Weaving Resources for Resilience: A Social Ecological Technique for Clinical Work with Children and Families

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Abstract
Clinical work with children and families with complex needs typically focuses on suppressing patterns of dysfunction and disorder rather than identifying resources for mental and physical health in contexts where resources are unavailable or inaccessible. This chapter explores a novel way of intervening with young people which respects the coping strategies they employ in challenging contexts. A discussion of a social ecological model of resilience begins the chapter. This model shows that resourced individuals perform better than rugged individuals in contexts where risk exposure is high. Using examples from clinical consultations, this chapter presents an integrated model of clinical practice which is ideally suited to identifying and mobilizing the resources children and families require to experience resilience. Putting this model into practice, examples are provided of how mental health professionals can use clinical case consultations to change perceptions of young people's coping strategies and develop case plans to nurture resilience. This innovation in case consultation has been used to inform plans for intervention which engage children and families in efforts to increase social, physical and institutional capital which are known to facilitate positive growth under stress.

Dr. Michael Ungar's Bio
Dr. Michael Ungar is the founder and Director of the Resilience Research Centre and Canada Research Chair in Child, Family and Community Resilience at Dalhousie University in Halifax, Canada. He received his PhD in Social Work from Wilfrid Laurier University in 1995 and is the former Chair of the Nova Scotia Mental Health and Addictions Strategy, executive board member of the American Family Therapy

Academy, and a family therapist who works with mental health services for individuals and families at risk. His international series of studies spanning six continents has helped changed the way resilience is understood, shifting the focus from individual traits to the interactions between people and their families, schools, workplaces, and communities.

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Clinical work with children and families with complex needs has relied on techniques that mostly suppress patterns of dysfunction and disorder. An emerging trend in the fields of developmental psychology, social work, family therapy and community psychiatry, however, has been to examine patterns of resilience and the social and physical resources that individuals and groups use to cope in stressful environments (Fraenkel, 2006; Gariépy, Honkaniemi, & Quesnel-Vallée, 2016). Studies of resilience, therefore, have helped to shift the focus from the antecedents of psychopathology among traumatized populations (such as clients of child welfare systems) to the capacity of these populations to survive and thrive when properly resourced (Madsen & Gillespie, 2014). This understanding of resilience, however, is itself a challenge to common discourses of resilience that emphasize individual change in cognitions or behavior as the basis for wellbeing under stress. Research is showing, instead, that resilience can be accounted for much better by the resources individuals have available rather than individual processes of recovery or adaptation. This more ecological model of resilience is particularly relevant to children and families with complex needs as it focuses attention on the differential impact of environments on child development rather than placing responsibility for change on the shoulders of clients themselves (Theron & Ungar, 2018).

This chapter builds on this ecological understanding of resilience and uses it as the basis for a novel way of holding case consultations to identify resources that children and families experience as useful when confronting problem behaviours and developing new, more adaptive regimes of coping to deal with multiple stressors. These stressors include, but are not limited to, social marginalization, exposure to domestic violence and emotional, physical and sexual abuse. Based on examples from clinical consultations, this technique opens possibilities for clients to find new ways of coping with persistent problems, exploiting potential sources of social (e.g., caregivers, peers, mentors), physical (e.g., housing, safe streets, food, recreation) and institutional (e.g., safe schools, child welfare services, financial support, mental health care) capital where these are both available and accessible.

The Relationship Between Resilience and Resources

Studies of resilience have become more systemic and complex with time (Masten, 2014; Ungar, 2018). While earlier work focused on a set of individual qualities (sometimes referred to as invulnerability [Anthony, 1987]), by the mid-1980s researchers has shifted their focus to interactive processes such as the opening of opportunities to succeed and enhancing self-esteem in stressed environments (Rutter, 1987). Likewise, research on resilience began to identify the multiple systems implicated in recovery and adaptation, with children's families, schools and communities all sharing responsibility for positive development under stress (Werner & Smith, 2001). More recently, studies of resilience have shown that children and families cope best when they are able to navigate to the

