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Overcoming Adversity in Adolescence: Narratives of Resilience

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Our overarching goal is to understand the unfolding of resilient development. Our person-based approach is based on a follow-back design, enabling us to examine previously recorded adolescent clinical and adult attachment interviews of now-competent young adults who experienced significant adversity during their adolescent years.

In their adolescent years, these young adults encountered three serious misfortunes. Between 13 and 16 years old (middle adolescence) they were sent to live in a psychiatric hospital, from 2 to 12 months. Their physical home ties with their parents and community friends were abruptly severed, as they lived full-time in High Valley Hospital. In addition, experiencing a serious psychiatric disorder leading to hospitalization, regardless of how time limited, can markedly change the experience of self, often leading to lowered self-regard and lowered personal competence. The label of psychiatric patient is made even more indelible by living in a psychiatric hospital. Their third serious misfortune was trauma. Many of the young adults previously reported serious child and adolescent physical abuse at the hands of immediate family members or other close relatives. Using a profile definition (ego development levels, attachment coherence, close relationships, and social competence), we identified nine young adults who were now

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functioning in the upper 50th percentile of all former patients and same age high school nonpatient adolescents. After being identified, our intensive study of the narratives embedded in earlier interviews revealed key themes for these resilient young adults—including agency, reflectiveness, relationship recruiting—differentiating them from contrasting young adults, who were also former patients. We illustrate these differences through narratives of two resilient young adults.

Nothing is so fascinating or complicated as a trajectory of a human life. We emerge partly programmed at birth, and we change with our experiences thereafter. Some of us finally blow apart in adulthood like long-fuse time bombs, while others grow to shine brightly like comets. Most of us have less spectacular careers, which are still hard to explain in hindsight, even to ourselves, and impossible to foresee in detail.

JARED DIAMOND (1995) OFFERS THIS REFLECTION IN HIS REVIEW OF E. O. Wilson's (1994) autobiography, a *narrative* highlighting the daunting challenges involved in understanding the course of individual lives. A distinguished biologist, Wilson describes his early origins as ones filled with major risks: the only child of parents divorced when he was seven, leaving him in the care of others; his father's debilitating alcoholism and eventual suicide; impaired hearing as a child; and in the year of his parent's divorce becoming virtually blind in one eye. Wilson's striking turn from early misfortune to stunning competence and success is a compelling feature of human lives that draws the attention, curiosity, and extended energies of many of us to longitudinal studies. In our longitudinal research program, we now use narratives and new narrative analyses to discover basic mechanisms and pathways underlying the kind of surprise life course changes that Wilson chronicles, exemplifying resilient development.

Resilience refers to unexpected adaptation in the face of serious adversity. How such development occurs remains an unsolved mystery. Through his inclusive and clear question, Roosa (2000) conveys this challenge, "What is it about some children and adolescents and their environments that allows them to maintain or subsequently achieve a positive developmental trajectory, when many of their peers in similar circumstances are not able to do so?" (p. 567)

Resilience has picked up many meanings in our popular culture—competence, resilient perfume, resilient marijuana plants, resilient politicians,

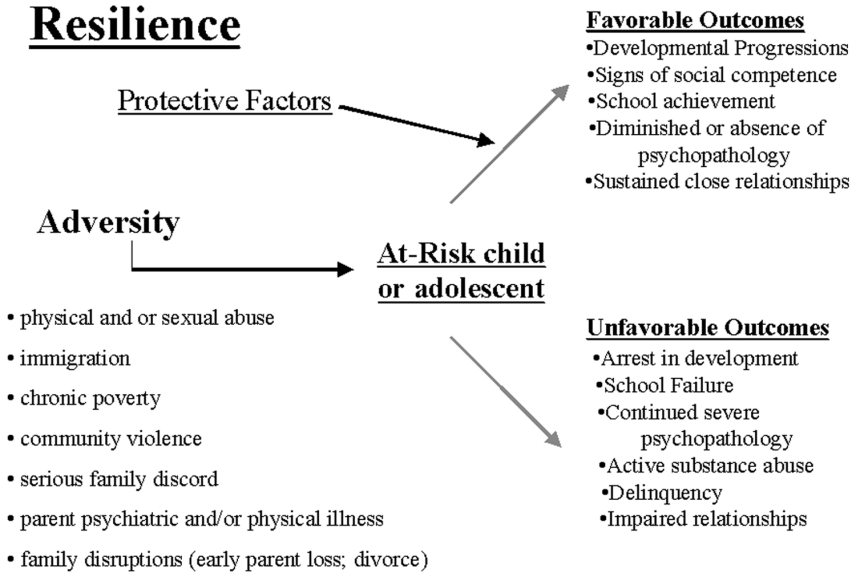

FIGURE 1.

resilient Taliban, and the supposed-invulnerable child. Figure 1 schematically presents a working definition of resilience, emphasizing that the idea of "resilient outcomes" refers to *only* competent outcomes that occur despite the individual's prior exposure to and experience of serious adversity.

Masten and colleagues (1990) point out that resilience can refer to three major classes of phenomena in the psychological literature. Different research approaches are associated with investigations of each set of phenomena:

1. Individuals in *high-risk groups* who have better-than-expected outcomes ("those who overcome the odds" against good development). Theoretical accounts and vignettes about successful people from highly disadvantaged backgrounds are of much interest to many psychiatric and social science observers (e.g., Beardslee and Podorefsky, 1988; Wang and Gordon, 1994; Harrington and Boardman, 1997). Stories of unexpected life paths are often consistent with the findings generated by variable-based

