

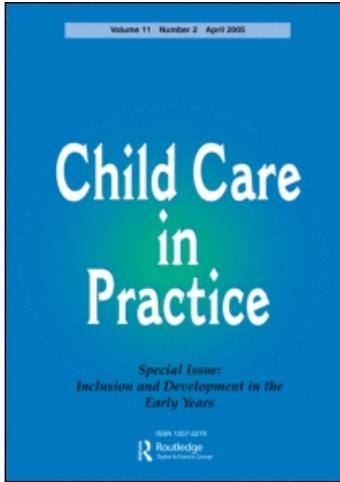
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Resilient Therapy: Strategic Therapeutic Engagement with Children in Crisis

Angie Hart & Derek Blincow with Helen Thomas

This article offers an overview of Resilient Therapy (RT) and outlines a case study of how it can be used in practice. RT draws on the resilience research base, and has been designed to meet the needs of children in crisis by providing insights and analytical tools that help carers and practitioners build relationships of trust in the hardest of circumstances. RT emphasises Masten's notion of "ordinary magic", and the idea of the "Resilient Therapist" has emerged through practice situations with parents, carers and colleagues, and through work with specialist Child and Adolescent Mental Health Services. The core competences of the Resilient Therapist are outlined, with a case example providing an illustration of how RT can be applied.

Introduction

Whether we like it or not, many children today will be growing up with multiple disadvantages. Despite our best efforts some children start off life on a trajectory of abuse, neglect or suboptimal care where an unequivocal time for early removal from such contexts is never resolved. Ensuring that families receive the benefits to which they are entitled, providing good family support and working collaboratively to alleviate poverty and inequalities are all helpful approaches to remediating the disadvantages children face. For other children who cannot stay at home there is accelerated decision-making, which moves them early on into adoptive placements with rigorous permanency planning (Harwin, Owen, & Forrester, 2001), a not uncontroversial solution. However, there will always be some children for whom decision-making is complex and protracted, and still others who are not being appropriately cared for by the social care system. These include children with special needs and disabilities who, as studies have shown, can routinely go unsupported

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(Audit Commission, 2003; Department for Education and Skills, 2003; Mukherjee, Beresford, & Sloper, 1999). The domestic situations of a number of these children, whether at home with their birth parents or in the care system, may remain in crisis. In the context of the United Kingdom, these children are often referred to Child and Adolescent Mental Health Services (CAMHS). Yet their problems are often seen as too difficult to engage in therapy. Many young people come and go through the professional system, with a series of brief and broken attachments that regularly mirror their domestic experiences.

In response, the authors have designed Resilient Therapy (RT), an outcome-focused strategic approach to meet the needs of just such children. Masten defines resilience as “a class of phenomena characterised by good outcomes in spite of serious threats to adaptation or development” (Masten, 2001, p. 228). RT methodology strategically harnesses essential therapeutic principles and evidence-based mechanisms to find the best ways of helping children and young people “bounce up” when life is particularly tough. The authors refer to “bounce up”, rather than “bounce back” quite deliberately: many children have rarely, if ever, been anywhere worth bouncing back to.

There is a synergy between the goals of RT and our model of delivery. This approach is intended not only to help children be more resilient, but also practitioners to work more resiliently with them. RT also has major systemic implications for the way we organise and deliver services. RT is inter-subjective. The explicit aspirations, experiences and actions generated by RT happen between people. The intervention is designed to improve children’s functioning and can be applied by individual workers, parents and young people in many different contexts. RT emphasises fighting health inequalities on both an individual and dynamic systems level.

RT is designed to be used with children and families in many different contexts, implying that application in frontline work has to be pragmatic and adaptive to many different situations. Furthermore, Resilient Therapists care as much about imaginative strategic management of therapy as they do about micro-therapeutic interventions in the moment.