resources they need to adapt to atypical stressors and negotiate for these resources to be provided in ways they experience as meaningful (Ungar, 2011). These dual processes of navigation and negotiation have helped to explain why children who access services that they find meaningful tend to show better behavioural outcomes than children offered resources that they experience as intrusive (see, for example, Abramson et al., 2014). This more ecological perspective of resilience is also demonstrating that children and families are more likely to show advances in mental and physical health despite exposure to multiple risk factors over time if the proximal and distal systems with which they interact are able to accommodate their needs even if exposure to risk persists (Cosco, Howse, & Brayne, 2017) For this reason, studies of resilience than have included assessments of housing (Gaetz, O'Grady, Buccieri, Karabanow, & Marsolais, 2013), community capacity (Cutter, 2016), economic supports (Conti, Heckman, & Pinto, 2016), the quality of a child's educational institutions (Fallis & Opotow, 2003) and cultural and family resources (Hassan et al., 2015) have shown that improvements in the resilience of any one of these systems is likely to exert a positive influence on the functioning of other co-occurring systems which, in turn, are likely to improve children's developmental outcomes.

As robust as the evidence has been that "resourced individuals" are more resilient than "rugged individuals" (Ungar, 2019) who rely most on changing their thinking to succeed, interventions informed by the theory of resilience still focus more on individual change processes. Typically, interventions are concerned with improving self-regulation, developing mindfulness, or inviting clients to take responsibility for behaviours like substance abuse and violence. For example, there is a large body of work that has proposed changing children's cognitions using third wave cognitive interventions like mindfulness-based stress reduction that emphasize a change in a child's relationship to her thoughts and emotions (Schonert-Reichl & Lawlor, 2010). These new versions of cognitive behavioural therapy have been shown to help children better self-regulate when they have experienced trauma. However, while these interventions show positive short-term outcomes, they seldom account for the level of stress exposure a child has experienced (i.e., are the interventions equally effective for children who have experienced more severe and chronic forms of abuse?) and complex interactions between systems (Cadima, Enrico, Ferreira, Verschueren, Leal, & Matos, 2016). Making individuals better resourced, however, may be a more sustainable intervention, especially when ecological and systemic therapies work intensely with families as a whole, or change school environments at the same time that children are given individualized treatment focused on their thoughts and emotions. The addition of interventions that improve access to resources (social, physical and institutional) ensures that the supports needed to sustain change after treatment ends remain in place for children if risk exposure continues to be atypically high. For this reason, the intervention described in this chapter is designed to help children and families who have experienced abuse and other potentially traumatizing events like forced migration or homelessness. It facilitates access to, and maintenance of, the resources they need to experience resilience.

Systemic Interventions to Improve Access to Resources

Child development, family therapy and case management professionals from many different disciplines are placing greater emphasis on nurturing the quality and quantity of resources available to stressed child populations using both individually-focused and

community work (Gilligan, 2008). These approaches have been known by names like Wraparound (Ferguson, 2007), Intergrated Youth Services (Ronis, Slaunwhite, & Malcom, 2017), Integrative Family Therapy (Lee et al., 2009), Multisystemic Therapy (Littell, 2005), and a critical contextual approach to clinical work (Garcia & McDowell, 2010). All of these approaches show reasonable potential to improve functioning (Carr, 2009) for child and adult populations presenting with problems ranging from anxiety to depression and conduct disorder, medical conditions like HIV (Rowe et al., 2016) or substance abuse (Kurtz, Buttram, Pagano, & Surratt, 2017). Collaborative approaches like these have also be shown to work with families from across cultures and those with lower status as a result of social marginalization (see, for example, Whiteside, Tsey, Cadet-James, & McCalman, 2014). They share a common set of practices which enhance social, physical and institutional capital, often identifying the opportunities and constraining factors that influence positive child development. Their success tends to be attributed to their ability to locate and mobilize resources that already exist but may not be fully used or may have never been engaged at all (Wessells, 2015). These resources, in turn, affect cognitions and attributions which change perceptions of experience and behaviour. In this sense, ecological and systemic therapies (Aldrich, 2012) engage clients in explorations of how healing processes, social structures and world views interact in recursive loops to sustain problems or help children find new patterns of thought and behaviour that support recovery and adaptation (Shapiro, 2013).