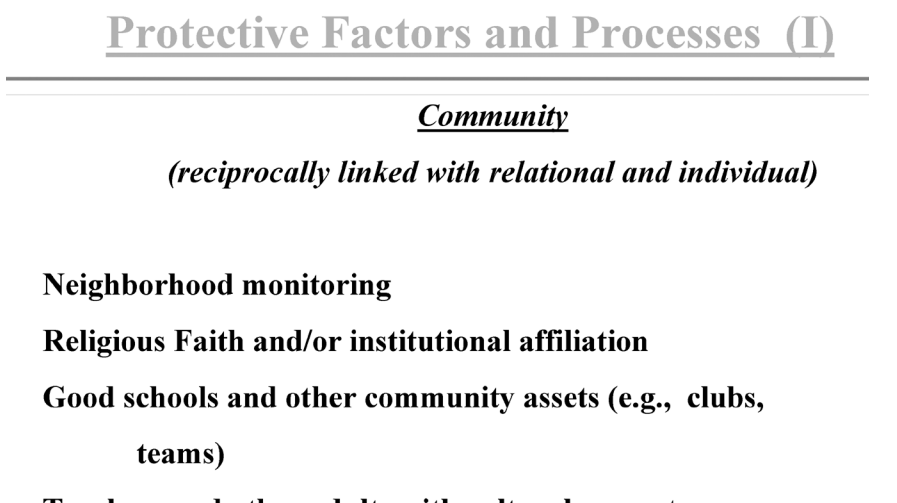

FIGURE 2.

studies of specific outcomes in resilient high-risk children. Studies of these phenomena pursue predictors of good outcomes and shed light on *protective factors* that might lead to such outcomes (Figures 2 and 3).

2. *Good individual adaptation despite adverse events*, experiences of misfortune. Sometimes there is a focus on a common experience such as divorce. Other times the interest is in the composite of heterogeneous adverse experiences during a specific time period in development. Still other times, there is an interest in the immediate impact and subsequent events following specific misfortunes, like the early loss of a parent, serious parental illness, sustained poverty. This second conceptualization leads to an individual life trajectory approach (Figure 4) in contrast to the epidemiological one inherent in the at-risk view portrayed in the previous slide.

3. Individual differences in *recovering from trauma.* Traumatic experiences represent adversities of great severity, with acute onset or chronic repetition (as in child abuse), going well beyond the challenges normally faced in

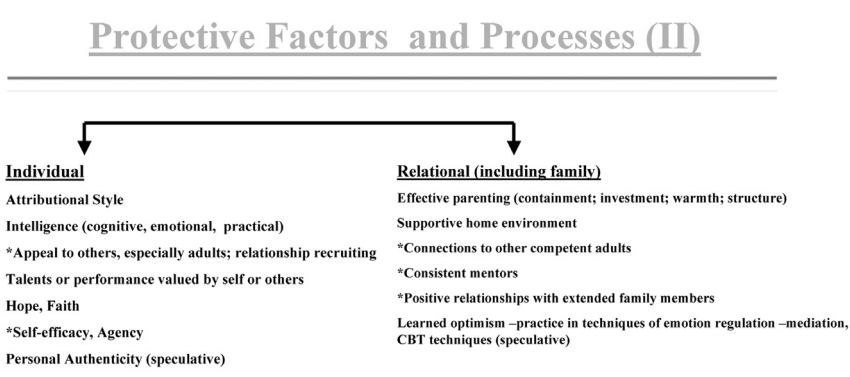

FIGURE 3.

development. Traumatic events or experiences may be natural ones—as in floods or earthquakes—or created by human design, as in war, torture, or child abuse. By their very nature, traumatic experiences are expected to reduce the quality of functioning. In the case of these extreme or life threatening stressors, resilience refers to patterns of recovery.

Besides illustrating this third view of resilience, this composite trajectory also conveys the idea that an individual's resilience *changes* over the life course. It is through person-based approaches, what Luthar and Cushing (1999) call "individual-based measurement for the study of resilience," that we study the unfolding of resilience in individual lives (also, cf. Gjerde, Chang, and Kremen, 1998). *Person-centered approaches* contrast with *variable-centered* strategies. In variable-based analyses we lack information about the exposure and experience of *specific individuals* to the hypothesized risk factors in the overall high-risk sample. Consequently, in variable-centered analyses we do not know which individuals within a particular sample actually meet the resilience definition specifying *both* high risk and high competence. Also omitted are other aspects of their lives and contexts, like their access to the resources provided by individual, relational, and community protective factors (Figures 2 and 3). For all three classes of resilience phenomena, authors generally define resilience in terms of successful adaptation despite challenging or threatening

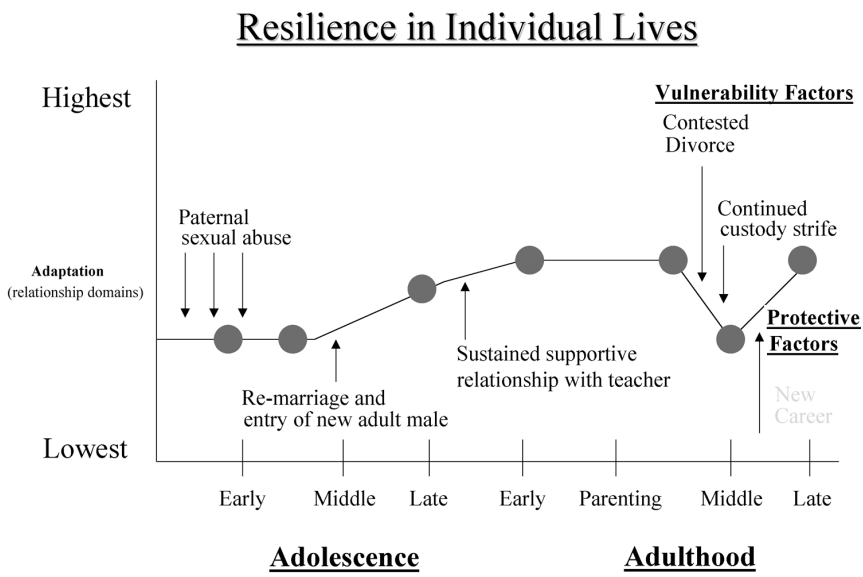

FIGURE 4.

circumstances. This adaptation usually includes internal states of well-being or effective functioning in the environment, or both (Masten et al., 1990). The definition of resilient development that we use includes internal states and observed actions.

