

1990 Eleanor Clarke Slagle Lecture

Resilience and Human Adaptability: *Who Rises Above Adversity?*

Susan B. Fine, MA, OTR, FAOTA

This Eleanor Clarke Slagle Lecture is a study of outcome—outcome that often defies the odds. It is a study of lives characterized by extraordinary hardships and remarkable abilities to move beyond them. It poses a core question: Who rises above adversity? It ventures beyond traditional concerns for pathology and vulnerability, beyond theoretical and statistical methods. In fact, its most valuable data come directly from the personal experiences of those confronted with chronic or terminal illness, physical and mental disabilities, abuse, impoverishment, the Holocaust, and other disasters. I have pursued many life narratives, not as a test of endurance in the face of human suffering (although it made for a more tearful year than most), not in search of heroes and heroines (although there were many), but in an effort to more fully understand factors that influence resilient responses. The voices of the resilient send a powerful message: Personal perceptions and responses to stressful life events are crucial elements of survival, recovery, and rehabilitation, often transcending the reality of the situation or the interventions of others. The inner life (affective and cognitive processes and content) holds the potential for transforming traumas into varying degrees of triumph. Ironically, these same phenomena are often ignored in the clinical reasoning and practice of many health professions, including our own.

Consequently, this paper is intended to heighten the reader's appreciation of the powerful interaction among a person's inner psychological life, his or her relationship to the surrounding world, and his or her emerging functional capacities. It pursues these themes by first providing an overview of theoretical constructs about the human response to adversity. Second, it focuses on extreme life events and the personal and social meaning ascribed to them. Third, it addresses the phenomenon of resilience and the means by which persons in extreme situations have coped. Implications for occupational therapy practice are then considered.

Overcoming Adversity: A Human Condition

The experience of adversity and the drive to rise above it are themes that characterize the human condition. The inevitability of life's trials and tribulations and the struggles between good and evil are evident in religious traditions, myths, the arts, and everyday conversation. Although adversity is ultimately a personal experience, in the bigger scheme of things it is faceless and timeless. We have grown up with both the ascendance of Cinderella and the failure of Icarus. We share such maxims as "It's always something" (Radner, 1989) or "You have to take the bad with the good." These universal themes attempt to guide us in matters of social order and disorder.

The Law of Disruption and Reintegration

There is also a professional literature devoted to understanding the human response to disruptions, the search for order and balance, and the consequences of prolonged imbalance. Although taxonomies and belief systems vary, a central theme, linked to Cannon's (1939) work in biology and physics, identifies a recurring cycle of disruption and reintegration as a natural and necessary part of one's growing capacities to adapt to internal and external change (Flach, 1988). In today's lexicon we speak of risk, stress, coping, competency, crisis theory, and biopsychosocial models. The past has been marked by a more disparate array of assumptions.

The relationship of stress to disease has been the highest priority among clinicians since Hippocratic times. Attempts at developing broader, systematic constructs have emerged from a number of disciplines. Psychoanalysis has given us ego mechanisms of defense as a metaphor for mental processes that handle crisis and threats. Freudian views emphasize a hierarchy of defenses that transform conflict-ridden impulses into more acceptable thoughts and actions. Ego psychology promotes reality-oriented, purposeful, conflict-free capacities (i.e., attention, perception, and memory) that are future-oriented and that render one capable of transforming situations rather than being transformed by them. In this formulation, adaptive functioning is seen as the relative use of coping capacities over defense mechanisms (Anthony & Cohler, 1987). The growth and cumulative effects of coping resources and skills over the life span are reflected in Erikson's (1963) classic developmental theories.

A behaviorist tradition also emerged with an early emphasis on the consequences of concrete problem solving. Today, as cognitive behaviorism, it is concerned with the cognitive components of coping skills and the Eriksonian belief that "successful coping promotes a sense of self-efficacy, which in turn, inspires more efforts at mastering difficult situations" (Moos & Schaefer, 1984, p. 6).

Endocrinologist Hans Selye (1978) assumed importance in the disruption-reintegration debate. Half a decade of work on stress and its hormonal and neurochemical correlates has had a great impact on professional and popular views of prevention and disease management. Selye's original emphasis on the singular importance of the stressful event itself has been mediated by a growing belief that the physical or psychological impact of any demand will vary depending on how we interpret the situation and how able we are to do something about it (Lazarus & Folkman, 1984).

Moos and Billings (1982) elaborated by organizing coping skills into three areas: appraisal-focused coping (i.e., efforts to understand and find meaning in a crisis), problem-focused coping (i.e., attempts to deal with the reality and consequences of the crisis and create a better situation), and emotion-focused coping (i.e., handling the feelings provoked by the crisis).