It is not surprising, then, that many of these approaches to practice are attentive to the way young people negotiate for the resources they believe they need most, often challenging dominant discourses that define them and their coping strategies as problematic. Thus, in contexts where few opportunities exist to cope in more socially desirable ways, engagement in violence (Bottrell & Armstrong, 2012), the parentification of children (Godsall, Jurkovic, Emshoff, & Stanwyck, 2004) and other seemingly troubling patterns of adaptation may be functional when children themselves have the ability to articulate their experience of having to survive as best they can with the few resources they have available. All of this suggests that by changing young people's access to more socially desirable and health-sustaining resources that they will be able to find ways of coping that bring fewer negative consequences. When resilience is understood this way, then an individual coping strategy that appears maladaptive may be relabeled as adaptive in contexts where choices are badly constrained. The challenge for clinicians is to understand children's use of resources and coping strategies in the context of where they live and the competing discourses that define their experience.

For these reasons, clinical processes that explore young people's resources, rather than expecting individuals to change on their own, tends to promote social justice rather than the neo-liberal ideal of individual responsibilization (Aldarondo, 2007; Liebenberg, Ungar, & Ikeda, 2015). Equitable access to resources is known to correlate with better mental health outcomes for all populations (Wilkinson & Pickett, 2018). Therefore, a mental health intervention that emphasizes modification of the environment that surrounds individuals is likely to facilitate psychosocial growth better than an individually-focused treatment regime alone. This approach is relatively common in community-based practice such as interventions to help vulnerable families become securely housed (Fraenkel, 2006) or helping patients with persistent mental health disorders re-integrate into their communities after deinstitutionalization (Nguyen et al.,

2017). A systemic approach to clinical work, however, requires clients to be actively engaged in identifying resources that are close at hand and for professionals to think about problems with sufficient complexity to resolve problems long term with strategies that sustain change. For example, Houle and her colleagues (2017) have found that:

> Public housing settings have the potential to be health-promoting environments that contribute to lessening social health inequalities instead of increasing them, however, this potential is often not fully exploited as public housing programs are often limited to providing shelter, without fully considering all the aspects that can contribute to (or hinder) tenants' positive mental health. (p. 2)

As the example illustrates, techniques are required to broaden the resources available to clients while also engaging them in defining what success looks like given their worldviews.

Approaches that do all this follow trends in community psychiatry where it has been acknowledged that despite advances to our understanding of neurological processes and psychopharmacology, treatment outcomes are still disappointingly poor (McCarthy, 2013). In response, social prescribing (a term which connotes directing clients to improve contact with social networks and institutions rather than cognitive or biological change) is an alternative care model which has shown potential to improve psychiatric outcomes (Kilgarriff-Foster & O'Cathain, 2015). This is not necessarily new as decades ago Clubhouse models for people with psychiatric disabilities showed that stable housing and social programming (resources) could prevent relapse and hospitalization (Raeburn, Halcomb, Walter, & Cleary, 2013). Likewise, child welfare services and the family therapists that work with families affected by domestic violence have found that Wraparound interventions that expand the resources available to families can help families break chronic cycles of neglect and abuse (Flemons, Liscio, Gordon, Hibel, Gutierrez-Hersh, & Rehbolz, 2010). Similarly, though with a very different focus, mobilizing culturally relevant resources can help structurally disadvantaged populations maintain mental health and resilience. For example, Samuels (2010) has shown that multiracial adoptees benefit from a number of strategies that expand the resources they require to reconcile complex identities, a common threat to their psychological health. These strategies include learning "how to be Black" through association with peers and seeking contact with biological parents as a way to develop a more authentic sense of Black kinship. Such strategies improve social capital and are associated with patterns of resilience. Again, clinicians who intervene in ways that identify and mobilize resources may be able to effect greater change in clients with complex needs than individualized therapy alone. There is good reason, therefore, to pursue more contextualized interventions when individual resources for recovery or adaptation are scarce or strained. The resilience-promoting model of consultation described next builds on the above examples but is distinguished by its ease of use by frontline mental health practitioners. It does not require specialized teams to support the intervention.

The Weave: A Tool for Clinical Case Consultation that Explores Resources for Resilience

The weave is a systems-oriented intervention that can be used as part of a case consultation with teams of professionals where there is at least one professional present who knows the client well enough to describe his or her interactions with multiple systems (or the client is present herself). The technique can also be adapted for use with

clients directly during clinical sessions. When done without a client present, the goal is always to bring the results of the weave back to clients for them to contribute to case plans that will make them better resourced.

