CHAPTER 17

Doing Critical Clinical Work from the Ground Up: Exploring the Dalhousie School of Social Work Community Clinic

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INTRODUCTION

This chapter highlights the story of the Dalhousie School of Social Work Community Clinic in Halifax, Nova Scotia, paying close attention to its critical and anti-oppressive foundations and the practical teaching approaches we use with our students. Experiential education at the clinic is focused on supporting students to make critical connections between theory and practice while embracing interdisciplinary learning and collaboration.

Our clinical work is deeply entrenched in critical social work theories through feminist, participatory, accompaniment-oriented, and post-structural analyses. This style of intervention will be explored, unpacked, and exposed throughout the chapter—speaking specifically to a clinical practice orientation that is situated within a critical social justice framework. This emphasizes situating the individual's struggles within broader structural dynamics while being critically reflective and reflexive. Engaging with individuals belonging to some of the most vulnerable groups in our community (e.g., low-income households, marginally or precariously housed individuals, lone-parent families, newcomers, individuals with complex histories of trauma, substance use, and mental health), the clinic demonstrates the importance of social justice on a case-by-case basis through the politicization of individual and societal problems. We work with our clients to deconstruct dominant social discourses impacting their lives while understanding that their experiences and stories are unique, varied, and diverse from one another.

This chapter illuminates the clinic's day-to-day work with marginalized populations—through such activities as intakes, assessments, note-taking,

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record-keeping, referral, advocacy, resource acquisition, counselling, and community outreach—as well as how we make sense of issues related to our work, including use of self, role of the social work practitioner, notions of ethics and power, and the process of developing therapeutic relationships. A range of practice models (i.e., feminist, narrative, trauma specific, crisis intervention, and solution-focused) that support our grassroots and community development techniques and that shape our critical clinical practice orientation will be highlighted. The chapter provides practice insights from our directors, staff, and one of our former BSW students.

As you read this chapter, ask yourself the following questions:

1. What does this chapter tell you about critical clinical practice in the community?
2. What are some of the core characteristics of the clinic that relate to critical clinical practice?
3. How does the clinic make connections between theory and practice on a day-to-day basis?
4. Why are critical reflexive and reflective practices important in community social work settings?

CONTEXT AND HISTORY

Four years ago, in the early spring of 2014, a meeting took place between faculty member Jeff Karabanow and field coordinator Cyndi Hall to discuss a shared dream. We sought to develop a community-based service in Halifax that could provide meaningful support to marginalized populations, while providing a unique space for university health professions students to engage in experiential education rooted in critical and anti-oppressive based theory and practice. Equally important, the vision involved all of this being done through a social justice lens that explores dominant discourses, power differentials, and systemic oppression.

We reflected on the lack of services in the city that provide case management and supportive counselling in an unconditional, immediate fashion to those who are poor, marginalized, precariously housed, or un-housed. The individuals we provide support to are those most often experiencing deep and

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unresolved trauma and mental health issues. At the same time, we spoke about the frustration around the increasing difficulty in securing quality student placements due to growing competition, enrolment, and organizational fatigue. Sites that are explicit in their social justice work were (and continue to be) scarce. There were very few community-based agencies that operated through a social justice and/or critical lens and that engage in anti-oppressive practice approaches for social work students. Lastly, most interprofessional placement opportunities were within hospital settings and the clinic was seen as a possible way to bring different disciplines together in a community setting.

ANTI-OPPRESSIVE PRACTICE

Anti-oppressive practice refers to a focus on the structural origins of service user issues as well as an orientation toward radical social change. It embodies an egalitarian value system that focuses on reducing the negative effects of the structural inequalities impacting people's lives. It engages in the critical analysis of practice relations with a focus on empowerment of service users (Dominelli, 2002; Healy, 2005).

Four years later, the Dalhousie School of Social Work (SSW) Community Clinic is operating in central Halifax. We have worked with over 500 clients and more than 40 organizations; we have provided practice experiences to approximately 100 undergraduate and graduate students from social work, occupational therapy, psychology, nursing, nutrition, and pharmacy, as well as project-based and service learning opportunities for medicine and management programs at Dalhousie University.

