandy's self-awareness is striking for a late adolescent.

Bill, a new boyfriend from her residential school, entered Sandy's life about this time. She spent much time with Bill's family, dazzled by their lively intellectual exchanges about politics and social issues. She loved being with this family, amazed by how much it differed from her own in its constant stress on achievement, social action, and understanding. Sandy was now thinking about how she resembled her father, along the lines of his concealing feelings and having to appear strong. Recalling his frightening violent episodes toward her mother and sister, she reflected more about herself, and her desires to be different in her relationships:

> I find it really hard to show emotions in front of people like crying….It is very hard to show weakness and I know that is like him, because he just has to be strong. And I don't trust many people, friends, which is really bad, because that is why I don't have too many close friends. And, I have always wanted to be on top. I always wanted to be ahead of everybody and the best in everything I did. Like competitiveness, I guess.

At the time of her final adolescent interview, Sandy was looking toward entering a large university, where her older brother was enrolled. She had ended her relationship with Bill, having decided that his close but complicated connection with his family, and his father's preoccupation with work were "weird." She continued to refine and sharpen her view of herself and her control over her life, and began to show signs of patience with her own development:

> I'm pretty sure of myself…I don't know if I've found my... true self or anything...but I don't like sit in my room for hours and say, "OK what am I and who am I and what am I going to be"...it'll come after awhile...After…lots of experience and stuff, I'll finally be someone. It's not like I'm wanting to go out looking for myself.

Sandy corrects the interviewer's simplistic question about whether she believes that life "unfolds beyond your will or you create the person you are," as always, wanting to acknowledge the complexity of self and of life (and to be in control of the interview):

> I think it's like everything altogether. Like you create ...what you like and what you want to do...and then stuff happens around you, that you have...no control over... influences from the outside...everything added altogether…I think I have more control…I mean like decide what kind of outside influences are going to be around you like...say if you really went to a high pressure school...then you might come out a really paranoid insecure person…like really neurotic and stuff…You get to pick what school you go to, what kind of school is going to have the kind of influence.

She was also thinking more clearly and complexly about how she affected others:

> When I get in a bad mood, I can really make things awful for people even...I regret it after and say I'm really, really sorry, I didn't mean to do that; but when I'm in a bad mood I don't care ... it's just that everything's really bad for me at that time...and I hate that, I hate that part of me.

Although wary of rejection and worried about being hurt, Sandy was hopeful about

the coming years and was now emphasizing her parents' assets -- her father's "really great mind" and her mother's "classiness."

Seven years following this late adolescent interview, we again met with Sandy who was now in her mid-twenties. Her interviewer's impressions, dictated immediately after spending several hours talking with Sandy, give a lucid summary of Sandy as a young adult.

> Sandy was very attractive, physically and personality-wise. She had just come in from work and looked very nice, in a pretty red dress and high heels and was a very pleasant person to interview, very personable ... She seems to have a very strong marriage, to be very committed to a career and very intent on finishing her college degree ... She seems to have ...some good friendships. Most of her friends are her husband's, except for her friend Karen, who she has known since high school. She was very engaged with all of the tasks. She also shared how much she enjoyed doing the interview and that she really didn't do it so much for the money, although she was going to buy herself an outfit. She was very interested and enjoyed sharing these things with us. She was a very pleasant person to have come to know.

Emerging Narrative Themes

Returning to the four themes we noted earlier, we can see how clearly they emerged from Sandy's narratives, even in the midst of so many confusing experiences and relationships in her life.

The overall coherence of Sandy's narratives is perhaps the most striking feature we see. What Sandy describes is confusing -- her life *is* confusing -- but her descriptions convey the

chaos, and the complex sense of self that she is developing within this chaos with exceptional clarity and force. From the very start, we have been struck with the ease of discerning the exceptional participants' stories -- at first about their paths to the hospital, then about their experience there. In these early accounts and in subsequent years, these patients offer coherent stories filled with intelligible responses to their recent and remote history of personal successes and failures. Sometimes these "ups and downs" are turbulent. Yet the interviewer, and later the reader, can readily grasp and comprehend much of the alternating disappointments and successes. Changes, and connections to the past were often the very first elements in a resilient participant's account upon again meeting the interviewer. Their stories existed in a larger context and they knew it and made it clear.