Protective factors are key constructs in conceptualizations of resilience. These dimensions moderate the effects of individual vulnerabilities or environmental hazards, so that a given developmental trajectory reflects more adaptation in a given domain than would be the case if protective processes were not operating. On the other hand, protective factors (and the underlying component processes that they include) do not *necessarily* lead to resilience. Many have observed that protective processes may not be sufficient if the severity of the adversity is too great (e.g., Sameroff, Seifer and Zax, 1982). Longitudinal and cross-sectional studies have illuminated protective factors from several domains. Figures two and three—synthesized from Rutter (1987), Werner and Smith (1992), Vaillant (1993), Wang and Gordon (1994), Masten (1996), Werner (1996)—summarize processes conceptualized as

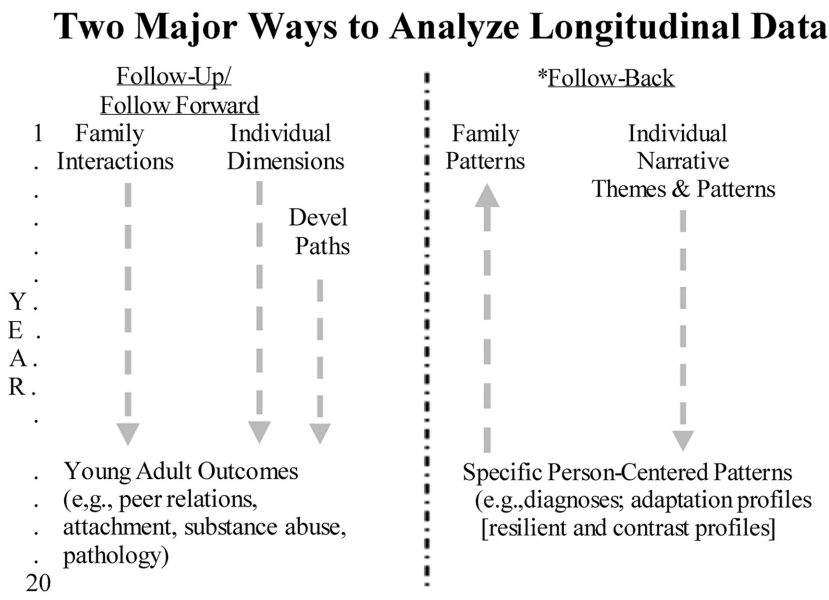

FIGURE 5.

fostering resilience. In discussing our resilience studies from a person-centered approach, we consider individual and relational protective processes, which we consider to be closely connected.

Our overarching goal is to understand how resilient development unfolds. Our approach is a person-based one, based on a *follow-back* design (Figure 5) through which we examine previously recorded adolescent and adult interviews of now-competent young adults who experienced significant misfortunes during their adolescent years.

In their adolescent years, these young adults encountered three serious misfortunes. First, between 13 and 16 years old (middle adolescence) they were required to live in a psychiatric hospital from 2 to 12 months. Their physical home ties with their parents and community friends had been abruptly severed as they became residents of High Valley Hospital. Second, experiencing a serious psychiatric disorder leading to hospitalization, regardless of how time limited, can markedly change the experience of self, often leading to lowered self-regard and lowered personal competence

(Cohler et al., 1995). The label of psychiatric patient is made even more indelible by living in a psychiatric hospital. The third serious misfortune was trauma. Several of the young adults, now functioning in highly competent ways, reported serious child and adolescent physical abuse at the hands of immediate family members or other close relatives.

As we now study these resilient young adults, we focus largely upon individual and interpersonal characteristics that—as protective factors—may have provided varied resources and strengths for countering the effects of adversities they had faced before ever becoming hospitalized psychiatric patients as well as ongoing difficulties in the hospital and after leaving it. Using their *narratives*, drawn from our annual adolescent and later adult semistructured, clinically guided interviews, we are locating formal and thematic components within the discourse of those young adults who followed resilient trajectories. While our findings can be most precisely understood as representing individual protective processes, the reciprocal connection between individual and relational protective factors suggests that these narratives will also reveal how the adolescents and young adults recruited, sustained, and experienced *relationships*. In short, in our quest to account for young adult resilient outcomes, we are now drawing upon new analyses of individual narratives expressed over a 20-year period. We expect our participants' many stories of themselves and their relationships can lead us to new conceptualizations of protective processes, more refined analyses of previously identified protective factors, and a more comprehensive understanding of how these processes ameliorate adverse experiences.

We begin with Eve.[1]

> I know I could try. But I know if I try I know how to go back. … In between you can go up or you can go down. And ifyou 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, just 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

[1]All names of subjects in this article are not their actual names. In addition, to protect confidentiality, other possible identifying information such as hospital names or locations, are also changed.

> sink down. Right now I'm sinking. But I think I might be able to work things out.

As a fourteen year old, Eve is thinking aloud about changing, a year after slashing her forehead and heavily abusing drugs. Sixteen years later, now a mother of three very young children, she tells about her struggles as a parent:

> I'm a good parent. … When the kids were younger, I always used to like arts and crafts with them. … And then I … went back to work. Before I would do a lot of stuff with them, and now it's more like "just find something for yourself to do." … Once in a while I'll get feeling real guilty, and now I'm gonna do something with my kids and I don't care if the house is falling apart. Then so be it. I'm going to do something and we'll go out. … We'll sit there and I'll make picnic lunches and we'll get a blanket. And we'll lay on the grass before I've got to go to work.

A decade after first meeting Eve, we discovered that she and eight other young men and women, seriously disturbed during their teenage years, were now leading competent and productive lives. As adolescents they experienced a remarkable derailment. Usually by surprise, they were abruptly admitted to a psychiatric hospital. Separated from their families, in new bewildering surroundings they had to respond to unfamiliar adults whom they never asked to be their caretakers and attend a special school they found repugnant. Picture these young adolescents: already seriously troubled, they were now thrust into a new disturbing neighborhood, a large hospital community, and a new school; they were forced to contend with many frightening peers, classmates, and adults. How did these teenage boys and girls make sense of this unexpected long stay at Amity, a hospital not of their choosing? And now, almost two decades later, how do these young men and women understand their time in the hospital and what happened after their departure?