OUR PHILOSOPHY: EXPLORING CRITICAL AND ANTI-OPPRESSIVE PRACTICE

Philosophically, the clinic utilizes postmodern critical social work as an umbrella theory, which incorporates anti-oppressive and post-structuralist feminist theories and practices. Critical social work theories allow us, as an organization, to emphasize the importance of language and discourse in the social construction of both service provider and service user realities (Fook, 2002; Healy, 2005). Such theories highlight how power can operate in various ways and create opportunities for our clients to resist and/or reconstruct dominant ideas about

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themselves related to oppression or victimization (Briskman, Pease, & Allan, 2009; Foucault, 1980; Fook, 2002). Feminist theory and practice is rooted in the belief that there are dominant social structures that work to privilege and empower certain groups while simultaneously oppressing others (Dominelli, 2002; Turner & Maschi, 2015). Anti-oppressive work involves a commitment to a more socially just society, as well as learning about the complexity of engaging in this work, both as individuals and organizations. As an agency informed by anti-oppressive practice, we strive to commit to using our power in our efforts toward social justice while being mindful of how privilege can make us complicit in the oppression of others (Baines, 2011).

CRITICAL SOCIAL WORK

For our purposes at the clinic, critical social work involves the recognition that structural issues continually impact both social workers and service users on a day-to-day basis, especially those associated with systemic oppression based on race, class, gender, ability, and sexual orientation. It involves a fundamental commitment to co-participatory relationships as well as the implementation of self-reflexive and self-reflective approaches to social work practice. It aims to reduce power differentials between service providers and service users while promoting the co-construction of knowledge in pursuit of social transformation (Healy, 2001).

POST-STRUCTURALIST FEMINIST APPROACHES

Post-structuralist feminist approaches to practice allow us to reconceptualize power in the relationship between service provider and service user while acknowledging that the personal is always political. Client stories and experiences can never be separate from the world in which they are socially constructed. Their experiences are contextualized through their own histories as well as social and political structures working to both oppress and privilege them (Brown, 2007).

From existing research around organizational dynamics of anti-oppressive practice (Barnoff, 2011; Karabanow, 2004; Ramsundarsingh & Shier, 2017; Strier & Binyamin, 2009), we know some key characteristics of anti-oppressive practice organizations, and know that our work at the clinic attempts to align with

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these principles and practices. Anti-oppressive practice orientations are significant foundations for critical clinical apparatuses. Anti-oppressive organizational structures embrace notions of "locality development"—providing immediate and meaningful services "on the ground" to those in need—in a compassionate and empowering fashion (Karabanow, 2004). We do not close files at the clinic and it is not uncommon for staff and students to reach out to previous clients to see how they are doing. Crisis events (such as a mental health breakdown, the loss of shelter, or the need for food) are triaged and we try to respond urgently to presenting needs. In addition, anti-oppressive practice organizations are committed to ongoing exploration of power and privilege, and ethical use of this privilege (Barnoff, 2011; Ramsundarsingh & Shier, 2017; Strier & Binyamin, 2009). This exploration of power and privilege at the clinic incorporates critical reflexivity and dialogue. These processes are embedded within the clinic through a culture of learning, with a focus on ongoing experiential education and training and an orientation toward innovation, risk-taking, and collaborative work.

Another organizational anti-oppressive practice characteristic that complements critical and feminist social work practice is the notion of expanding beyond individual work and toward social structures and action (Barnoff, 2011; Karabanow, 2004; Mullaly, 2010; Ramsundarsingh & Shier, 2017; Strier & Binyamin, 2009). This fits with an understanding of people's challenges as impacted by societal oppression, and with a commitment to working toward a more socially just society. The clinic works with numerous coalitions/alliances (such as anti-poverty roundtables, income assistance restructuring, and a basic income committee) that are situated within more mezzo/macro explorations of equality and social justice.