The cognitive appraisal process (how we interpret personal experiences) is central to a great deal of contemporary thought on coping. Stress itself has been defined as a “relationship between person and environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being” (Lazarus & Folkman, 1984, p. 19). Although social psychology traditionally emphasizes the role of external stressors and cognitive strategies (i.e., logical analysis, mental preparation, cognitive redefinition, and avoidance or denial), internal phenomena must not be ignored. Personal theories of reality about oneself and one’s world, developed over time and generally outside of awareness, serve as a filter through which we perceive, interpret, and respond to experiences (Janoff-Bulman & Timko, 1987). Disturbing thoughts and memories can also heavily influence the appraisal process (Houston, 1987).

The credibility of the cognitive appraisal paradigm is enhanced by the newly integrated discipline of psychoneuroimmunology, which is “the study of the intricate interaction of consciousness (psycho), brain and central nervous system (neuro) and the body’s defense against external infection and aberrant cell division (immunology)” (Pelletier & Herzing, 1988, p. 29). The impact of personal mood and attitudes on the immune system has opened new doors for researchers and clinicians. Studies have found that one’s immune system benefits from confronting traumatic memories, looking at life optimistically, and living at a mildly hectic pace (Goleman, 1989). This line of thought will no doubt continue to provide us with newer and different hypotheses about the laws of disruption and reintegration.

For now, contemporary biopsychosocial formulations represent a robust model. Capacities to meet challenging demands and stand up to disruptions depend on inborn and acquired skills, the material and interpersonal resources in the environment, and the psychosocial capacities to handle anxieties that arise when one is performing various life tasks. Successful adaptation is dependent on the degree of fit among these factors. Although mastery is both developed and sustained by manageable challenges, challenges that are too demanding or too dangerous defeat resources for coping and reintegration (White, 1976).

And dangers there are! The law of disruption and reintegration does not promise, or always deliver, a rose garden. Life events continually test the durability of the balance we try to maintain.

Ordeals Beyond Our Control

There are life events that are experienced as traumatic because they are severe ordeals beyond our control. Under circumstances of predictable, moderate stress, persons call on conventional patterns and solve problems with characteristic resources and adaptive styles. But extreme situations and the stress accompanying them are not conventional. By their nature they are beyond the range of the predictable; previous experiences have not prepared us for

them. How does one prepare for a spinal tumor, a brain injury, a schizophrenic episode, or a devastating earthquake? How does one comprehend Auschwitz or Dachau, where

Dreams used to come in the brutal nights,
 Dreams crowding and violent
 Dreamt with body and soul,
 Of going home, of eating, of telling our story.
 Until quickly and quietly, came
 The dawn reveille:

Wstawàch.

And the heart cracked in the breast. (Levi, 1965, p. xi)

Extreme experiences such as these are characterized by a lack of conventional social structure, a loss of anchor in reality, and a lack of ability to predict or anticipate outcomes (Torrance, 1965). Although we associate such phenomena with the high drama of hostage situations, prolonged combat, or concentration camps, they may also define the experience of persons whose lives are linked with ours on a daily basis, that is, our patients. Perhaps we ourselves have endured trauma or the sudden onset of a life-threatening illness.

Being full of strength and vigor one moment and virtually helpless the next . . . with all one's powers and faculties one moment and without them the next . . . such a change, such a suddenness, is difficult to comprehend and the mind casts about for explanations. (Sacks, 1984, p. 21)

There are those, like Lifton (1988), who view man "as a perpetual survivor . . . of 'holocausts' large and small, personal and collective, that define much of existence" (p. 12). Although the Holocaust was a horrifying reality, as a metaphor it illuminates many other ordeals, helping us to understand and negotiate them. The vivid words and images of those with illness and disability also reveal the deeper meaning of their experiences—meaning that defines the nature of their adaptive task and shapes the quality of their reintegration.

The Personal and Social Meaning of Trauma

There are many reasons to perceive extreme life events as threatening. The most stressful dimensions appear to be those that challenge personal assumptions about oneself and the structure of the world one lives in. Much of this is linked with the phenomenon of control: the ability (or the perceived ability) to change, predict, understand, or accept environmental transactions within a meaningful context (Potocki & Everly, 1989). The sense of being in control and the desire for such control are believed to be crucial aspects of personality affecting physical and mental health as well as recovery potential.