This paper focuses on applying the principles of RT to the interactions of workers or volunteers involved with abused or neglected children, including children with special needs, on an individual basis. Here, the term “therapeutic practice” is used fairly loosely to describe the work of any adult in a helping relationship with disadvantaged children (for a full discussion of the authors’ conceptualisation of “therapist” and “therapeutic”, see Hart & Blincow with Thomas, 2007).

RT draws from resilience literature, from workshops undertaken in the authors’ community of practice with colleagues and parents of children in difficulty, and from embedded knowledge, tested in “tacit” practice situations. This “tacit” practice is derived from the authors’ own child and family work in specialist CAMHS together with our experience of running resilience workshops with parents of children with special needs. One of the authors, Angie Hart, is also the parent of three children adopted from the care system. RT also encompasses the psychiatric, social work and

family therapy work of our collaborators (Hart *et al.*, 2007). Application of tacit knowledge has led to the development of new concepts not as yet articulated within the research base. These are presented as coherent elements of RT.

This paper outlines the core competencies of the Resilient Therapist; namely, accepting, conserving, commitment and enlisting. In RT, these four principles are called the *noble truths*. The contents of what the authors have termed, in their work with parents and young people, the *magic box* are then outlined. Each section is represented as a compartment or *remedy rack*. There are five such compartments: *Basics*, *Belonging*, *Learning*, *Coping* and *Core Self*. A range of “ordinary magic spells” is generated from each rack. To illustrate the utility of this approach in action, a typically complex CAMHS case is also presented. Belinda’s case study portrays an example typical of the authors’ CAMHS work. The paper concludes with reflections on the practice implications of RT for work with the individual child.

Tricks of the Trade: The Resilient Therapy Magic Box in Action

Following Masten, the RT *magic box* makes explicit the kind of “ordinary magic” that needs to happen to foster resilience in children. It encourages practitioners to work with imagination and creativity. This section gives a brief overview of what goes into the *magic box*, illustrating its application by drawing on a practice example (Belinda).

The Magic Box

There are five main conceptual arenas in the *magic box* (see Figure 1). For some audiences these conceptual arenas have been termed “remedy racks”. The racks are *Basics*, *Coping*, *Belonging*, *Learning* and *Core Self*. As with all the categories, most of the “potions” generated from this remedy rack are conceptualised as direct applications of the research base.

Basics, *Belonging* and *Learning* include strategies and practices for use in working directly with clients but also involve therapists strategically linking with, and reaching out, to others. For example, *Belonging* is about helping children create better relationships. There is much evidence that *belonging* has been shown to be a key factor in resilience development. Some researchers even go so far as to argue that belonging lies at its very heart (Fonagy, Steele, Higgitt, & Target, 1994). *Basics* does what it says on the bottle. It addresses the most basic necessities needed in life. *Learning* not only includes working on effective schooling for children, but includes helping them with their life skills, talents and interests.

While the authors have drawn extensively on the research base, there are also some strategies and practices that have been developed uniquely through RT. A key one here is “take what you can from any relationships where there is some hope”, referred to elsewhere as “hopeful attachments” (Hart, 2005). “Hopeful attachments” are people who care about the young person, but are not necessarily the people most involved with young people. Furthermore, they may themselves need considerable support to make the relationship work. RT is pragmatic and realistic about fostering