The second theme which emerges clearly in Sandy's narrative as well as those of the other exceptional patients we interviewed was a capacity for self-reflection and an ability to hold in mind a complex, nuanced view of self. Sandy can see herself as helpless (in the face of drug use at one point), as in control (even while threatened with four point restraints), as strong, and as afraid to show weakness. These characteristics are not contradictory for Sandy, but simply part of the complexity of her human experience, which she accepts implicitly. We've consistently seen similar patterns in the narratives of other exceptional patients. For example, each year, with much pride, one exceptional patient brought up what he called his "many life styles." He expressed this theme through his appreciation of different kinds of music: "I want to go to school and learn more and more and more. I have a lot of different kinds of music and sometimes I am really contradicting of how I think...because sometimes I am really violent and sometimes I am very passive."

Ever apparent were the resilient participant's vacillating appraisals of themselves. By no means were these evaluations increasingly positive over the years. More typically, they were marked by swings of confidence and disappointment accompanied by optimism and pessimism about life's chances. More important was participants' *awareness* of these changing self-evaluations and movement in the direction of kinder self-regard each year. Asked about what was the key to how much she had changed in the last year, Rachel explained that she felt so good about herself because of her newly found independence:

> All of a sudden you say, "I've had enough"…I think it comes with independence ... as you learn to stand on your own two feet, you learn to like yourself a lot more, because you are doing things for yourself and not letting other people do them for you...I think that's it. I'm really pleased that that is what I did.

Tolerance of ambiguity and negative facets of the self characterize this and our other exceptional patients' narratives. Self-awareness flows from this ability to view the self in all its richness and unevenness.

A strong sense of agency, or what Bandura (Bandura, 1989) has termed self-efficacy was a third theme which characterized the narratives of Sandy and the other exceptional patient s. As evidenced by Sandy's discerning observationsview, at the end of her young adult interview about how her role in life unfolds, the narratives of the resilient participants in our study show increases in a sense of self-efficacy, a belief in one's or ability to influence one's course in life. A second exceptional patient, Rachel, began to express such a view after leaving the psychiatric hospital in adolescence. At first dismayed, and then relieved, Rachel began to see herself differently:

> I didn't know where to turn ... all these people had been doing everything for me and they sent me out and they said, "Well, here you are"...and I just had to start looking for my own life ... and so after a few weeks I started realizing that things had to be done and that I was the only one that had to do them. It was easier after I started thinking that way...I'd never been able to do things on my own and then that started changing. I could control my own life; it was something else. I enjoyed it.

The following year, sad about her parents' reaction to her becoming pregnant and planning to marry, Rachel "pulled out" of her sadness:

> I stood up and said to myself, "Hey, this is my life, and this is what I want to do. I wish you could accept it. If you can't, that's too bad...that's how I stood up and said it. And they started to come around. Once they knew I was going to finish school, they knew I could get it together then. Then they felt better.

Related to this belief in agency are the resilient participants' detailed visions of their futures and the roles they see for themselves in effecting these aspirations. For Rachel, this future contained her views of becoming, in rapid succession, a wife and mother.

Each of the exceptional participants described how he or she sometimes refused to settle for a specific solution --from the hospital, therapist, or family. Several, like Sandy, found new schools for themselves, refusing to attend the school recommended by the hospital and finding a school where their academic and social development prospered. They had a sense that *they,* and not others, would be in charge of their own lives, and while typically ill-equipped to put this into

practice as adolescents, it was a goal toward which they moved unerringly as development progressed.

Finally, an intense focus upon developing relationships was a theme which emerged forcefully through all of the exceptional patients' narratives. The exceptional patients reflect often about others' motives, feelings, and thoughts. Then there is the immense importance that these individuals attribute to close friends. They persistently think about and invest in maintaining relationships. Rachel, marrying at 16, spoke of her life unraveling when she runs away from school for two weeks. And she recalled feeling "all messed up" after she and her boyfriend ended a relationship in which they both felt too dependent on each other. Soon after meeting her future husband she became more hopeful and energized, deciding then that she was "... going to pick up where I left off and not get so dependent on other people."

The exceptional participants also frequently remind us of the many intersections among representations of self, representations of relationships, and actions. Rachel, for example, spoke of the ways in which her growing good feelings about herself led her to find new friends; and how these friends, in turn, confirmed and amplified these positive views of herself.

Interface with Systematic Family Observations

Our emphasis in this chapter on personal narratives in no way negates the value of information gleaned from more traditional, quantitative methods such as systematic family observations. We expect each approach will enhance the other. In part, observations of family interactions may help in identifying the source of some of the remarkable traits displayed by our exceptional patients. Family systems theory and research has documented the role of families in protecting children and adolescents from psychopathology or poor developmental outcomes (e.g., Davies & Cicchetti, 2004; Rutter, 1998). Research by Anthony (1974) found the parents of resilient

children to be less possessive and anxious than those of the "average" child, and more likely to allow their child greater autonomy. Although much thought and research has been devoted to identifying these broad attitudes and values, fewer investigators have examined the specific ways in which parents and children may interact so as to promote resilient outcomes. In developing our approach to family observation, we were influenced by Lieber (1977) and Wynne, Jones, and Al-Khayyal (1982) who argued that healthy patterns of communication could provide the high-risk child with the resources and coping strategies that underlie subsequent resilient functioning.