The perception of self, with its elements of body image, identity, and self-worth, were dominant themes in every narrative I encountered, whether the trauma occurred in Vietnam, Theresienstadt, a hospital in London, or a city in Arizona. The pervasive threat to, or loss of, identity was as potent a force as—and sometimes more significant than—any real threat to life and limb. The tattooed number on the arm of a concentration camp inmate had its counterpart in the history number on a hospital ID bracelet. As startling as this analogy may seem, in the eyes of the "number" it may well mean humiliation, a lack of personal validation, and

varying degrees of dehumanization. Just as prisoners of war are stripped of rank, role, and place in their reference group, victims of fires suffer losses of important nonhuman anchors for personal identity (Rosenfeld, 1989). Stroke victims, made captive by their disease and an impersonal hospital environment, lose the ability and opportunity to act on their own behalf.

In losing one's identity, one must replace it with another. How one chooses the new altered self is no small task. "Feelings of fear, vulnerability . . . sadness over losses and weakness about not being able to control one's life or one's emotional reactions, contribute to feelings of defectiveness" (Marmar & Horowitz, 1988, p. 96). The impact of confinement, isolation, and perceptual distortions is described by neurologist Oliver Sacks following a near-death accident, serious leg injury, disturbing hospitalization, and role change from doctor to patient.

I was physiologically, in imagination, and feeling . . . a pygmy, a prisoner, a patient . . . without the faintest awareness. How could one know one had shrunk, if one's frame of reference itself shrunk? (1984, p. 157)

Experiences that reflect a loss of self-control are often a central issue in psychiatric disorders as well. It is evident in schizophrenia, for example, when unpredictable symptoms turn "sparkles of light into demon eyes" (McGrath, 1984) or when a partially observing ego is "aware enough to recognize the dangers of not being able to control what I'm doing or thinking" (a patient, personal communication, October 1989).

Psychological stress, induced by threats of loss of self or failure, is also highly dependent on social values and the person's acceptance of the culture's definitions of what is valuable. Finding a new self or coming to terms with the only self one has ever known is reflected in the mirror others place before us. There is humiliation and pain generated

by a gait to embarrass, to make children laugh, a clumsy countering locomotion . . . from only the most exacting, determined efforts to control. Inside my rolling head, behind my shocked, magnified eyeballs, my brain orders, with utmost precision, each awkward jerk of thigh, leg, foot. (Weaver, 1985, p. 43)

Jean Améry provides us with a powerful metaphor for thinking about a person's sense of his or her own body and place in the world when mastery and control of that body is violated through intentional political torture, abuse, or from the pain of illness and medical procedures.

He who has suffered torture can no longer feel at ease in the world. Faith in humanity—cracked by the first slap across the face, then demolished by torture, can never be recovered. (Améry, 1986, p. xiii)

There are, of course, many forms of torture. The torture that physical illness may bestow need not be limited to bodily discomfort or pain, but "visits upon [people] a disease of social relations no less real than the paralysis of the body" (Murphy, 1987, p. 4). Anthropologist John Murphy viewed his spinal tumor, growing paralysis, and confinement as an assault on his identity and a disruption of ties with others. In depicting his illness as an extended field visit to an unfamiliar culture, he identified a primal scene of sociology—the social confrontation of persons with significant flaws, where someone looks or acts differently and we are uncertain as to what to say or where to look. This robs the encounter of cultural guidelines, leaving those involved uncertain about what to expect and what to do. For Murphy, "it has the potential for social calamity" (p. 87).

This calamity is also experienced as being in limbo. Sacks (1984) viewed this as a by-product of his body agnosia and the empathic agnosia of his surgeon, who insisted that nothing was wrong. His disease and lack of a human foothold (i.e., adequate communication and validation) left Sacks with a sense of double nothingness. "Now doubly, I had no leg to stand on; unsupported, doubly" (p. 108). Kleinman (1988), in turn, characterized limbo, for those with chronic illness, as "the dangerous crossing of borders, the interminable waiting to exit and reenter normal everyday life . . . the perpetual uncertainty of whether one can return at all" (p. 181).

I heard this again and again: a common thread, a theme that plagued Holocaust survivors and Vietnam veterans as well as the physically and mentally disabled—the gulf between the self and others (family, friends, caregivers, society). Who will listen? Who will understand what we are experiencing? Who will believe where we have been and what we have endured? Who will validate us as we continue to deal with adversity and its imprints?

Resilience

For some, the imprints are so deeply etched that they succumb. Others endure under conditions that seem unsupportable to health. Redl's (1969) work with adolescents who have beat the odds inspired the concept of *ego resilience*, that is, the capacity to withstand pathogenic pressure, the ability to recover rapidly from a temporary collapse even without outside help, and the strength to bounce back to normal or even supernormal levels of functioning. Demos (1989) suggested that, in its most developed state, such buoyancy requires "an active stance, persistence, the application of a variety of skills and strategies over a wide range of situations and problems . . . [and] flexibility . . . to know when to use what" (p. 5).