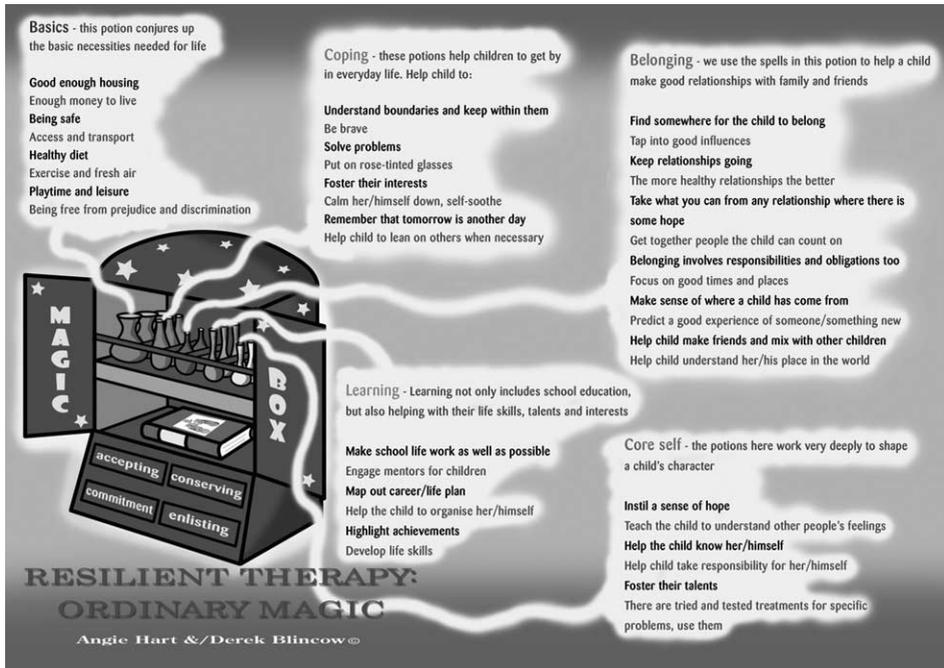


Figure 1 The RT Magic Box. Note: text accompanying the illustrations has been written in a style that parents endorse.

“hopeful attachments”, recognising that in family contexts of great emotional and psychological fragility these relationships might in themselves need therapeutic nurturing. A further component of this potion in the *Belonging* compartment is that of predicting a good experience with someone or something new. Such optimism, expressed in practice, is about linking clients with other people and setting them up to have a good experience.

Core self and *Coping* each present a set of micro-therapeutic “spells” designed largely for working directly with individuals, possibly in collaboration with co-therapists. The major difference between the two is that *Core self* focuses on working at an interpersonal level, while *Coping* provides children with strategies for managing better in the moment, rather than waiting for some deeper personal transformation to occur. Of course there is some overlap between the two, and like all the categories they are to some extent heuristic.

Case Example: Belinda¹

Belinda is 10 years old and living in her 10th foster home in a year, the current one being 40 miles away from the CAMHS clinic she has been attending nearly all her life. Belinda lived with her mother, Louise, until she was three years old. Following severe emotional and physical abuse from Louise’s husband, Belinda and her two half-sisters were removed from their mother’s custody. After two years in care, Belinda returned

home to Louise, who had by then moved in with another man. A year later she was rejected by Louise, who kept her two sisters. Belinda has been in foster care ever since and her latest referrals for an emergency psychiatric assessment (symptoms of dissociation) came from her current foster carer and her social worker. Their concerns centre on her “acting like she’s someone else (she sometimes calls herself John), severe depression, self-harm, unmanageable behaviour at school and in the foster home, and constant forgetfulness.” At the time of referral, she had just been excluded from her mainstream school where she received full-time one-on-one support. Her case is allocated to a family therapist, Jane, and a psychiatrist, Penny, who work together in the same clinic

In the hands of the Resilient Therapist

Mechanisms and positive chain reactions in young people do not just occur by themselves. Resilient Therapists have an important hand in initiating change and ensuring continuation. By using the magic metaphor, we are explicitly recognising our power as professionals to do the wrong kind of ordinary magic too: we can actually make things worse for children instead of better (Hart & Freeman, 2005). A cursory look at the files of children like Belinda provides clear illustration of this.

How we start working with young people is very important. If we want to make a difference it is essential that we engage with disadvantaged children in a way that fully appreciates the dynamics and details of their everyday circumstances and lived experiences. A core component of RT is what we call *noble truths*. These truths provide principles for practice and continuously inform how we work. The authors have conceptualised these as *accepting*, *conserving*, *commitment* and *enlisting*.