Our new longitudinal resilience project takes up these and related questions. In 1978, we began meeting with the 146 middle adolescents *and* their families (Hauser, 1991). Equal numbers were drawn from two groups: nonpsychotic patients from a private medical school teaching hospital and volunteers from the freshman class of a local high school. The patients included three major diagnostic groups: disruptive behavior disorders,

TABLE 1
Original Adolescent Sample

	Male	*Female*	*Total*
Psychiatric	39	31	70
High school	34	42	76

mood disorders, and personality disorders. We excluded psychotic patients and those with evidence of mental retardation or medical conditions associated with psychiatric sequelae. The patient and high school samples were comparable in age, race, and family type (one-parent and two-parent); they were predominantly Caucasian middle and upper-middle class. (Table 1 provides a fuller description of this original adolescent sample.)

Over successive adolescent 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 (Table 2).

During these one to two hour clinical research interviews, participants were encouraged to associatively respond to inquiries about their family and individual history, peer and family experience, school life, dealing with conflicts, and visions of the future. In previous analyses we used the tapes and transcripts of these interviews to assess coping strategies, self-images, and emotion expression (e.g., Hauser, Powers, and Noam, 1991; Hauser and Safyer, 1994). Now we are examining our original participants' interviews in a new way, looking closely at the stories they told about their lives, within extended yearly interviews over three adolescent years and one young adult year.

Eleven years ago, we located *all* of the former high- and low-risk adolescents and met with 97.2% of those young adults still alive (Table 3). In this developmental era, through a spectrum of conceptually relevant measures, we assessed dimensions referring to their psychosocial development, close relationships, attachment representations, and several aspects of social competence (Table 4). Many of the young adults were beginning new families, alerting us to the opportunity for extending our longitudinal program to study marriage and parenting in a third generation.

TABLE 2
Adolescence: Annual Assessments

1.	Ego development (Washington University sentence Complection Test [WUSCT] Hg & Loevinger, 1996
2.	Adaptive strengths and defenses (clinical research interview and coping scales Beardsleen, W.R., Jacobsen, A.M., Hauser, S.T., Noarn, G.V., et al., 1986)
3.	Emotion expression (Clinical Research Interview, and Affect Expression Coding Scales [AECS]; Hauser & Sayfeger, 1994
*4.	*Narrative accounts of self-themes, relationships, and resolutions (clinical research interview and readers' guide)*
5.	Self-image integration and continuity (self-image Q-sort)
6.	Self-esteem (Coopersmith self-esteem inventory; Coopersmith, 1967)

*Data and coding providing the primary material for the narrative analyses used in this paper, and in Hauser, Allen, & Golden, 2006

After meeting with our young adult participants, several interviewers were astonished when the person they had been speaking with for the past couple of hours revealed she lived in High Valley Hospital as an adolescent because of her teenage near-lethal suicide attempts. Their amazement was especially meaningful, since our interviewers were deliberately kept unaware of the psychiatric histories of anyone with whom they were meeting. These surprises led to our new questions and curiosity about resilience.

To begin with, *what* about these young adults was surprising the interviewers? Interviewing our interviewers and exploring the resilience literature (e.g., Rutter, 1987; Masten, Best, and Garmezy, 1990) led to our conceptualizing resilient young adult development in terms of *individual outcome profiles*, encompassing ego development, close relationships functioning, and social competence. We translated this conceptual definition into an empirical one. Most noteworthy is that by applying this definition we

TABLE 3
Young Adult Sample

	Male	*Female*	*Total*
Former psychiatric	37	29	66
Former high school	34	42	76

Note. Total = 97.3% of original sample.

TABLE 4
Young Adult Functioning Dimensions Assessed

1. Ego development (Hg & Loeveinger, 1996)
2. Quality of peer interactions perceived by friends (Kobak & Sceery, 1988)
3. Close peer relationships (Berscheid, Snyder, & Omoto, 1987)
4. Adult attachment representation coherence (Main & Goldwyn, 1998)
5. Social competence—three measures: criminal behavior, substance abuse, and psychiatric symptoms (Eliot & Ageton, 1980; Eliot, et al., 1983; Derogatis, 1983)

could systematically identify those young adults functioning in ways consistent with what the extant literature terms *resilient outcomes.* In addition, we defined a comparison group, those former patients with "average" outcomes, showing neither stellar nor dismal functioning in their young adult years. Having conceptually (and then empirically as described below) defined these special groups, we then used *a narrative approach* to intensively study the adolescent experience of each woman or man, thereby tackling the question of whether there were early clues, markers, in their spoken narratives—expressed in successive years between ages 14 to 17—that might have predicted which of these boys and girls would later show resilient outcomes. In other words, we followed a group of resilient and average outcome young adults *back* to their adolescent years (Figure 5). Fortunately, we had consistently audio recorded all interviews, though not then for the purpose of studying resilience, since we had not been thinking of such questions when we began this project.

Our most pressing initial task was to empirically define both (a) what we thought the interviewers were seeing when they expressed such surprise to us and (b) the comparison group of young adult former patients. By linking specific assessments with each dimension of our resilience conceptual profile, we could then create an empirical definition of resilience. We first identified former patients whose array of development and close relationship scores were *above* the 50th percentile for the entire sample (all former patients and nonpatients). We used four measures: ego development (Loevinger, 1976), ego resiliency as judged by friends (Kobak and Sceery, 1988), relationship closeness (Berscheid, Snyder, & Omoto, 1987), and attachment representation coherence (Main and Goldwyn, 1998). Our evidence of former patients' social competence was their having scores *below* the 50th percentile for the entire sample (all the nonpatient high school students and former patients) on three indices:

hard drug use in the past six months (Elliot et al., 1983), criminal behavior in the past six months (Elliot et al., 1983), and global psychiatric symptoms (Derogatis, 1983). Four men and five women, 13% of the 67 former patients, fit this profile definition of young adult resilience. We then defined the "average functioning" group as young adult former patients who fell between the 40th and 60th percentile of *all former patients* on all seven young adult functioning measures (Figure 4).