The formal study of resilience emerged in epidemiological studies on susceptibility to heart disease over 25 years ago. It is only within the past 15 years, however, that more rigorous efforts have been made to extricate it from a disease model and focus instead on "good psychosocial capacities such as competence, coping, creativity, and confidence" (Anthony & Cohler, 1987, p. x). Although healthfulness remains a less-than-perfect body of knowledge, a variety of popular and scientific resources provide direction for the reader's ongoing investigation, including descriptions of personal experiences (Brown, 1990; Browne, Connors, & Stern, 1985; Cousins, 1979; Egendorf, 1986; Gill, 1988; Heller & Vogel, 1986; Miller, 1985; Minear, 1990; Nolan, 1987; Sheehan, 1982; Trillin, 1984), situational studies of combat (Elder & Clipp, 1988; Rahe & Genender, 1983), studies of disasters (Bolin & Trainer, 1978; Lifton & Olson, 1976) and illness (Cleveland, 1984; Cohen & Lazarus, 1973), studies of the invulnerable child (Anthony & Cohler, 1987; Dugan & Coles, 1989; Garnezy & Masten, 1986; Murphy & Moriarty, 1976), and longitudinal investigations of adaptation (Chess & Thomas, 1984; Vaillant, 1977; Werner & Smith, 1982).

Resilience has been chronicled in studies of famous men and women who were highly stressed and traumatized as children, among them, George Orwell, Charles Dickens, Anton Chekov, Kathe Kollowitz, Pablo Picasso, and Buster Keaton (Goertzel & Goertzel, 1962; Miller, 1990; Shengold, 1989). Resilience, however, is evident in all walks of life. What is less clear is

how persons manage to marshal the necessary resources. What enabled young Ryan White, confronted with two life-threatening illnesses, humiliation, and rejection, to become so articulate a spokesman for AIDS? What contributed to the brutalized Central Park jogger's remarkable recovery and recent promotion in her highly competitive investment banking firm? These are questions whose answers have as many nuances as there are people and ordeals, for resilience is not all of one piece.

Resilience is made operational by cognitive and behavioral coping skills and the recruitment of social support. Lazarus and Folkman (1984) suggested that such skills do not come all at once. Rather, they are acquired through a developmental process—a process of selecting from available alternatives and having persons reinforce the skills that are necessary to make coping possible. Studies of vulnerability and competence in children and adolescents have provided valuable insight into some aspects of this multifaceted and shifting phenomenon. Theoretical models of stress resistance view the relationship between stress and personal attributes from several perspectives: as compensation (personal attributes help to improve adjustment when stress diminishes competence), as protection (personal traits interact with stress in predicting adjustment), or as a challenge (stressors enhance competence) (Garmezy, 1983). Dispositional attributes of the child, family cohesion and warmth, and the use of external support systems by parents and children are mechanisms that buffer stress and promote resilient responses. Temperament, sex, intellectual ability, humor, empathy, social problem-solving skills, social expressiveness, and an inner locus of control have been found to influence adaptation under adverse conditions (Garmezy, 1985). These phenomena, however, show variability over time and at different developmental periods (Werner & Smith, 1982) and are influenced by changing demands of the environment. Coping, for children and adults alike, reflects traitlike and situation-specific elements (Kahana, Kahana, Harel, & Rosner, 1988).

Resilience is often measured behaviorally on the basis of the person's competence and success in meeting society's expectations despite great obstacles. Internal indexes (thoughts and feelings) are often ignored, despite evidence that impressive social competence may well be heavily correlated with depression and anxiety (Miller, 1990; Peck, 1987). Clinicians and researchers are alerted to attend to the distinctions and interactions between adaptive behavior and emotional status. Resilience needs to be examined and understood from both perspectives.

Resilient Perspectives

Truly functional coping behavior has been characterized as not only lessening the immediate impact of stress, but also as maintaining a sense of self-worth and unity with the past and an anticipated future (Dimsdale, 1974). It involves two distinct tasks: a response to the requirements of the situation and a response to the feelings about the situation. Author Nancy Mairs (1986), struggling with multiple sclerosis, chronic depression, and agoraphobia, explained the process:

Each gesture . . . carries a weight of uncertainty, demands significant attention: buttoning my shirt, changing a light bulb, walking down stairs. The minutiae of my life have

had to assume dramatic proportions. If I could not . . . delight in them, they would likely drown me in rage and self-pity.