The first two *noble truths*—*accepting* and *conserving*—draw on Rogerian, Winnicottian and psycho-analytic theory. *Accepting* refers to the need for Resilient Therapists to engage precisely where their clients are. *Conserving* is a more complex concept, representing the authors’ interpretation of the psycho-analytic idea of “containment” (Brown, Pedder, & Bateman, 2000; Winnicott, 2005; Fonagy, Target, Cottrell, Phillips, & Kurtz, 2001). The symbolism and metaphor through which the concept is explained relates to ecology and food technology. *Commitment* means staying with a case and remaining alongside clients through their difficulties. In the modern service, which is characterised by fragmentation and “promiscuity” with regards to client contact, this is far easier said than done. Practitioners and organisations have to work hard to make this a reality rather than rhetoric. Finally, *enlisting* refers to the process of establishing and engaging a team around a child with which to work, as well as educating others about the RT approach.

So how do these ideas about *noble truths* work in relation to Belinda? *Accepting* is evidenced by the fact that practitioners in this case were prepared to start at the point where Belinda and her family were, to understand in detail the mechanisms that would facilitate their engagement with any service provision. Jane (family therapist) took the step of setting up the initial appointments over the telephone with the social worker. She assessed that a meeting straight off with Belinda and her carers would

have been anti-therapeutic, and would not have assisted in fostering hope for Belinda, a goal of RT. This was because, at the time, Belinda's carers did not seem to be in a position to contain their concerns about her. They needed the opportunity to give voice to their own distress before they could move on to being recruited as co-therapists in what Jane and Penny (psychiatrist) had identified as key resilient promoting interventions for Belinda.

Regarding *conserving*, care was taken to determine and understand all attachments that, however problematic, could still be beneficial to Belinda. *Conserving* also involves accommodating the high degree of anxiety in the system at this point of referral. Jane made contact with the social worker and foster carer as soon as she could and explicitly stressed to them that she and her colleague Penny, a psychiatrist, were now alongside and would stay involved as long as they were needed.

Resilient Therapists also strategically connect with other "conjurers" (clients, practitioners and others in the network), trying to help clarify the value of a resilience approach. This is the essence of *enlisting*. Thus, in the case of Belinda, Jane and Penny shared their assessments (including Belinda when she became more available to them in a session some weeks later), negotiated a strategy and engaged able others to assist in the use of selected *potions*.

Drawing on the magic metaphor may assist us here. Finding the right *spell* holds an element of trial and error. But as others have argued, factors beyond those laid down in the "spell books" are relevant (White & Stancombe, 2003). The authors find it helpful to remain aware that therapeutic practice with disadvantaged children fuses art, science, organisational culture, monetary resources, policy directive and psychodynamics. Of course the *noble truths* are further guides to us here. For example, Jane and Penny must work with what is acceptable to Belinda and members of her networks.

As previously mentioned, RT is a pragmatic and strategic approach to intervention involving the explicit prioritisation of areas to work on. This approach does not appear at first sight to fit the resilience evidence base, given that, as some have convincingly argued, resilience research lacks theoretical development in understanding which particular mechanisms should be prioritised (Fonagy *et al.*, 1994). Recently, the cultural specificity of individual resilience mechanisms has also been identified (Ungar, 2005).

Despite the conceptual difficulties in knowing absolutely what works for whom and in what context (Carter & New, 2004), we do have some understanding of what kind of *spells* and *potions* we need in the *magic box*. And we also know that some *spells* or *potions* can be useful for most situations. We agree that the evidence base is not that instructive about whether to try, say, a particular *belonging* potion first and then a particular one from *core self*. *In lieu* of definitive answers that may yet be forthcoming from research, we have to mobilise personal judgement with the available evidence base to help formulate a plan of action in the moment (White & Stancombe, 2003). Therapeutic work with Belinda, as with most disadvantaged children, draws on all five compartments of the *remedy rack* (although in this paper the authors concentrate on *belonging*, *coping* and *core self*), incorporating *noble truths*

strategically. In the case of Belinda, *belonging* and *coping* were prioritised for initial engagement, and we will illustrate the use of the *magic box* in relation to them.