Organizations that are centred on critical approaches to practice (anti-oppressive, feminist, anti-discriminatory, etc.) are cognizant of how organizational policies and procedures impact employees. The rationale is that "if the workplace itself is oppressive to the workers, the workers will in turn be oppressive to those whom they are serving" (Ramsundarsingh & Shier, 2017, p. 2321). Some examples of organizational policies that emerge through critical approaches include a commitment toward inclusion and diversity, both in workforce and clientele (Barnoff, 2011), and working toward more egalitarian organizational structures (Strier & Binyamin, 2009). Our clinic strives to structure itself in a non-hierarchical model, fostering collaborative approaches among staff, students, and directors.

THE CLINIC: WHO WE ARE, WHAT WE DO

The clinic employs a critical clinical and case management platform to support our clients who are, for the most part, individuals living in poverty in various

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communities. Coordinated by MSW graduates from the SSW, the clinic not only complements and supplements existing resources in the Halifax Regional Municipality, but also serves as a field placement site for BSW and MSW students, supervised by our clinic coordinators, and students from other health disciplines, supervised by faculty from their discipline. The "critical" aspect emerges from the clinic's overarching social justice philosophy, which is embedded throughout the student experiences through knowledge sharing, collaboration, mutual learning opportunities, case conferencing, critical reflection, critical reflexivity, and debriefing on cases and article discussion groups.

CRITICAL REFLECTION

Critical reflection at the clinic involves a process of "unearthing deeper assumptions" (Fook & Askeland, 2007, p. 521). Critical reflection explores our own assumptions, values, beliefs, and attitudes about the world around us with the purpose of supporting and improving our social work practice. Practising critical reflection allows us to examine power through our personal and professional experiences through "social, cultural and structural contexts" (Fook & Askeland, 2007, p. 522).

CRITICAL REFLEXIVITY

Critical reflexivity, or critical reflexive social work practice, involves examination of power relations in professional practice as well as the critical questioning of how our knowledge about clients is produced (D'Cruz, Gillingham, & Melendez, 2007). This process of looking inward and outward to explore how we create knowledge through understanding our own beliefs, values, and assumptions is important in allowing us to ethically engage in social work practice (Fook, 2007).

BUILDING AN INTERPROFESSIONAL PLATFORM

As noted earlier, our intention was to develop the clinic's foundation from a critical and anti-oppressive practice community-oriented social work lens and then to bring in other health professionals to support service delivery and student training. Pharmacy was the first profession to integrate into the clinic and

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has helped lay the groundwork for a model of collaborative interdisciplinary partnership. This collaboration has been supported by existing research, which has shown that rehospitalizations for mental health are reduced when social work and pharmacy work together (Gil, Mikaitis, Shier, Johnson, & Sims, 2013). Building on this model of interprofessional collaboration, in the last two years we have incorporated occupational therapy, psychology, nursing, and nutrition students. We have worked to bring together other professions as our need evolves and are developing meaningful relationships with these professional schools around field experiences and client services.

Through interprofessional rounds, article discussions, and consistent explorations/discussions (critical reflections), we are beginning to see the ways in which we can learn from one another, celebrate the unique contributions of diverse professions, and reflect on how working together can build deeper understandings of social justice work in the community. Existing research notes the benefits of collaboration and integration of multiple professional approaches in the process of working toward a truly interprofessional approach to practice (Wang & Bhakta, 2013). Through interprofessional learning, students can gain greater respect for the contributions of other professions (Dacey, Murphy, Anderson, & McCloskey, 2010).