Yet I am unwilling to forgo the adventurous life; the difficulty of it, even the pain, the . . . fear, and the sudden brief lift of spirit that graces . . . the pilgrimage. If I am to have it . . . I must change the terms by which it is lived. . . . I refine adventure, make it smaller and smaller . . . whether I am feeding fish flakes to my bettas . . . lying wide-eyed in the dark battling yet another bout of depression, cooking a chicken . . . [or] meeting a friend for lunch. . . . I am always having the adventures that are mine to have. (pp. 6–7)

Mairs accepted the challenge and altered her life-style in the face of unpredictable capacity while maintaining some semblance of control over her life through a commitment to scaled-down adventures. Even in the presence of many serious problems she demonstrated what Kobasa (1979) and colleagues have called *hardiness*. Hardiness is characterized by challenge, commitment, and control attributes. Challenge is expressed as a belief that change, rather than stability, is normal in life and is an incentive for growth rather than a threat to security. Control is expressed by feeling and acting as if one is influential rather than helpless. Influence is operationalized through the use of imagination, knowledge, skill, and choice. Commitment is a tendency to involve oneself rather than feel alienated from situations; it involves a generalized sense of purpose that allows one to find events, things, and people meaningful and to approach situations rather than avoid them.

In extraordinarily stressful situations (the ones that diminish social structure, connections with reality, and a sense of predictability), opportunities to operationalize commitment, control, and challenge orientations are greatly compromised. Nonetheless, cognitive and behavioral coping mechanisms and efforts to recruit social support emerge and find expression in the most remarkable ways. The personal perspectives of the persons whose anecdotes follow are a tribute to the resourcefulness of the human mind and spirit. Their thoughts, feelings, and actions reflect the true character of resilience.

Hope and the Will to Overcome

Hope and the will to overcome are evident in the poignant poetry of children who found comfort and inspiration in the resilience of nature while confined in a Czechoslovakian camp in 1944:

The sun has made a veil of gold
 So lovely that my body aches.
 Above, the heavens shriek with blue
 Convinced I've smiled by some mistake.
 The world's abloom and seems to smile.
 I want to fly but where, how high?
 If in barbed wire, things can bloom
 Why couldn't I? I will not die! (Anonymous, in *I Never Saw Another Butterfly*, 1978, p. 52)

Hope and the will to overcome emerge in others as a fierce, sometimes raging will to live, that is, "the burning desire to tell, to bear witness" (Gill, 1988, p. 59), "to testifying on behalf of all those whose shadows will be bound to mine forever" (Wiesel, 1990, p. 15), "to live not for oneself, but to lament those who died [in Hiroshima]" (Tamiki, 1990, p. 30).

Affiliation and the Recruitment of Social Support

Acquiring a sense of belonging to a social group or, for that matter, to all of life, is a powerful way to sustain oneself in the face of death or other extremes. It may manifest itself by turning one's attention inward to memories and images of loved ones, by participating in an organized underground movement, or by devising a tap code to communicate through cell walls to other Vietnam prisoners of war. It also emerges through the collaboration of a therapist and a severely mentally ill woman who is struggling against great odds to restore a semblance of autonomy and self-respect:

You believed in me . . . were willing to take a chance on my being able to handle an apartment when my family felt it would be a waste of money. We had hopes; I didn't want to let you down . . . and I haven't. (a patient, personal communication, 1989)

Finding Meaning and Purpose

The identification of purpose, or finding meaning in an ordeal, was described by Viktor Frankl (1984) as "the last of human freedoms"—choosing one's attitude in any given set of circumstances, having at least the power and the control over how you interpret and explain what happens to you. Individuals find meaning and purpose in many different ways. Some find it in an increased commitment to religion, a political ideal, or a social cause. Others find it by using intellect and creativity to combat devastating fear. Many concentration camp victims and prisoners of war played chess and built houses, nail by nail, in their mind's eye; one man prepared a full German-English dictionary on scraps of paper during his incarceration and published it after his release. Others claimed that even forced labor was sustaining.

Interestingly, despite confining, constraining situations with extremely limited resources, many sought to find meaning and retain interests, values and skills through focused, self-regulating activity. "The prisoners who fared the best in the long run were those who . . . could retain their personality system largely intact . . . where previous interests, values and skills could to some extent be carried on" (Hamburg, Coelho, & Adams, 1974, p. 413). In situational studies of combat, illness, and the anticipated death of family members, Gal and Lazarus (1975) reported reductions in anxiety and feelings of helplessness even when activities did not provide actual control over the situation. In contrast, the vulnerable were described by Eitinger as those who "felt completely helpless and passive, and had lost their ability to retain some sort of self-activity" (Hamburg et al., 1974, p. 413). Our continuing efforts to understand the complex role of occupation in remediating illness and maintaining health may be greatly enhanced through studies of the spontaneous behavior of those in stressful situations.