Belonging tools were multi-purpose, being used to improve Belinda's mental health by working up what Jane and Penny had assessed as her "most hopeful attachments". Secondly, they were also used to engage tools of *coping*, which were used in collaboration with Belinda's mother, more of which will be explained later.

On assessment, Jane and Penny discovered that Belinda's "hopeful attachments" included her social worker and recreational key worker, individuals who, although exasperated and overwhelmed by Belinda, clearly cared about her and were committed to working with her long-term, particularly if they could engage others to help. They were certainly more stable attachment figures in her life than her foster carer at the time. In explaining their strategic method, Jane and Penny were explicit with these individuals about how important they were in Belinda's life, and shared with them the concept of "hopeful attachments" and how they could contribute to Belinda's progress meaningfully.

In devising a therapeutic strategy with Belinda, Jane and Penny were aware that, although relationships in such birth families are very difficult, young people often end up living near to, or with, members of their birth family. As such, they controversially identified Belinda's birth mother Louise as a hopeful attachment figure too, and encouraged joint therapy with Belinda and Louise in a fairly unusual therapeutic strategy for young people in foster care. Although the pros and cons of contact between birth parents and their children have been debated at length, these relationships are rarely conceptualised as worthy of sustained therapeutic intervention in themselves (Archer & Burnell, 2003; Hart & Luckock, 2004). Prior to this CAMHS intervention, contact between Belinda and Louise had been sporadic, chaotic and emotionally uncontained, whilst contact with other extended family members was completely cut off. Yet Jane and Penny's initial assessment, to which Belinda's social worker contributed, concluded that Louise and indeed other extended family members were very important to Belinda. If carefully supported, Louise had some capacity to develop a more hopeful attachment with her daughter. Based on their understanding of the research evidence and their practice experience, Jane and Penny concluded that Belinda's depression, conduct problems and disassociative symptoms might well improve if they could engage Louise in structured and carefully supported therapy with Belinda. Careful stage-managed inclusion of extended family members within the therapeutic encounter was also included. Crucially, Belinda herself favoured this approach. Prior to the involvement of Jane and Penny she had not continued with any therapy offered to her.

Jane and Penny's intervention strategy can be understood in RT terms as a pragmatic, future-oriented strategy with the Resilient Therapists to improve the capacity of hopeful attachments as key. Psychotherapy and play techniques (including pool and basketball outside the clinic when therapy became too intense for Belinda or Louise) were used weekly for a year, and thereafter monthly, to help keep Belinda and Louise engage in a more realistic and sustainable relationship.

These techniques were also used to help Belinda understand and reflect on her mother's rejection of her from the family home, and to use the idea of the co-therapist in a strategic way to enlist Louise's help in working with Belinda (Hart & Thomas, 2000). The term "strategic" is key here. Of course, it would be clear to most people that Louise was not able to be a mother to Belinda, let alone a co-therapist. And yet elevating her role in this way, at least for the therapy period, helped her engage with Belinda in a helpful manner, particularly by using coping tools. Tools of "understanding boundaries and keeping within them", "solving problems" and "calming herself down" were all tackled. So, for example, together Belinda and Louise role-played and video-recorded dramatic scenes depicting some of Belinda's particular difficulties. Under supervision of the therapist they enacted different characters, offering different solutions to past dilemmas, especially in relation to Belinda's aggressive outbursts in the foster home.

Joint therapy sessions were supplemented by motivational psycho-educative letters to each of them that emphasised achievements and bolstered attachments. Meetings with others in the network, school visits and Looked After Children Reviews² were also undertaken as part of the RT approach. Crucially, the lead therapist, Jane, drew on the resources of a voluntary agency to provide a dedicated support worker for Louise. This support worker operated under Jane's supervision as an apprentice to RT. She gradually took over the direct work, maintaining fidelity to the RT approach, employing the *magic box* and *noble truths* as Jane and Penny had taught her.