To do a weave, a structured conversation is held which asks a series of questions regarding the resources that are realistically available and accessible to the client. The weave is a visual representation of these conversations. To begin, the caseworker (or the client) is asked to draw the client (or a symbol that represents the client) at the centre of a piece of paper (flipchart paper taped to a wall works very well as an animation tool). One by one, a client's many resources are named, with a word or symbol drawn on the flipchart paper to represent the resource. Lines are drawn between the client and the resources with the colour and style of each line used to represent the client's experience of the resource that is identified. Different lines represent positive or negative experiences (e.g., solid straight lines can mean a helpful, secure relationship with a resource; wavy and dashed lines can represent conflicted or weak relationships). Expect some resources to have multiple lines from the client to the resource to reflect complex relationships over time. Each weave is different, with the emphasis on visually representing the resources that each client experiences as meaningful. As the weave grows, questions are repeated and adapted to expand the number of systems accounted for during the exercise.

The Questions

A pattern of questions is used to identify resources that promote and sustain resilience. These can include the seven aspects of resilience identified by Ungar and his colleagues (2007) in cross-cultural studies of at-risk child populations, or any similar list preferred by the caseworker. Ungar and his colleagues, for example, include in their list of resources: (1) supportive relationships from family, peer and community members; (2) a positive identity (developed through interactions with others); (3) experiences of power and control; (4) experiences of social justice; (5) access to basic material resources like food, clothing and safety; (6) a sense of belonging, spirituality, and social cohesion; and (7) cultural continuity. Factors that contribute to disorder are less relevant to the weave (it is assumed most case conferences already review evidence of psychopathology and disordered functioning), though barriers to accessing resources are always explored as part of the weave. Where barriers are identified, they are mapped onto the weave but the emphasis remains on understanding how young people exposed to atypically high levels of stress adapt in contexts where access to resources appears strained. When the exercise is done with professionals without the client present, the questions are adapted to read "From the perspective of the client, what has been *their* experience of [specify the resource]?" The following are examples of sample questions that can be used to guide the case consultation and build the weave. For the sake of illustration, the construction of the questions assumes that the client is in the room and participating in the case consultation. As mentioned, this is not always the case, with a key informant sometimes representing the views of the client when the client does not want to be, or cannot be, in the case consultation.

Part 1: Resource Audit

Starting with people and institutions that are most significant to the client, ask:

- "From your perspective, what has been one of the most significant relationships in your life?"

- "In your experience, has this relationship been a source of support? Or has it been harmful or stressful? Or perhaps it has been both? Can you explain what you mean by your answer?"
- "From your perspective, what is another significant relationship in your life? Again, has it been supportive and helpful, or a source of conflict or stress?"
- "Thinking beyond people, are there other sources of support or stress in your life? Maybe a place you spend time, like school, or work?"
- "Do you have activities in your life that bring you support, or cause you stress? Like a sport that you play, or maybe a habit like substance abuse? Do these activities add positively to your life, or create more stress? Do they help you cope? When are they most useful?"
- "How are these people, places and activities related to each other? Do these interactions make other resources more available or accessible, or do these relationships and resources place barriers in your life or prevent you from coping with life's challenges?"

This part of the exercise can take less than an hour, or it can go on for several meetings, with each resource being discussed at length. The point is to identify the client's strategic use of resources that improves his ability to cope under stress, even if these coping strategies appear to be maladaptive. The more resources and relationships between resources that are identified (the more lines in the weave that connect the client to each resource and connect resources to one another) the more opportunities there will be to build resilience. When considering which resources to ask about, consider as many aspects of resilience (both internal and external) as come to mind.

Part 2: Interpretation

Once the weave is rich in detail, it is useful to first shift the conversation from the audit of resources to interpretation of what the lines mean all together.

- "Looking at the weave, is there anything that catches your attention the most? Anything that surprises you?"
- "Are there more/fewer positive supports than you would have expected?"

From this review of resources, it is critical to next look for patterns in the resources and which are being used most effectively. Just because a coping strategy appears to be maladaptive (e.g., an abused child socially withdrawals from her caregivers, as represented by a weak, dashed line) each pattern should be discussed from the perspective of the client. Does the client find this relationship with the resource useful? Does it improve the client's sense of safety? Does the client experience her coping strategy as functional? Once these questions are answered, it is possible to look at where else the client has found positive and supportive resources and whether these connections can be strengthened. To repeat, it is crucial that the caseworker not interpret resources as negative or positive, but that the client's experience of her resources be the focus of the case consultation. Alternative resources that fulfill the same resilience-promoting and protective roles can more easily be found if the treatment team fully appreciates how a client currently uses resources in contexts that may be highly stressed.