The Capacity to Step Back

Frankl's (1984) disgust with his own trivial preoccupations with survival found him, in fantasy, lecturing on the psychology of concentration camps. Both he and his troubles became the object of a psychoscientific study undertaken by himself that later contributed to the development of a school of psychotherapy. Frankl demonstrated the capacity to step back and, in so doing, preserved a part of himself from extraordinary degradation, pain, and loss. Functioning somewhat like a solution to a figure-ground problem, this process provides one

with the option of ignoring aspects of the situation that are out of one's control. It may appear as a differential focus on the good, or it may be marked by a heightened capacity for observation, that is, a period of exalted receptivity when details of events, faces, words, or sensations are retained (Levi, 1987). This is evident in the writings of Wiesel (1990), Cousins (1979), Heller and Vogel (1986), Brown (1990), and Nolan (1987). None perceived themselves to be victims or survivors, but rather, witnesses to their own experience.

There Is More to Oneself Than Current Circumstance Suggests

The discovery of the new or real self is artfully reflected in Frank's (1988) study of embodiment—the experience and meaning of disability in American culture. She described a young woman born with quadrilateral limb deficiencies who stressed her assets instead of her deficits—her womanly figure (like Venus de Milo's) and her ability to write better with her stumps than with her artificial arms. Interestingly, her rehabilitation team viewed her refusal to use prosthetics as poor adaptation.

Dugan and Coles (1989), in turn, described a 6-year-old Black girl who was initiating school desegregation in New Orleans in the face of mobs, violence, and threats to her life. She hoped she would “get through one day and then another,” and if she did, “it will be because there is more to me than I ever realized” (p. xiv).

Novel Applications of Problem-Solving Strategies

Coping involves creative and reflective behavior (White, 1976). Resilience is manifest in the ability to turn a familiar way of solving problems into a novel application, one that may save a life. When Sacks (1984) sustained his injury while mountain climbing alone, he was at great risk for dying of exposure. He reported that there came to his aid a kinetic melody, rhythm, and motor music. “Now, so to speak, I was musicked along” (p. 30). Remembrances of the Volga Boatmen's Song gave him the strength and rhythm to “row” himself along the ground for many hours until he found help.

Transforming Dross Into Gold

Vaillant's (1977) longitudinal study of the life and coping strategies of a group of Harvard graduates documented the way in which the mature ego mechanisms of altruism, humor, suppression, and sublimation function to transform disturbances into adaptive behavior, thus turning “dross into gold” (p. 16). This is, in part, the way the speechless, palsied Irish poet Christopher Nolan (1987) found his mellifluous voice:

Fossilized for so long now, he was going to speak to anyone interested enough to listen. . . . Now he shared the same world as everyone else; he could choose how much to tell and craftily decide how much to hold back. His voice would be his written word. (p. 98)

The same mechanisms allowed comedian Buster Keaton to devote his life to making others laugh, while unable to laugh spontaneously himself (Miller, 1990). Long before Norman Cousins found health and fame in laughter and neuroscience linked it to our immune systems, humor was acknowledged to be one of the truly elegant defenses in the human repertoire (Lefcourt & Martin, 1986). “Like hope, humor permits one to bear and yet

to focus upon what may be too terrible to be borne" (Vaillant, 1977, p. 386). This is precisely what ailing critic Anatole Broyard (1990) did when he quipped, "What a critically ill person needs above all is to be understood. Dying is a misunderstanding you have to get straightened out before you go" (p. 29).

Resilience is not a miraculous rescue. It can be a mere thread that wrestles itself to the surface of an otherwise despairing existence. It is reflected in the struggle of a 50-year-old chronically mentally ill woman who sustains her sense of altruism despite unrelenting suspiciousness, fear, and rigid thought processes. She is an ardent giver of small gifts, of greeting cards weeks before the actual event, and of postage stamps she hopes will acquire great value for the recipient's future grandchildren. The dignity and control she experiences in giving to others when she herself is in such great need allow her more comfort than she might otherwise have. It buffers her from the painful realization of how isolated and vulnerable she really is.

Hamburg et al. (1974) summarized the essence of survival under extreme duress by underscoring the importance of the maintenance of self-esteem, a sense of human dignity, a sense of group belonging, and a feeling of being useful to others.

How Durable Is Resilience?

Resilient responses to ordeals have phase-specific attributes. In the acute phase, energy is directed at minimizing the impact of the stress and stressor. In the reorganization phase, a new reality is faced and accepted in part or in whole. And then there is the rest of one's life. How durable is resilience? We know it is neither a single act nor a constant state. How and under what circumstances does it emerge, shift, or fail the person? Camus (as cited by Maquet, 1958) described its emergence: "In the depth of winter I finally learned that within me there lay an invincible summer." In contrast, Monette (1988) experienced its decline: "I used up all my optimism keeping my friend alive. Now that he's gone, the cup of my health is neither half full nor half empty. Just half" (p. 2).