Having identified the young adult resilient subjects, we could now—through our follow-back design—examine our years of adolescent observations. Available were data generated by a panoply of methods encompassing semistructured interviews, self-report questionnaires, and systematic coding of observed family interactions. We chose a new point of departure: the *complex and resonant personal narratives* embedded within the many hours of each subject's adolescent and young adult interviews. Through new detailed studies we expected to discover previously uncharacterized individual and relational protective processes, components likely not readily assessed by our previous measures of self-images, self-esteem, and coping mechanisms. Because we planned to follow, for each subject, up to eight interviews over two developmental eras, we would also be positioned to probe yet another compelling question: Do the nature and effectiveness of these presumed protective processes change over the life course for resilient and less resilient subjects?

Gay Becker (1997) describes narratives as the stories people tell about themselves, reflecting people's experience as they see it and as they wish to have others see it. "Through stories people organize, display and work through their experiences." She argues, "narratives can be a potent force in mediating disruption, whether the disruption is caused by illness or personal misfortune" (p. 25). Through narrative analyses we can begin to grasp how individuals create and maintain coherence over time. Rita Charon extends these ideas in her recent writing about narrative medicine, a framework she and others propose as a model of humane and effective medical practice:

> As patient meets physician, a conversation ensues. A story—a state of affairs or a set of events is recounted—by the patient in her or his acts of narrating, resulting in a complicated narrative of illness told in words, gestures, physical findings, and silences and burdened not only with the objective information about the illness but also with the fears, hopes, and implications associated with it. As in psychoanalysis, in all of medical practice the narrating of the patient's story

> is a therapeutically central act because to find words to contain the disorder and its attendant worries gives shape to and control over the chaos of illness (Charon, 2001).

Narrative approaches have a long history in the social sciences and psychoanalysis. Linguistics, anthropology, psychology, history, philosophy, and sociology have all contributed different approaches and associated emphases. Within psychoanalysis, Schafer (1992) and Spence (1986) use narrative frameworks in their considerations of psychoanalytic dialog, constructions, and epistemology. Besides Becker and Charon, influencing the narrative methods we're developing are contributions by Jerome Bruner (1990, 1994), Elliot Mishler (1995), Carol Gilligan (Brown and Gilligan, 1992), Michael Lewis (1997), Mary Main (Main and Goldwyn, 1998), Katherine Reissman (1993), and Bert Cohler (e.g., Cohler, Stott and Musick, 1995).

Based on our reading of the resilience and adult attachment literatures and many reviews of the adolescent interviews, we created a guide for analyzing narratives within the open-ended interviews.[2] Our guide alerts the narrative analyst to content areas and structural features likely relevant to resilient outcomes. We begin by demarcating *two stories*, the patient's path to the hospital and his or her life within the hospital. These stories are extracted from all of the first year interviews. Important formal aspects of these and subsequent key stories (described below) are coherence and passivity or vagueness in discourse (Main and Goldwyn, 1998). Thematic components of interest include representations of *self* and of *interpersonal relationships.* With respect to *self* we consider ways of disclosure and privacy, self-reflection, agency, self-efficacy, self-esteem, aspirations, helplessness, and long-term visions. Representations of relationships include the extent to which the person speaks about them as interconnected—how he or she seeks, recruits, and maintains ties with others.

Noteworthy is the fact that we did *not* intend our guide to be a constrained coding system, a rigid template forcing categories onto these rich texts. Rather, our guide was designed to sensitize the reader to important clusters of themes, while encouraging openness to novel patterns within the interview discourse. After the hospital year, we continued to analyze

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

subsequent years' interviews, using the same guide. Now our questions about self and relationship representations were applied to new stories about *current life* and *self-described changes.* But when a participant brings up her path to High Valley hospital and to her life there, we pay close attention since we expect that this revisiting may shed new light on the changing ways resilient adolescents made sense of this extraordinary time in their lives. Since we believe that it is through following individual lives over time that we can gain the strongest insights from our narrative analyses, we return to Eve, tracing her parenting narratives through her adolescence (about her parents) to her early thirties (as a parent).

Eve

Restless and desperate at school and at home, Eve was admitted to Amity Hospital at age 13, actively confused, with disorganized behavior, and self-mutilation. For years, Eve expressed mounting disappointment about her parents. Although she first described her father as supportive, in all later years she portrayed him as severe, dogged, angry, and disrespectful. She felt deeply troubled by him in two ways.

> My father gave up trying. … He told me no matter what, he would never give up. … He let me down and he let himself down. … I knew all the time my father was going to give up. … And it wasn't a shock to me. … It's like you are waiting for someone to die. When they die, you know.

The second way was by consistently telling her how bad her thinking and friends were, stubbornly insisting that she's an "asshole."

> … [I'm] getting to the point I'm not gonna care. I am gonna end up being a jerk—I'll probably go away.

Yet sometimes, while anguished over her father's verbal abuse and her mother's passive agreement with the abuse, Eve reflects about them:

> … they always blamed their problems on us. We could be a little bit of the cause. … But they didn't have to do half the shit they did. The choice was theirs.

Similarly, Eve recognizes that it is her *own* choice to "do anything wrong. … "

> Because I know what's right and wrong … I'll just make decisions for myself … and if it turns out that I'm an asshole by making a decision instead of him, then that's tough luck. … I found out the only person who could fix things is me. … If I mess up, at least I will know it's my fault.

Within Eve's reflections about herself is an important quality—recognizing her responsibility for her thoughts and actions—what David Bakan (1966) terms human "agency."

In late adolescence, Eve describes more peaceful times with her parents, now liking her mother "better" and not talking to her father because he makes her too uncomfortable. In great detail, she characterizes his fixed ideas; in any discussion with him he "always comes back with his opinion and his opinion would always have to be right … whatever he says goes." What's now fostering greater harmony within the family is Eve's not confronting him by yelling at him. "I'll say [to him] this is what I want to do." Seeing she's like her father in being "dead set against things," is a new insight she has in her last adolescent interview.