The interpretation should also challenge negative relationships with resources by asking the client whether these resources are always helpful and if there are alternative resources that might be just as useful if they were made more available and accessible. In this way the caseworker helps the client to explore possibilities to change the colour or

style of lines connecting the client to each resource, perhaps "breaking" positive lines that sustain a client's problems or removing the client from negative relationships altogether. Likewise, the weave can become a source of inspiration for identifying potentially positive resources that could be exploited further.

Guiding Principles

Several guiding principles are helpful when conducting a weave.

1. The weave is always a story told from the perspective of the individual at the centre. Labelling resources as positive or negative must reflect the experience of the client and not the professionals facilitating the process.
2. The resources that are identified must be relevant to the client. Even if the professionals would like the client to access a resource (like therapy), it should only be included in the weave if it is something the client experiences as meaningful. The only exception to this principle is when a resource has been offered and rejected, or experienced negatively, by the client. These experiences can be added to the weave.
3. The questions asked should cover the influence of as many systems as possible, exploring multiple aspects of resilience. These systems can even include cognitive processes. For example, the client's thoughts or emotions can be represented on the weave as helpful or unhelpful resources. Counseling that is focused on changing cognitions may also appear on the weave and be connected to both the client directly ("Has counseling been helpful or unhelpful?") and the client's thoughts ("Has the counseling affected the frequency of negative or positive thinking?").

An example of a weave with a 12-year old boy, Ethan, follows.