Three family interaction variables were tentatively identified by Wynne and colleagues as being associated with greater competence in high-risk children: maternal warmth; a warm, active and balanced family interaction; and healthy and benign parental attributions toward the child. Building on this argument, Lieber observed that "positive focusing behaviors" (one parent taking a leadership role, clarifying and encouraging further exploration) were associated with familial "low risk" status. Through independent analyses, families' "positive behavior" predicted risk more strongly than the absence of disturbance in communication. Lieber concluded that *parental facilitation* of communication was worthy of further exploration.

Parental facilitation, or in our terms, "enabling," is likely an important family component, perhaps particularly so during adolescence. We were initially motivated by an interest in examining whether families of disturbed adolescents can be distinguished by parents' attempts to interfere with the autonomous and agentic functioning of their children. Among these impediments to independent perceptions and actions are "binding" (constraining) interactions through which parents actively resist the differentiation of their children. Building on Lieber, we expanded this theory to account for *enabling* interactions, through which family members encourage or support the expression of more independent perceptions or thoughts. Beside the

detailed study of parental constraining and enabling, our work emphasizes bi-directionality, as we examine interactions from adolescent to parent as well as those from parent to adolescent.

Shortly after each year's individual assessments from which our narrative analyses were drawn, patients and parents also participated in a revealed differences procedure (Strodtbeck, 1951). Each family member met separately with one experimenter and responded to the same set of Kohlberg (1981) moral dilemmas (Hauser et al., 1984; Hauser, 1991). The family then reassembled to defend and attempt to resolve their differences for three different coalitions that we identified in advance based on their answers to the dilemmas: adolescent and mother versus father; adolescent and father versus mother; and adolescent versus mother *and* father. The intent of this procedure was to probe how adolescents and their parents resolved differences around deep moral questions -- like the morality of robbing to save a wife's life; or how a son should respond to his father's breaking a long term promise when the father impulsively takes his son's newspaper boy earnings to use for his own fishing trip. Driven by theoretical and clinical considerations, we designed a microanalytic approach, the Constraining and Enabling Coding System (CECS), to identify the presence of behaviors (e.g., acceptance, cusiosity) that *enable* interactions and those (e.g., devaluing, distracting) that *constrain* interactions (see Hauser et al., 1984 for more details). The CECS also captures whether the complexity and clarity of the family's discourse improves across speech turns or degrades.

In previous studies (e.g., Hauser et al., 1984; Hauser, 1991), we found greater prevalence of enabling interactions in families whose adolescents function at higher levels of ego development, as contrasted with the increased frequency of constraining within those families whose adolescents are functioning at lower ego development levels. More recent analyses indicate that the exceptional adolescents, while hospitalized, were consistently more enabling

toward both parents. In other words, during —a particularly stressful period these boys and girls were more accepting and empathic towards their parents in conversations about difficult moral dilemmas. Moreover, both parents expressed higher levels of enabling towards these exceptional boys and girls. Were their enabling behaviors reflecting the robust ways that these patients were coping with this chaotic time in their lives? Or could it be that the hospital was providing a welcome "time out" fr om a distressing, perhaps even destructive, family and school environment? Coming togetherReunited again with their parents,, while no longer living at home on atogether on a daily basis,, could then reflectmight potentially facilitate the development of renewed interest in productive interactions not diminished by daily hassles. These two interpretations are *not* mutually exclusive.

The unique interaction patterns in the families of the patients that turned out to lead exceptional lives in the early adult years -- higher levels of many kinds of affective enabling expressed by the exceptional adolescents and specific kinds of cognitive and affective enabling expressed by their parents (i.e., curiosity, empathy) -- suggest that this group of patients may have been able to maintain adaptive relationships with their parents, in which their attempts at connection were reciprocated in ways that facilitate family discourse. These mutually positive engaging interactions are especially striking in that they were occurring during a time that was turbulent for the adolescents and their parents, as their sons and daughters were resentful and disappointed. Do these interactions contain the seeds of the coherence, sense of self, agency, and relationship focus, which were displayed by our exceptional patients? This is a question we must await future research to answer, although the linkages we observed suggest this is a promising avenue to pursue.