Application of findings from resilience research suggests that improved self-efficacy for Belinda would in part emerge as a natural by-product of an improved relationship between mother and daughter. However, Belinda's constellation of difficulties suggested that, in addition to fostering this hopeful attachment, some direct behavioural interventions were necessary. General child and adolescent mental health evidence demonstrates the effectiveness of focused work (Fonagy *et al.*, 2001). Practice accounts of work with children with attachment difficulties, in particular, increasingly emphasise more directive approaches (Archer & Burnell, 2003; Hart & Luckock, 2006; Levy & Orlans, 1998). Belinda needed to understand quite explicitly how and why she was making herself unpopular with others around her, and explore strategies for alternative action. For example, in one therapy session Louise was recruited to role-play with Belinda how she might have acted differently to avoid what turned out to be a volatile meal at her foster home. Louise's direct help in showing her daughter other ways of behaving helped Belinda understand that there were other strategies she could use in the future.

These examples illustrate how the issue of personal agency is dealt with in relation to disadvantaged young people. Disadvantaged children are clearly not responsible for their adversity although their actions can contribute to its continuation. RT encourages them to move towards a positive internal locus of control, and to accept a degree of responsibility for personal growth, thereby addressing disadvantage through generating an ongoing counter-dynamic.

Key Challenges for Resilient Therapy in Contexts of Complexity

The above section offers concrete examples of how RT is used in relation to a particular child. The remainder of this paper tackles the case for RT as a wider strategic development.

As previously stated, RT models itself on key concepts from resilience literature and has the explicit aim of improving the odds for disadvantaged children. From a health inequalities perspective, this task is imperative. As current UK policy emphasises, we cannot wait in our consulting rooms for the most needy and vulnerable children to come to us: we have to go to them. They are the ones most likely to experience the poorest outcomes (Department for Education and Skills & Department of Health, 2004). Nevertheless, undertaking therapy with children when their lives appear to be either persistently in limbo, or chronically suboptimal, presents its own challenges. RT practitioners view these challenges in an optimistic light rather than as failings from an ideal that precludes effective work. Working in situations of multiple disadvantage presents challenges to practitioners at four different levels that RT is designed to address.

Practitioners are taxed *emotionally* when engaged in sustained, productive work where they feel there is little hope of positive outcome. When work is often experienced as stressful and demoralising, practitioners may invoke professional defences that leave clients feeling pathologised and blamed (Hart & Freeman, 2005; Menzies-Lyth, 1988). Consequently, work with disadvantaged children often has low status within organisations, meaning that often the least-qualified and worst-paid workers find themselves assigned to work with the most complex children with little support. The desire to superficially process these children through the organisation, to locate the problem in the child's special need or disability, or to refer them on to other agencies and/or workers can be immediate and intense. So too is the need to ascribe responsibility for the child's future to other agencies. Growing fragmentation of the mixed economy of care in the United Kingdom and many other countries compounds the negative effects of professional defences. In response, RT facilitates productive engagement with children in the moment, rather than having to wait until their lives settle.

Technically, decisions regarding types of intervention and/or potential diagnoses can be problematic when a child's situation seems excessively uncertain or chronically depressing. In all instances, formulating the precise logic behind diagnosis demands therapeutic engagement allowing for carefully thought-through strategies. Some therapists may treat children narrowly in accordance with their professional training rather than looking first to the available evidence base, as RT encourages us to do. For example, the temptation to label children who display some extreme behaviours according to psychiatric categories can be compelling. Yet it is often more productive, albeit very difficult, to determine whether there is a serious mental disorder present or whether symptoms can be understood normatively, as a dramatic response to adversity (Grant, Mills, Mulhern, & Short, 2004). Given the long-term implications of labelling children at a young age, treatment implications and loss of focus on

context that may ensue, diagnoses need to be applied with caution. It should not be denied that often parents find such diagnoses of strategic use in the pursuit of material resources. Many would argue, however, that a developmental vocabulary of resilience can help practitioners avoid the exclusive search for pathology in accordance with a deficit model of child mental health (Masten, 2001; Wolin & Wolin, 1994).