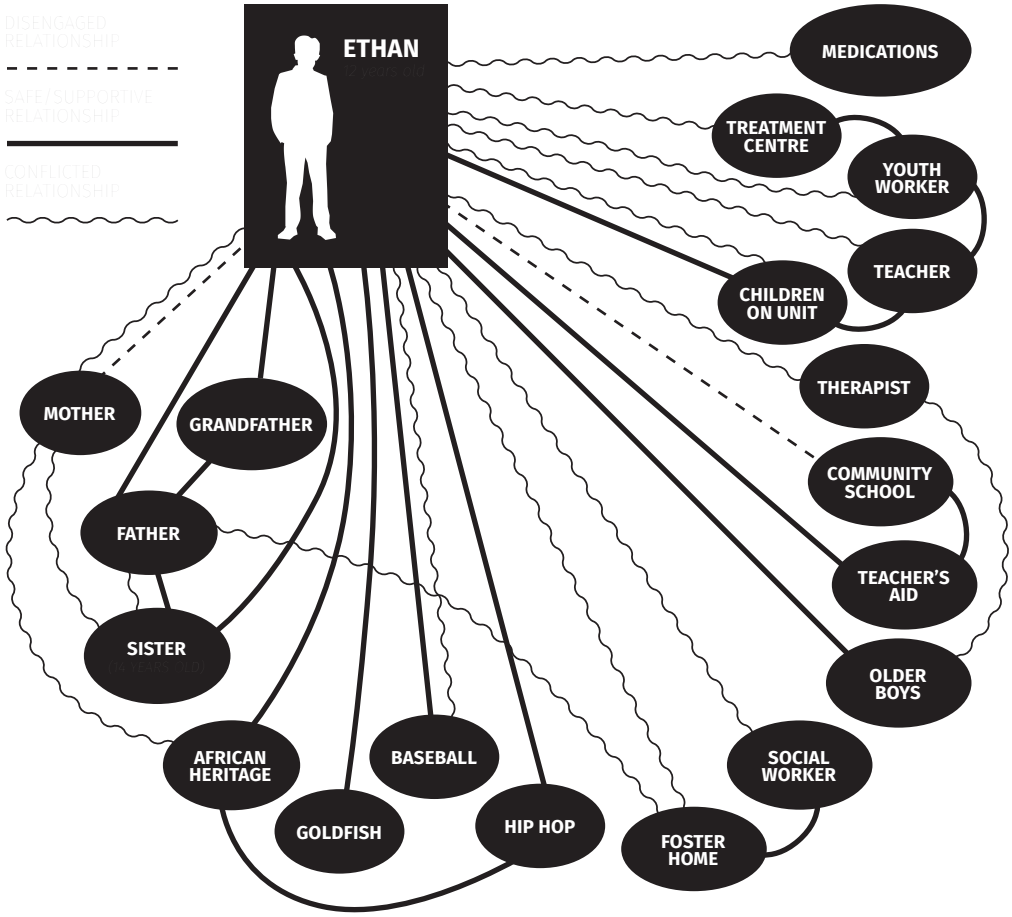
Case Illustration: Ethan

Ethan, age 12, and his 14-year old sister both live with their father who suffers from a chronic condition of depression. He receives a disability allowance from the government and is followed by a psychiatric team at a local hospital. Ethan's mother left when Ethan was 8, and seldom sees the children. She shows signs of Borderline Personality Disorder, is very impulsive and can be explosive during case conferences when she disagrees with Ethan's case plan. In recent months, Ethan had become increasingly violent and made multiple suicidal gestures, such as lying down in traffic, and holding a knife to his throat. When he was not in school (which he attended inconsistently), Ethan spent much of his time with older male peers involved in criminal activity. At the time of this consultation, and as a consequence of his worsening behaviour, Ethan was placed temporarily in a treatment centre for children 2 that includes an onsite school program with a low student-teacher ratio. Ethan tends to resist treatment (individual and group therapy) and knows that he is likely to be transferred home shortly as he ages out of the service (patients are discharged or transferred when they turn 13). In the treatment centre, Ethan provokes fights with the other children, steals, and is constantly manipulating staff, all of which makes younger children living on Ethan's housing unit afraid of Ethan. Ethan's sister remains at home, though social workers are anxious about her safety as she is responsible for most of the chores at home and is expected to also monitor her father's mental and emotional functioning, calling the hospital if he becomes excessively dysregulated.

When in school in the community, or in the treatment centre, Ethan is rarely productive. He has made several allegations teaching staff and staff on his housing unit

touched him inappropriately. There is no evidence that this has occurred, though it has raised concerns that Ethan may have been sexually abused in the past.

When Ethan's behavior is brought to his attention he says he acts this way because he believes life is hopeless and he hates himself. He even asked to be removed from his home though when social services offered him a foster placement, he refused to leave his father and sister.



All of this information was included in the weave which was created during a case conference at the treatment centre (see Figure 1). Ethan was represented as having a close and supportive relationship with his father, a distant and angry relationship with his mother, a strong alliance with his sister, and conflict with his youth workers, teachers and therapists. Ethan also resisted taking his medications which were recorded as a negative relationship. Though Ethan did not attend the case consultation, his therapist showed Ethan the weave later and asked him to add more resources and lines. Ethan added his pet

goldfish which he worried would be dead by the time he returned home, as well as the older boys at his community school which he felt were very supportive of him (his clinical team felt the boys exploited Ethan and got him to steal and fight for them, but Ethan's experience with them was recorded as positive on the weave). As the weave continued, Ethan also reported enjoying the one opportunity he had to play baseball (at his second game he threw his bat and was not allowed to play for the rest of the game—he never returned for another game). He also liked frightening the younger children on his housing unit (this made him feel big and strong), and he liked his one-on-one teachers aid, but not his teacher, at his school in his community. Ethan felt that the teacher's aid, a woman in her forties with a great deal of patience and an endless number of excuses for Ethan's difficult behaviour (she believed he has ADHD and has been traumatized by the loss of his mother) was trustworthy. He never acted badly when he was with her and had shown some progress academically when he attended school. If the teacher's aid went to Ethan's home on days Ethan was truant, he willingly let her take him to school.

There were other significant people included in the weave as well. Ethan's grandfather who had died two years earlier was placed in the diagram as Ethan felt that his grandfather had been very supportive, teaching him to use an air gun and taking the boy occasionally for respite weekends. Aspects of Ethan's culture were also represented in the weave. Ethan's mother's father was African Canadian, which gave Ethan a sense of being partially "black" in his words. For Ethan, this was a potentially powerful identity as he liked to listen to Hip Hop and felt his racial heritage gave him a special appreciation for the music.