Seven years later, when we meet Eve as a young adult, she portrays more complex pictures of both parents *and* continues to speak about themes she expressed in her adolescent narratives. Her mother, as Eve looks back on child and adolescent years, was giving, caring, and understanding. These are clearly more positive attributes than ever appeared in Eve's adolescent narratives. Yet Eve recalls how confused her mother was, "because she didn't know what to do," and how mad she was, because "she was stuck in the house all day with her three children, unable to go out and find a job or return to school."

Eve's young adult narrative of her father first appears more generous—fun loving, caring, kind. In a few moments, her more ominous image appears:

> He had a mental way of working on you, [making you] feel … you were worthless … he'd put you down about everything you did. … If you cared about your friends, he'd say, "your friends are a piece of garbage," and to us they were important. … No physical abuse … just threats. …

Now a parent of three children under five years old, Eve describes her almost automatic reaction of quickly closing down and not listening, the moment she senses her father is about to criticize her, to get in one of his states where, " … he's being so ignorant about being not able to budge either way in understanding where you're coming from."

As she looks back, Eve's strongest regrets about her father remain: That he couldn't be more empathic, see where she was "coming from," and not intimidate her. While some of her constructions of him have become more nuanced and positive, her powerful awareness of his stubbornness and verbal abuse persist, presenting constant dangers to her growing sense of confidence and well-being.

Three years later, Eve tells us about her second child. She sees her four-year-old son, Bobby, as "more like his dad, because he's real slow." And not only is he slow, "it's like he's not trying. … He gives up more. … He'll go back one day and finally get it." Added to his slowness and lack of persistence is his stubbornness, short attention span, and provocative temper tantrums. Echoing her experience of pervasive criticism by her father are Eve's strong and many-sided disappointments with Bobby.

Eve refuses to tolerate Bobby's weaknesses. She believes her attitude will help him know that other people are not going to tolerate his limitations either. Her father and husband converge, as she describes her husband as looking at things "like either it's right or wrong and that's not it." In contrast, Eve is proud of her propensity to step back and think about there being …

> different ways, different perspectives and depending on … the way you are in life, … things change so you can't always be contradicting things or criticizing things. You have to be more of an open-minded type. I got that from my teenage years.

Finally, Eve believes that one of her most serious limitations is her reluctance to strongly discipline Bobby. Her parents were also reluctant, and her father still regrets not beating her. She has Bobby go to the corner, take time out, hold his breath. Similar to her parents, who "didn't hit us much," Eve does not want to punish her children in "heavy duty" ways.

Along the lines of content (discipline, specific child criticism of stubbornness, and lack of persistence) and style (being reflective, taking responsibility), we see Eve expressing—over a decade later—varied continuities from her adolescent narratives. Yet we also find signs of change in terms of

TABLE 5
Two Young Adults: Resilient and Average Outcomes I

Adolescence	
Eve (Resilient)	*Pam (Average)*
Suicidal, drugs	Suicidal, withdrawn
Many episodes with both parents	Minimal description of mother or of relationship
Numerous disappointing and rejecting interactions with mother and father	Father absent from any episodes
Reflections about each parent	No stepping back from either parent
Recognition of her contribution to parenting relationship	No reference to any effect she has on mother or father

her more multifaceted and forgiving descriptions of her parents. Nonetheless, her father's closed-mindedness, criticizing, severity, and angry disappointment are pervasive in her descriptions of him; and they suffuse her images of her husband and young son.

Sharply differing from Eve, Pam speaks in limited ways about her new parenting experiences. Only occasionally does she speak of her own parents. She is unhappy as a parent—Pam is tired of her several marriages, of having children each year. And she has lost custody of her children. Many of the average outcome former patients tell us of unstable marriages, together with barely decipherable connections with adolescent parenting images. Their stories are stark, portraying great loneliness, few signs of agency or hopes for change, and few relationships. Tables 5, 6, and 7 summarize several differences between Eve and Pam's parenting narratives, told during their adolescent and adult years.

Pete

A second resilient young adult arrived at Amity after 12 public and private school expulsions where his explosive violence made him almost instantly unwelcome in each new setting. Yet with unusual ease for a 14-year-old, Pete tells new adults at Amity about a family life replete with threats, tempers, and sudden physical brawls. His abusive relationship

TABLE 6
Two Young Adults: Resilient and Average Outcomes II

Young Adult	
Eve (Resilient)	*Pam (Average)*
Married, mother of three children	Single mother of four children; and has lost custody of them
Mother now represented as giving, caring, understanding: yet confused about adolescent Eve	Mother in childhood and adolescence portrayed as angry and menacing
Father described as rigid, devaluing, rejecting in adolescent and adult years	Father in adolescent years now portrayed as gentler and caring, but often angry in adolescence

TABLE 7
Two Young Adults: Resilient and Average Outcomes III

Parenting as an Adult	
Eve (Resilient)	*Pam (Average)*
Critical, devaluing of her 4-year-old son, Bobby	Contrasts her patience with child, relative to her mother's
Tolerant of his weaknesses	Baffled by discipline conflicts
Patient with his stubbornness	Much conflict over any separations from her children
Reflects about her conflicts over disciplining Bobby, and considers her troubles in understanding him	Daily long talks with her mother

with his father was a model, from early times, for volatile destructive episodes with others. Pete witnessed seemingly uncontrolled abuse between his father and his siblings, recalling scant protection from his mother. And when his father was drunk, these experiences and the aftermath of regrets were even more dreadful. In the midst of these most turbulent and troubled adolescent years, we hear Pete's lively inner conversations about troubled relationships and desires. He needs friends, desperately at times. And each friend frightens him. Guided by his formidable talent in sizing up himself and others, Pete recruits various adults—whom he calls his "mentors"—to be his companions. This recruiting talent is one of his greatest assets.