At times we work together with a client, while at other times one profession takes the lead to support the particular issues presented. Unique to our clinic is that every client is connected with a social work staff member or student—at least initially. It is a very organic, flexible, and adaptive process. We continue to learn as we go. It is our belief that critical (social work) theory is a way forward in engaging in interprofessional practice dynamics and experiential education. The integration of a critical lens with interprofessional practice and education could provide a greater affiliation with social work ethics and social justice. Postmodern critical theory allows for the integration of multiple ways of knowing and understanding the social world (Briskman, Pease, & Allan, 2009). It also contends that professional practice must be grounded in equitable relationships and social justice (Healy, 2005). To engage in this kind of collaborative work there must be some congruence in ideological perspectives regarding how service provision is delivered. Using a critical lens and engaging in critical reflective/reflexive practices could create more space for collaborative knowledge construction and adaptability between professions that historically have been very different in their educational training practices and professional ideals and values (Karban & Smith, 2010).

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WORK AT THE CLINIC: CRITICAL CASE MANAGEMENT AND CLINICAL PRACTICE

Critical case management is a continuous and collaborative process where clients, and their community supports, identify needs and goals. Case management within the clinic works to connect marginalized individuals to the social and health care systems from which they are often excluded. Employing a critical clinical case management model, the clinic incorporates system navigation, supportive counselling, crisis intervention, resource support, community outreach, accompaniment, advocacy, and group work, as well as needs assessments. Further, working in partnership with other organizations, the clinic fills in gaps in services while working toward the reduction of the high caseloads and waitlists of existing agencies as discussed earlier in the chapter.

CRITICAL CASE MANAGEMENT

Critical case management involves centring client experiences while affording collaborative provision of services and navigation of resources to meet client needs. It highlights the importance of both process and outcome to advocacy work in order to not only support clients through the acquisition of resources and services, but also to promote client empowerment throughout the advocacy process (Fook, 2002). Critical case management at the clinic also involves clinical therapeutic work, as the majority of clients identify experiencing mental or emotional health concerns and complex trauma histories. Working with these service users requires the development of therapeutic alliances and supportive client-worker relationships. Engaging with our clients requires an in-depth knowledge of trauma-specific approaches and crisis intervention.

Our version of clinical case management involves working to decrease worker-client power differentials through transparency and shared knowledge, promoting client choice and agency in clinic services, providing safety both in the physical space and the working relationship, validating client experiences of strength and resistance while challenging dominant oppressive narratives of self, and exploring structural origins of individual oppression.

Rooted in the "accompaniment" approach to practice, our program serves as a resource centre for marginalized individuals who may not fit into traditional

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support settings or those who are not yet connected to the existing network of social service agencies in Halifax. Accompaniment is "rooted in an interdependent understanding of psychological and community well-being, not in an individualistic paradigm of psychological suffering" (Watkins, 2015, p. 327). It involves taking a stance to "walk with" or "journey with" those we work with, resisting Western notions of individualism and power-over. This approach helps us reach out and connect to individuals who have experienced barriers accessing services, centring their experience and knowledge, reducing alienation, and fostering connection and hope. This approach espouses the core dynamics of critical clinical orientations.

Much of the current day-to-day work involves supporting clients with applications and appeals concerning Income Assistance and Special Needs, Canada Pension, Disability supports (letters of support, accessing documentation from doctors/nurse practitioners/services, mediation, advocacy, attending annual reviews, and requesting special needs funding for transportation, special diet, medication coverage, and medical expenses), and housing supports (remaining housed, support with landlords and dispute mediation, finding affordable housing, filling out housing applications, viewing apartments, moving support/costs, referring to housing agencies, attending housing meetings, residential tenancies applications and hearings). It also involves crisis intervention and supportive counselling. Many clients have been referred to the clinic from formal mental health services due to not meeting requirements to access care (e.g., acuteness, accessed services in the past, diagnosis). The clinic is able either to bridge a gap while clients are waiting for other formal services or to support those who have been denied access. Engaging in counselling at the clinic involves trauma-specific, narrative, feminist, and solution-focused approaches. Clients are given space and support for their stories and experiences to be explored and unpacked while workers constantly listen for unique outcomes (i.e., the contradictions that arise once a person begins to separate themselves from their dominant or unhelpful stories or the times the issue is not present or not as present in their lives) that highlight strength and resistance (White, 1991). Additionally, clients are offered skill-building options to manage overwhelming emotions (e.g., grounding exercises, deep breathing, visualizations, mindfulness, progressive muscle relaxation).