Practically, resources often fall short of what might be required to begin to adequately address the extent of the problems identified. For example, caseloads are routinely large and over-burdening for government-employed frontline workers. Compounding this problem is the issue of how to get children to and from formal clinic-based therapy in a way that is therapeutic. Such transport can be time-consuming and may necessitate close liaison with birth parents, foster carers, social workers, a range of related social supports and even taxi firms directly. RT provides a framework within which therapeutic decisions can be most effectively made given the resources available.

Finally, *politically*, engaging with disadvantaged children in crisis can be complex. These children and their families are not always prioritised by services and often have few advocates. Current government policy on services to children and families in the United Kingdom urges us to address health inequalities (Department for Education and Skills & Department of Health, 2004). However, in UK practice both CAMHS and social services have yet to demonstrate a coherent approach to addressing how therapists should best approach the health inequalities debate. Not all practitioners work with what has been described elsewhere as an “inequalities imagination” (Hall & Hart, 2004; Hart, Hall, & Henwood, 2003; Hart *et al.*, 2001), in which such professionals become more reflective and responsive to the way they, and others, work with disadvantaged clients. For those that do work in this way, a thorough understanding of the effects of health inequalities is at the heart of their practice, as exemplified by initiatives such as Just Therapy (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003). In RT, the context of inequality and social exclusion becomes a specific focus that is worked through in such a way that the therapist is not overwhelmed and eventually undermined by these contextual barriers to successful growth.

Also political is the current redefinition of resilience as more than the traits of an individual. It is important to focus on what can be done by practitioners to enhance resilience for children contextually, irrespective of each child’s personal capacity to overcome adversity. Hence, RT avoids what Masten, Neemann, and Andenas (1994) lament as a potential blaming of individual children for not having “what it takes” to rise above a challenging situation by constantly accounting for contextual factors of each child in a case-by-case approach. Nevertheless, the issue of individual or family traits cannot be ignored. Indeed, from a health-equality perspective it can be argued that children with weak individual capacity for resilience should be prioritised for mental health services. There is also a tension here between acknowledging the merit of structural explanations for children’s adverse situations and helping them to develop their own capacities to move towards better outcomes. In practice, the debate

can become polarised, with one view leading us to see children as victims and another making them wholly responsible for their own destiny.

Resilient Therapy as Strategic Practice

As a strategic intervention, RT incorporates Bonn's (2001) three attributes required for strategic thinking: *a holistic systems understanding* of the organisation and its environment, recognising the linkages and complexity of the various substructures and relationships; *creativity*, thinking "out of the box" for new ideas and frequent reworking of old ideas and practices; and *a vision for the future*. In relation to strategic thinking, RT methodology also requires a fourth attribute: *understanding what helps children and parents achieve better than expected outcomes and how to operationalise those mechanisms in routine practice*.

Beyond family therapy, the term "strategic" is rarely applied in relation to any therapeutic technique with children. In family therapy, however, there are some potent critiques of a resolutely strategic approach that should be noted. Reimers and Treacher (1995), for example, argue that family therapists' unbridled pursuit of specific goals has meant that ethical issues and any attempts for therapy to be user-friendly were often left by the wayside. The authors agree. However, this should not mean that strategic thinking has no place in our work. For practitioners, social complexity can lead to defensive practice and burnout. Whilst it is important to recognise these aspects of working with disadvantaged clients, it is crucial that we bring positive energy to situations. A strategic focus helps.

Peters' (in Reimann & Ramanujam, 1992) premise of strategic thinking as a method for finding a vision and obtaining perpetual invigoration from that vision is also helpful in the strategic approach of RT. As helpful is Ohmae's (1983) emphasis on the combination of analytic method and mental elasticity involved in strategic thinking, and Mintzberg's (1994) belief that strategic thinking emphasises synthesis, using intuition and creativity.