Just before coming to Amity, he makes his fury toward his father more visible and frightening. Stealing his grandfather's gun, Pete sends a message to his father. "I didn't tell him directly. But I'm sure he had heard about it.' Cause I told enough of his friends and enough of his relatives that I'd kill him if he touched me again." Now a young teenager, Pete has discovered a way to control his father's blazing rage: directly and indirectly threatening his life. Pete now recruits a new mentor, Bob Jenkins, a school social worker to whom he reveals both his hatred of his father *and* how terrified he is about carrying out his deadly threat.

> One time it got so bad and I couldn't hack it any more. And I just went to [this friend] who worked at the school. I said, "You gotta do something … put me anywhere, but away from him. [his father] … I had a lot of [other worries] too … like my walking a younger kid into the park at knifepoint. That's why I went to the emergency care shelter, cause everything was driving me crazy, and I would have killed myself."

After much progress in his fury control, Pete faces many setbacks: close relationships ending; disappointment and discouragement at an acting school where he imagined becoming a great star; and the threat of alienation from his mother, the most powerful and revered adult in his life. With these accumulating setbacks, Pete decides to leave the "state" and under a false identity, travels across the country for a year, constraining himself from making any strong new relationships. He returns to his home state and to our study one year later, once again valuing relationships and more explicit about how much he is excited by watching and joining violent activities. Pete has also found a new close friend, Arnie, with whom he lives and travels from late adolescence through his young adult years. Alongside intermittent intense disruptions in their relationship, Pete experiences Arnie as a caring, devoted older friend. One more important man is the line of his older male friends, mentors he has been recruiting since before high school:

> These were all mentors. These were all the people who had a lot of bearing, a lot of influence on my life. And I know it sounds weird. I don't have a lot of friends my age. … I guess I was replacing my father like 10 times over.

In their 10-year stormy friendship, Arnie and Pete have traveled together all over the world. Between trips Arnie rescues Pete from urgent situations, like bailing teenage Pete out of jail after big public fights or drug busts. Over the years they talk about their loneliness, about Pete's becoming "tongue tied" in close relationships with girls. They have intense arguments in airports and on trips, usually triggered by Arnie's jealousy over Pete's new sexual flirtations, or by Pete's idea that Arnie is "playing games" with him, threatening by innuendo or not saying what is really on his mind. Arnie points out to Pete times when he's withdrawing, becoming one more voice pressing Pete to think about his "barriers."

> … [Arnie's] one of the people who accuses me of having emotional barriers. And he always wants our friendship to get even deeper, emotionally. He's not coming on to me. … But he always says I keep a barrier, just a certain distance. And it pisses him off … I was brought up like that. Because my mother was a little like that. … My grandfather was a little like this. So he feels it. … He's from a very warm Italian family … people love and hug and cry together. And, Jesus, that just doesn't happen in my family. …

Pete's and Arnie's very different backgrounds cannot fully explain Pete's vacillating closeness and distance in other relationships, perceptions described to him by other disappointed partners. Another reason he sees is his exquisite fear of being hurt by others, leading him to jump back, cut off, and then slowly return to the other person. More clearly becoming aware of his fears over being abused, submitting, and surrendering is what Pete's referring to when declaring that he's grown emotionally through friendships and "tons and tons and scads of therapy … and I worked very hard to work myself out. … I had more support somewhere." The tension between his appreciating the importance of close friends and his difficulties tolerating close relationships is the central dilemma of Pete's young adult years.

So why, as I describe these continued internal and interpersonal struggles, do I also tell you that Pete represents a resilient former patient? Across several domains—ego development, attachment coherence, substance abuse, emotion regulation—25-year-old Pete is stunningly different from 16-year-old Pete, a bereft and furious boy rushing to leave the state, a teenage boy with violent maiming fantasies about his father and stepfather. In fact, marking Pete's psychological development is the radical change in his

relationship with his stepfather. Once called a subhuman "computer" with no feelings, a man whose 62-year-old bones Pete wanted to crush, he has now come to be a valued friend. At age 35 Pete told me he was going to Europe to take a bike trip across Belgium with him. I asked him if this was the same stepfather he spoke about in teenage days. And he said, "Oh, yes. I've really changed; now we're close friends." Pete illustrates well the idea that resilience is not a monolithic unchanging trait within a person. It is a dynamic patterning of strengths and sensitivities responsive to age and context. This profile of an individual's resilient features changes over the life cycle with respect to its salient dimensions.

Through new narrative analyses of these resilient young adults, we are becoming aware of experiences of self and of relationships that simply were not tapped through previous empirical procedures. For instance, our more traditional analyses were theory driven and constrained by rigorous coding conventions and technical language as we were pursuing indices of defenses, adaptive strengths, self-images, expressed effects, and enabling interactions. In working with our previous methods, we often had the impression that we were *not* capturing significant aspects of the subject's experience, not grasping the poignant past and current relationships they so vividly described. And when our coders would bring up these limitations, we would usually speak—somewhat dismissively—about the compromises forced upon us by systematic empirical research, how we could not possibly study all the unique features embodied in one subject's interview. But our coders were, in hindsight, obviously accurately pointing out a meaningful problem. Their concerns had to do with at least two issues. First, the units we were analyzing were too constricted. Fuller portions of text are required to locate certain nuances of form and meaning. Second, our eyes were on categories derived from theoretical perspectives we believed relevant to testing our hypotheses. In other words, we were *not* identifying personal meanings, ways a subject was making sense of his or her world. Verghese (2001) speaks of this problem: "Any professional language brings with it the risk that it will also put blinders on us, bring about an atrophy of our imagination, a waning of the ability to understand the suffering of the patient" (p. 1015). These concerns led to our constructing a new kind of analytic procedure, our "Guide for Interview Texts," designed to systematically and reliably extract structural and content dimensions from our semistructured adolescent and adult interviews. An expanded version of "Pete" narratives, together with three others and new

analyses can be found in *Out of the Woods: Tales of Resilient Teens* (Hauser, Allen, & Golden, 2006).