TRAUMA-SPECIFIC APPROACHES

Trauma-specific and trauma-informed approaches to practice involve a focus on building therapeutic relationships that emphasize safety, collaboration,

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and power-sharing while focusing on strengths and empowerment (British Columbia Centre of Excellence for Women's Health, 2009; Varghese, Quiros, & Berger, 2018). There is a focus on coping skills and emotional wellness where clients are directly involved in their own service provision and planning.

Students completing practicums at the clinic are able to clearly analyze different system structures and policies and how they affect clients' lives. The broad core goals of field education for students are met through the day-to-day activities in the clinic. In addition, each student develops and works to meet their personal learning objectives, which tend to include:

- observation/shadowing of the intake process and individual needs assessments
- increasing their knowledge of community resources and programs
- participation in case planning and coordination of services among community partners
- advocacy
- crisis intervention
- interviewing skills
- counselling skills
- participation in group supervision
- building critical analysis skills on the impact of formal and informal system operations
- interprofessional collaboration
- self-care

TRANSLATING THEORY INTO PRACTICE

The following section explores how the clinic translates critical and anti-oppressive theory into practice not only in the work we engage in with service users, but also in the experiential education opportunities we provide for our social work students as well as those from other health professions.

Low Barrier Approaches

A practical example of how the clinic offers an alternative critical approach to care involves our commitment to low barrier services. Clients are often referred

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from other health, government, or community agencies because of rigid policies and mandates that limit the work they can engage in with service users. Service users coming to the clinic regularly report oppressive experiences that make it difficult for them to access services at the institutions designed to help them. Clients are commonly referred to the clinic because they are not "acute" enough to be seen or the organization has a brief model of practice (i.e., the number of sessions is ending).

Seemingly simple tasks such as filling out paperwork to obtain services or compensation are sometimes impossible for our clients for various reasons, such as literacy, mental health, and/or (dis)Ability. The clinic receives several referrals from a number of agencies and organizations for clients to gain support in filling out paperwork for various services such as Workers' Compensation claims, Canada Pension Plan, and/or Income Assistance. There is an existing gap in health and community services where workers are unable to spend time with clients engaging in this kind of work. Being able to spend more time with clients who are identifying a need and engaging in services that they have little or no access to at other organizations provides power, choice, and agency.

Exploring Ethics

Utilizing a "walking with" approach within case management at the clinic can often involve an ethical component that staff and students are tasked with navigating. Recently, a student working at the clinic was responsible for engaging in advocacy to support the acquisition of the disability tax credit benefit. The ethical challenge that arose for the student was navigating Service Canada, which outlined a strict and rigid definition of what living with a (dis)Ability means in order to receive the tax benefit. The student wrote an appeal letter opposing the decision to deny the tax benefit. The letter demonstrated how the client was adhering to the definition of (dis)Ability. The student felt the letter emphasized individual struggles, deficits, and suffering that fit within the institutional definition of (dis)Ability.

In general, work with clients at the clinic focuses on listening to and validating experiences of (dis)Ability, trauma, or suffering while highlighting resiliencies and strengths. The student in this case felt uncomfortable with the language and underlying discourse highlighted in this letter, given the potential for an ethical trespass (see Weinberg, 2005) or harm to the client having to read their experience outlined in such a way. To work through this ethical dilemma, the student engaged in a critical reflection process with the clinic coordinators. Validating this student's feelings of discomfort, social workers are often placed

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in the difficult role of being both agents of change as well as agents of oppression. Social work practice requires upholding the dignity and worth of persons, but pursuing social justice often requires social workers to manoeuvre within oppressive social systems and structures to access services and resources for clients. Part of moving through this process was exercising transparency with the client in both going over the letter, explaining why it was written with deficit-based language, and seeking approval before sending. This highlights the importance of advocacy work in critical case management through both process (critical reflective and reflexive practice, transparency, and providing the client with the relevant information and final choice over the next steps) and outcome (sending the letter and supporting the client to access government compensation).