A focus on the collective effects of social forces leaves the door wide open for mental health workers, teachers, social workers, parents and other practitioners to participate in the development of resilience in children. Rutter (1990) suggests that therapeutic actions need to focus on steps that reduce negative chain reactions. He argues that protection may also lie in fostering positive chain reactions. Although far easier said than done, attention must then be given to these dynamics in therapeutic planning. Indeed, what may count as trauma for some can prove for others in certain circumstances, resilience promoting (Hart *et al.*, 2007). While some refer to this as post-traumatic growth, we call this inoculated resilience (Hart *et al.*, 2007). RT provides a framework for the customised application of these processes to the individual child.

Practice Implications for Resilient Therapists

RT is reflexive, aimed as much at individual practitioners themselves as it is at disadvantaged children and their families. Consequently the *magic box*, the principles

that govern its use and the particular interventions it contains can be seen as working to improve practitioner status and their own resilience in the face of required work and related demands. For example, by putting into practice our *noble truths*, *accepting*, practitioners immerse themselves in the detail of children's lives. For children like Belinda, one look at their files and this seems like a daunting task. The trick is to work out precisely what detail really matters, and then to work with that detail, as illustrated in our case study. Following others (Elizabeth Henderson, Independent Consultant, private communication, 2005), we refer to this as the management of effective detail, and see it as a vital skill in delivering RT. Understanding the right details about a child's life helps us to avoid generalisation, defensive practice and pathologising language.

Similarly, *conserving* means establishing all that is already working for a child and to work with this constructively, and not inadvertently, through our therapy, undermining what are functional strategies. *Conserving* also means containing our responses and not allowing them to spill over into unmediated reactions. *Commitment*, in our experience has often proved to be one of the most difficult elements of RT for practitioners to embrace, initially, as the concept generates concern over fostering dependencies. Our experience is that *commitment* does the opposite, making real partnerships possible and countering defensive practice.

Enlisting recognises that therapists can rarely change disadvantage by themselves. However, at the same time we need to avoid collaborative confusion and the inertia that can follow from too much ineffective involvement by too many care providers.

Our *noble truths* underpin each intervention. Yet RT is customised, taking into account the complexity and multiple aggravating processes that maintain children's disadvantages. While understanding this, Resilient Therapists need to be fired by an inequalities imagination: there is always something we can do, however dire the situation. In complexity, little things can often make a major difference. Just one new experience for Belinda had the power to open up a completely new horizon for her. We have to be realistic but also hopeful in order to try and try again what we know might work. The relentless pursuit to make a difference is key in RT. Hopeful practice is active work. It also has the effect of boosting our own self-esteem as therapists, conferring an appropriate status to the work as a direct antidote to the more customary detached, defensive and demoralised stance that working with disadvantage can engender.

Conclusion

The above case study offers one illustration of how therapists can use the *noble truths* and *magic box* strategically to apply RT in a specific context. The framework provided by RT helps practitioners design and carry out interventions that enhance resilience in young people. It offers a user-friendly account of evidence-based strategies that can be merged in an application to one specific context. As we have found, the metaphorical language of "ordinary magic", "spells" and "potions" appeals to parents and children, going some way towards demystifying the complex language of

resilience mechanisms and outcomes. For more information about parental involvement in the development of RT see Hart and Aumann (2007).

The case we have formulated demonstrates RT achieving positive outcomes; however, they are not definitive ones. RT accepts that work with disadvantaged children is often unpredictable and does not always follow as steady a course as we would wish it to. The potential for us to use whatever spells or potions we can to help children bounce up must be constantly held in mind.

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Notes

- [1] To maintain our clients' anonymity, we have not given any details of a real person on our caseload.
- [2] It is a legal requirement in England and Wales that children who are looked after by social services be regularly reviewed. Looked After Children Reviews are required to alter care plans (see also DfES/Looked After Children Division, 2005; <http://www.everychildmatters.gov.uk>).

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