While Ethan did not find his staff at the treatment centre helpful, he did like to roam the campus and would drift to the kitchen where the senior cook would let him watch her work and occasionally invite Ethan to help her with small tasks like rolling out cookie dough or sorting cutlery. While Ethan's behaviour was typically very disruptive, in contexts like this he could be remarkably compliant and attentive to detail.

Interpretation. When Ethan's therapist asked Ethan to comment on his weave, Ethan said that he really like the positive relationships he had with people who helped him be bad. But he also said he liked people that didn't boss him around too much, like his teacher's aid and his grandfather. He didn't mind having to help his father, and said he actually felt important when he did things that made a difference, like cooking dinner, but he also resented people taking him away from his home.

The staff team also interpreted the weave, commenting that they were surprised by the number of positive relationships Ethan perceived in his life. Rather than seeing an angry, disruptive boy with multiple disorders who refused to comply with his course of medication, they could see that Ethan was a child who had suffered some serious losses and who was desperately looking for secure relationships with adults and peers and ways to feel useful and more grown-up.

As a consequence of the weave, a treatment plan was developed that encouraged Ethan to [remove the conflicted relationships, enhance the supportive ones, and strengthen other resources that could become supportive based on his past experience. He was, for example, encouraged to spend more time with non-professional staff at the centre, and to connect him back with his teachers aid in the community through a series of meetings to help him phase his return home and back to his regular school. A cultural mentor was also introduced to Ethan who showed Ethan that his identification with his

African Canadian grandmother meant far more than just an a right to listen to Hip Hop. And the team worked on finding Ethan another opportunity to play sports, though in a controlled environment. In order to shape his peer group, Ethan was helped to connect with a youth program at a local Boys and Girls Club where facilitators were experienced working with troubled adolescents. These adaptations of Ethan's social ecology were accompanied by continuing cognitive therapy with his therapist. That work helped Ethan develop the skills he needed to make these new relationships and activities more successful.

Discussion

The clinical technique described in this chapter can be adapted to working with individuals or teams of professionals in clinical and institutional settings like mental health treatment centres, hospitals and schools. By being integrated into common practice settings, it has the potential to address the tendency for processionals like social workers to end up in excessive administration rather than direct contact with clients. Studies of social workers, for example, like that by Ferguson and Lavalette (2006) have found that across a number of different settings, including child welfare and community services, workers spend as little as 17% of their time directly with clients during an average week. A more systematic assessment of resources that clients can mobilize may be one way of addressing this problem by helping clients find the supports they need. There is evidence to suggest that improving the prominence of these other resources in young people's lives ensures continuity in the supports and services vulnerable populations need to overcome adversity. The best resources are typically those that are more localized, meaningful and already engaged by clients (Tanner, Glasby, & McIver, 2015).

The weave is similar to other systemic approaches to clinical work, though it is especially well adapted to situations where clinicians do not have the time or money to develop separate programs (i.e., Wraparound and Multisystemic Therapy) to facilitate growth in a client's external network of resources. The weave provides an audit, and then an opportunity for reflection on the supports already available in a young person's life. The caseworker's role becomes finding ways to decrease negative and unsupportive relationships with resources clients reject and increase access to resources the client has found useful and meaningful. The systematic approach to the work means that the client's voice is heard and the chances of a successful intervention are increased.

While cognitive therapies are often highly manualized, more contextualized therapeutic approaches available to clinicians in their office like the weave remain largely *ad hoc*. There is, arguable, need for more detailed approaches to clinical work that can expand a client's own culturally and contextually relevant resources. Informed by research on resilience which explains why some individuals cope better than others in contexts of adversity, the weave is a technique that privileges a client's own solutions to finding and maintaining the right resources to address chronic challenges.

Conclusion

It can be incredibly difficult to tailor interventions to individual youth, much less to animate conversations in ways that clients feel they are actively engaged in the co-construction of their individual narratives which explain why they have made the decisions they have made and the coping strategies they have used. The technique discussed in this chapter is part of a growing trend in clinical casework that places as much importance on changing external factors as helping clients to change internal

cognitive processes. When done well, the weave should open new possibilities for a client like Ethan to access resources that are meaningful. It should also help clinical teams formulate case plans that offer substitute pathways to meet clients needs in more socially desirable ways. While the weave is evidence-informed, further work is required to examine how it influences both client satisfaction with therapy and influences at risk children's developmental and behavioural outcomes.

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