Based on these explorations, we think there are strong reasons to add narrative analyses to our ongoing lifespan studies. From our examination of more than 35 adolescent and adult-era interviews from the resilient young adults—spanning over 20 years—we have a better grasp of resilient participants' constructions of themselves and their relationships during a time of major disruption; and we have seen ways these constructions change over time. Moreover, we now include narratives of these same subjects parenting the next generation. In terms of constructions of *self*, we have found five content themes and one structural feature:

1. Self-Reflection. Self-reflection was illustrated by individuals' increasing awareness of their feelings and thoughts, within each adolescent year and later thinking about their experience and performance as adults and new parents. Within weeks after entering Amity, Pete was stunned right after grabbing Joey, another student annoying him at school:

> … I stopped about that close to his face. And I said [to myself], "What am I doing? … What the hell am I doing?" … that's not like me anymore, to jump up and take that extreme. I usually say something before [I get totally furious] and they'll stop.

2. Agency. As adolescents, the resilient patients played an active part in deciding where they would go after leaving Amity and how they would take care of themselves when again in trouble. Sandy admitted herself to a community hospital two years after leaving Amity when she could not stop taking "uppers" and "downers." Pete left the state in order to disrupt the destructive cycle he was becoming caught up in at his acting school, leading to a deterioration that was threatening his relationship with his mother. As adults, they make conscious choices about parenting and how to put their ideas into practice—recall Eve and her picnics. Related to this theme are the resilient adults' detailed visions of their future and their intentions to make sure they are optimistic.

3. Self-Complexity. We've seen this feature in Eve's recognition of her many sides. Pete speaks of his complexity as he many times tells us about his multiple worlds—his tough biker pals, his concert crowd. We've found evidence of complex continuities over time, the resilient

subjects recognizing parenting themes from their past; their embracing and rejecting influences from earlier parenting experiences.

4. Persistence and Ambition. Resilient patients describe refusing to settle for a specific solution offered by a hospital, a therapist, or their family. Several find new schools. Two years after her discharge, Sandy arranges for admission to a community psychiatric facility to help her with a new drug problem and then discharges herself when she thinks the problem is solved. Others return to complete training many years after interruptions.

5. Self-Esteem. Ever apparent are the resilient participants' vacillating appraisals of themselves. By no means were these evaluations simply increasingly positive over the years. As we've seen with Pete, they were marked by swings of confidence as well as disappointment, optimism, and pessimism about life's chances. Important were their awareness of these self-evaluations and the overall balance tipping in the direction of kinder self-regard each year.

6. These are *coherent narratives.* From the start, we were struck by the ease of discerning the resilient subjects' stories—first about their paths to Amity, then about their experiences there. In subsequent years, they provide coherent accounts of their lives, conveying personal successes and failures and new views of their hospital experience. Sometimes their "ups and downs" are breathtaking and turbulent. Yet the interviewer, and later the reader, can grasp the alternating disappointments and successes. Changes, and connections to the past, were often the very first things resilient subjects talked about each year when they met with their interviewers. Audiences hearing their stories are often touched by the alternating disappointments and successes.

Turning to constructions of *relationships*, we see three themes:

1. The resilient adolescents do much reflecting about others' motives, feelings, and thoughts. Second, the resilient individuals attribute great importance to close friendships and have a thirst for friendships.

2. They tell us about *recruiting* relationships. They do not imagine simply meeting people by chance. They tell us of how they *find* new friends and how these friends help in their recovery from disrupted teenage years. Recruiting and retaining mentors was a crucial theme through Pete's adolescent and young adult years. The special significance of relationships further unfolds in adulthood as the resilient participants speak of their new spouses and about parenting with their spouses.

3. Finally, the resilient individuals see many *intersections* among themselves, their relationships, and their actions. In different ways, they speak of how growing good feelings themselves are leading to more positive ways they are seeing and respecting new friends.

In the long run, what can we gain from narrative analyses of sequential adolescent and adult interviews? One key benefit can be greater understanding of how these adolescents' narratives contributed to their subsequent adult development. For example, we could hypothesize that an adolescent's increasing narrative complexity and coherence may herald signs of psychological health in adult years. An additional intriguing possibility is that adolescent patients' conscious recognition of personal change predicts ongoing and subsequent adaptations. As we think about direction of influence, it is important to recognize the strong possibility that causal paths may not necessarily move from narratives to outcomes. These narratives could be markers reflecting changing life circumstances and optimism, leading to changes in narrative understanding and then to new effects from the narratives themselves, to actions, as the resilient participant makes plans—like forming future families and having children.

Through longitudinal interview analyses of these nine resilient patients, alongside parallel analyses of average outcome patients, we can begin to delineate some of these complex causal chains. For instance, our first analyses of average outcome patients suggest that they experienced greater helplessness, rage, and diminished self-esteem as adolescents. Fewer steadily supportive and protective relationships with friends and family were available. Nor did these participants consistently recruit relationships. Their adult marital relationships are volatile. Parenting is not easy or cherished. As we identify these contrasting themes, we will take the next step of defining new variables—like reflectiveness, agency, and relationship recruiting—that we will then systematically search for in the adolescent and adult interviews. We can begin to specify how these narratives may shape important adult outcomes, including close relationships, parenting, and psychopathology.

Understandings generated by this new way of looking at our data should also shed light on how these patients adapted to trying circumstances during a most turbulent adolescence. Tracing the flow of meanings constructed by adolescents and young adults can lead to our locating new individual and relational protective factors. Formal characteristics of their teenage narratives, like increasing coherence and diminished passive discourse, may be among the special features that distinguish the resilient

young adults from the other former patients. Through such developing strengths, these adolescents may have compensated for serious psychopathology and adverse hospital and home circumstances, as well as capitalized on available resources—psychotherapy, special teachers, friends, and schools. Our other instruments may not be attuned to the subtle manifestations of these strengths. We are taking this narrative turn to see how personal meaning and meaning making can foster unexpected pathways from adolescent misfortune to young adult competence in friendship, marriage, and parenting.

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