The suicides of Primo Levi and Bruno Bettelheim prompt similar questions. Why did Levi, successful chemist and award-winning author who recorded his Holocaust experiences because there "were things that imperiously demanded to be told" (1987, p. 9), choose to die? Did cancer and the ill health of his mother chip away at the mission he had set for himself? Did a history of exemplary behavioral competence distract from the depression and anxiety that often accompany it? Did a major depression go untreated? What about Bettelheim? His essays bore witness to Nazi atrocities; his provocative style challenged a world he saw as too passive and naive. He enacted solutions to some of humanity's problems by developing therapeutic environments for severely disturbed children. Did retirement, physical ailments, or the loss of a familiar social network limit his ability to play out a meaningful life story? Did his resilience run out? Or was this last sorrowful act a measure of his need to be in control, exercising his own will, his way, while he could? He spoke prospectively of these issues in the introduction to *The Uses of Enchantment: The Meaning and Importance of Fairy Tales* (1977):

If we hope to live not just from moment to moment, but in true consciousness of our existence, then our greatest need and most difficult achievement is to find meaning in our

lives. . . . Many have lost the will to live, and have stopped trying, because such meaning has evaded them. An understanding of the meaning of one's life is not suddenly acquired at a particular age, not even when one has reached chronological maturity. (p. 3)

These anecdotes demonstrate the changing and highly personal nature of resilience, often attained at the cost of some degree of spontaneity and flexibility. This and the interplay among such factors as age, general health status, and changing roles and relationships may conspire to diminish the once raging will to live in some, while allowing others to continue to find meaning and commitment in changing life circumstances. Resilience appears to be less an enduring characteristic and more a process determined by the impact of particular life experiences on particular conceptions of one's own life history (Cohler, 1987), leading one, once again, to conclude that it is not so much what happens to people but how they interpret and explain it that makes a difference.

Integrating Personal Meaning, Behavior, and Reality: Implications for Practice

Who rises above adversity? Perhaps it is sufficient to say that human capacities can shrink, hibernate, and flourish under circumstances of extreme stress; the influence of personal perspective; and the people, places, and things in the environment. The lives I sampled in the course of this study heightened my appreciation for the richness of the coping process and the difficulties many face with the unrelenting demands of their illness and the oft-times unresponsive health care system. Even a resilient outcome does not represent a simple linear trajectory. It often requires the empathic attention and skillful assistance of those, like us, who are empowered by training and, I hope, by inclination.

Ordeals Provide a Window of Opportunity

Physical and emotional disruptions, the circumstances that bring us and our consumers together, provide a window of opportunity. Timely and meaningful interventions can have a significant impact on the reintegration process. These interventions may involve us in multiple tasks, such as helping persons find meaning in their crises, helping them handle feelings provoked by their situation, helping them with the reality and consequences of their condition, and fostering the functional skills and behaviors that they will need to fulfill their potential. Unfortunately, individual needs and capacities do not necessarily run on the same time standard as that of third-party payers. Potential for resilience may be noted and nurtured, but not necessarily birthed in 6 inpatient days or 12 annual reimbursed outpatient visits. Illness, and certainly disability, is an ongoing process in which personal problems may constantly emerge to undermine technical control, social order, and individual mastery (Kleinman, 1988). The conflicts that arise among individual needs, professional values, and the system's priorities pose real challenges to those who need access before the window of opportunity is shut. We must examine our own role in perpetuating this dilemma. We must reevaluate and, in some instances, reframe, short- and long-term practice models. Additionally, we must educate colleagues, administrators, and insurers to

the personal and financial impact of psychosocial factors on recovery and rehabilitation outcome in all areas of specialization.

Many Factors Influence Individual Response to Ordeals

Many intervening variables affect patients' major life changes on the one hand and illness outcome on the other. The good news is that those who rise above adversity do not belong to an exclusive club. It is not a closed system. However, some people are their own best facilitators, while others need help. Neither group should face its ordeals at the hands of caregivers and environments that induce more stress by diminishing humanistic contacts and links with reality, by neglecting the person's need to predict or anticipate outcomes, or by ignoring the inner elements of coping and competency behaviors. It is troubling to note how well many of our treatment centers fulfill the criteria for extremely stressful, negative life events.

The variability of resilience may come as bad news for some, because it does not permit a simple recipe for treatment. Instead, we must commit ourselves to understanding the complexities of personality, coping capacities, and environmental influences and use them to identify goals, interventions, and environments that are meaningful to a given person under a given set of circumstances.