The Role of Narrative in Resilience

In the long run, detailed readings of these narratives may help us address questions about the ways in which they may have contributed to these patients' subsequent young adult development. How, for example, do self-narrative complexity and coherence lead to recovery and psychological health? Does the patient's recognition and expression of these accounts enhance ongoing and later adaptation?

As we think about the direction of influence between narratives and adaptation, it's important to recognize the strong possibility that causal paths may not necessarily move from narratives to outcomes. These narratives could be markers of adaptation, reflecting changing life circumstances and optimism. In this view improved adaptation is reflected in more reflective and coherent narratives. Alternatively, reflection and narrative construction may be critical coping resources that help the individual thrive in the face of adversity. New visions and life plans along with renewed motivation may be the product of sustained reflection that is reflected evidenced in narratives.

Longitudinal analyses of the interviews of these nine former patients, combined with parallel analyses of more typically functioning patients, can help elucidate some of these potentially complex causal pathways. For instance, our analyses suggest that average outcome patients experienced greater helplessness, rage, and diminished self-esteem as adolescents than exceptional adolescents. Fewer steadily supportive and protective relationships with friends and family were available. Delineating key dimensions through these qualitative analyses should make it possible for others to take the next steps of defining new variables that can be systematically coded in these and other adolescent interviews. These constructs can then be examined in relation to other theoretically relevant adolescent variables, such as ego development and self-esteem. Most importantly, future work might clarify how narratives such

as these might predict the development of young adult close relationships, attachment, and psychopathology.

Understanding generated via narrative analysis can also shed light on the ways in which exceptional adolescents adapted to trying circumstances during a stressful period in their development. Tracing the flow of meanings adolescents give to the self and to relationships points to mechanisms that might underlie exceptional outcomes. Formal characteristics of their teenage narratives, such as increasing coherence over the years and emerging self-reflection, may be among the special features that distinguish these young adults from their more typical peers. Through such developing skills, these adolescents may have compensated for serious psychopathology and adverse hospital and home circumstances, as well as exploited available resources such as psychotherapy, special teachers, and schools. Traditional pencil and paper measures and even careful observations of behavior may not be attuned to the subtle manifestations of these inner strengths.

Implications and Future Directions

The narrative and family observation data raise many issues and questions. The central question, to be sure, is what they add to our knowledge of resilience. The narrative approach we have taken has several methodological and substantive implications. In terms of methods, it represents a shift from a traditional focus on small, isolated elements of interviews to a more integrated and contextualized focus on larger narratives. Our previous analyses of interviews were based on dimensions (e.g., expressed affect, defenses, adaptive strengths) reflected in one or two speech segments. In the narrative work presented here, we have deliberately shifted to distinctions requiring larger texts to detect their presence. As we worked with our previous methods, we often had the impression that we were *not* capturing fundamental aspects of a

participant's experience or grasping his or her past and present representations. And when coders would point out these limitations, we'd usually speak, somewhat dismissively, about the compromises involved in carrying out empirical research; how we could not possibly study all the important, and unique, features embodied in one individual's rich interview, since our analyses weren't "clinical" ones. Looking back, we can now see that these compelling questions, raised by sensitive students, were tied to two problems. First, the units we were analyzing were too constricted. Fuller portions of text are required to see and identify certain nuances of form and meaning. But more importantly, our eyes were focused on categories derived from our own theoretical lens. Defenses, adaptive strengths, and specific emotions all come from theoretical perspectives that we assumed relevant to answering our questions and led us to a variable-focused approach that captured elements of these constructs. Concerns about the limitations of these variable-centered approaches led to our constructing a new way to analyze narratives within adolescent and young adult interviews, our Narrative Guide for interview texts.

What can we learn about resilience through looking at the interviews and narratives? Cohler (e.g., Cohler et al., 1995) has most consistently argued for incorporating this approach in the study of resilient development, but more recently personality psychologists have championed the potential of narrative analysis for understanding adaptation across the life cycle (Lilgendahl & McAdams, in press; Pals, 2006). Cohler (1987) has argued that narratives offer "...information about the manner in which persons understand or interpret misfortune. For some persons ...particular forms of adversity are experienced as insurmountable obstacles; others are able to use these misfortunes as the basis for renewed efforts at coping, leading to continued resilience" (p. 397). And he reminds us that "little is known about the manner in which persons create particular narratives and become committed to particular strategies for resolving problems

that are most consistent with their sense of self and the totality of their life histories" (p. 398). Through the narrative analyses presented here, we already have a better grasp of how our exceptional participants perceived and understood themselves and their interpersonal worlds at the time of major disturbance, and ways these constructions changed over time.

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