Transforming Adversity Into Possibilities

Murphy (1987) reminded us that "there is a need for order in all humans that impels us to search for systematic coherence in both nature and society, and when we can find none, to invent it" (p. 33). Thoughts, feelings, and actions, influenced by neurobiology and environment, are the means by which our patients attempt to invent coherence and order that is acceptable to themselves and the outside world (White, 1976). The experiences documented in the present paper are testimony to how innovative and powerful human thoughts, feelings, and actions can be.

These capacities are also our most elegant professional tools for transforming adversity into possibilities, when we take the time to conceive of them as such. As always, Sacks (1984) captured the essence of this phenomenon best:

Rehabilitation involves action, acts . . . [and] must be centered on the character of acts—and how to call them forth, when they have come apart, disintegrated, been "lost"—or "forgotten." (p. 182)

Calling forth the character of acts involves the therapist's understanding and using the patient's thoughts and feelings, collaborating with him or her, establishing trust, and reaching for the personal context that is partner to external reality and individual potentials for functional behavior.

Professional Entreaties

How well do we call forth the character of acts? I believe that as a group we are far more effective at defining reality and assessing and promoting performance than we are at assessing and making use of patients' views of themselves and their situation. Although our clinical prowess has grown greatly, we are too often committed only to present manifest performance. These

snapshot approaches to capacity fail to reflect the unique adaptive style and potential of each person. If we are to enhance outcome, we must integrate the patients' experience of their condition and their preexisting patterns of self-regulating activity with our concerns and strategies for functional mobilization.

Kleinman (1988) proposed the use of clinical miniethnographic methods for acquiring a better picture, much like an anthropologist does in assessing a different culture. The ethnographer draws on knowledge of the context to make sense of behavior, allowing herself to sample the subject's experience. Occupational therapists are ethnographers of sorts. We have unique access to information about activities of everyday living and what it is like to live with an illness or disability. We need only to acknowledge and actualize it. But do we? Do we draw out the patient's perception of his or her situation? Or do we focus only on those aspects of function we can see, palpate, or measure?

Practice has changed dramatically over the past 30 years, as much a product of our growth and development as it is a measure of new knowledge and shifts in the health care system. We certainly have not been idle. It is therefore no surprise that we find ourselves pursuing the future with such vigor that we sometimes fail to look back to see if we have left something of value behind. I believe we are at great risk of leaving in our wake some of the most central and precious components of our practice—how people think and feel about themselves and the world in which they live. Evidence suggests that we may have already reframed the rehabilitation process to fit today's economy rather than to fit today's patients.

Our connections to the deeper personal experiences of our patients seem to be unduly mediated by professional objectivity, our personal reluctance to hear, and a narrow view of what belongs to a given area of specialization. Fleming (1989) identified the presence of practice dichotomies concerning the relative importance of the patient's personal phenomenological status and how best to relate to him or her. Although some therapists appear to use such information and their relationship in treatment, their ambivalence about acknowledging it relegates it to an underground practice and reflects troublesome conflicts in values. We must remind ourselves that psychosocial phenomena belong to everyone, irrespective of their diagnosis and health status. Practice that separates feelings from function and psychosocial from physical perpetuates disorder rather than fostering reintegration.

The profession's current efforts to examine the actuality of clinical reasoning show great promise for rescuing the person inside our patients and for allowing us to acknowledge the credibility of this element of clinical activity. Similarly, the study of resilient persons provides us with important opportunities to share their experience, rethink our beliefs about occupational therapy's domain of concern, and enrich the emerging science of occupation. Like the subjects of this paper, "each of us maintains a personal theory of reality, a coherent set of assumptions developed over time about ourselves and our world that organizes our experiences and understanding and directs our behavior" (Janoff-Bulman & Timko, 1987, p. 136). I believe that our responsiveness to the inner lives of others can add perspective to our professional assumptions and enhance our understanding of human performance capacity. In so doing, we will find ourselves far better able to help our patients refine their adventures, find meaning and purpose in their ordeals, discover there is more to themselves than current

circumstance suggests, and transform the dross of their adversity into the gold of their accomplishments.

Epilogue

This is a work in progress. My purpose has been to examine the relevance of resilience to our practice. However, one person's efforts to orchestrate the chorus of resilient voices cannot do them justice. I urge the reader to explore this literature as well. It is likely to stimulate extraordinary personal and professional awakening. Moreover, it merits our collective thought and action, because the efforts of many are needed to give meaning to the hardships our patients endure and the difference occupational therapy can make.

Acknowledgments

I dedicate this lecture to three resilient women whose adaptive style and commitment to challenge have greatly enriched my personal and professional life: my mother, Elsie Babbitt; my mentor and friend, Gail Fidler; and my daughter, Deborah Fine. All three not only see the cup as half full, but strive to keep it overflowing for themselves and others.

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