Record-Keeping

Social work is a unique profession in the sense that the core values of the profession impact every aspect of social work practice, especially in regard to case note-writing. Clinic staff and students recognize the importance of being critically reflective and reflexive toward any record-keeping or documentation procedures, given the power they can hold over clients. Being aware of language practices that oppress and reinforce dominant discourses for clients is a central part of teaching and learning at the clinic. Intakes, needs assessments, and case notes need to be grounded in critical, feminist, and anti-oppressive principles.

Psychiatric discourse has long been largely accepted as the dominant norm in working in health professions (Strong, 2012; Strong, Gaete, Sametband, French, & Eeson, 2012). Although this terminology is commonly used in mental health services and can sometimes be useful for both assessment and service acquisition, we attempt as much as possible to be conscious of the language used and its contextual place in a medicalized society through recognizing and understanding its foundation in dominant social constructs. Drawing on Fook's (2002) ideas about critical assessment, we resist using categories and labels as totalizing ways of defining the service users we work with. We approach assessment as a means of co-constructing service user narratives, being aware that there is often no one cause of client issues but a number of competing and contradictory factors (Fook, 2002). We keep in mind that, as service providers, we play an active and reflexive role in the narrative created, which could be helpful or harmful to the clients we work with (Fook, 2002).

As such, the information gained in the intake and assessment embodies the client's own language. We are transparent about the information we are

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recording and are checking in with clients about including certain information such as psychiatric diagnoses. We are also politicizing client experiences in having discussions about diagnosis, powerlessness, and oppression. Many of our clients find this validating and supportive in creating alternative stories about themselves, especially those who have been given multiple diagnoses or feel they have been misdiagnosed.

For the purposes of our work, it is often only helpful to have such labels if we are advocating for other services, resources, or supports that require them. Oftentimes we will record the distressing symptoms and emotions clients are experiencing as opposed to a diagnostic label (e.g., trauma history, panic attacks, sleep disturbances, night terrors, hypervigilance). Our case notes are written using language and discourse that are rooted in empowerment and feminist principles. We write them as if our clients or other health professionals will be reading them, as well as if they could be subpoenaed by the criminal justice system. We are continually aware of how our records could be either helpful or harmful to client situations. We use non-judgmental language, avoid detailed descriptions of trauma histories, and only include information that is relevant to the goals established by the client or that is important for our clinic team to know moving forward.

Crisis Intervention

Crisis intervention at the clinic uses empowerment principles and solution-focused approaches. Drawing on Dass-Brailsford (2007), crisis intervention involves three main steps: (1) pre-intervention (having as much information about the crisis as possible), (2) assessment (exploring safety and providing efficient and comprehensive evaluations that focus on how clients have handled crisis in the past—what worked and what did not), and (3) disposition (allowing clients to lead discussion around their experience of crisis while promoting their active participation in problem-solving or solution-finding). Individuals experiencing crisis situations (e.g., food insecurity, housing, suicidality, violence) require brief and short-term interventions that are going to support their immediate basic human needs (i.e., food, shelter, and safety). The focus is working to provide immediate needs while also implementing ongoing support plans to avoid crisis in the future. Building compassionate and authentic rapport and exploring together next steps are key ingredients to the therapeutic relationship. Staff and students at the clinic regularly discuss during debriefing sessions that clients report "feeling heard for the first time" and "feeling safer being able to share." The clients we

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work with often report being cut off, belittled, dismissed, and pathologized by formal systems (e.g., health care, mental health, community services). We have found that providing clients with space and time to tell their stories consistently has them leaving the interaction feeling better than when they came in (even if only for a short time). Moreover, knowing that they are free to call and/or come back to speak to a worker whenever they desire helps to alleviate some stress/anxiety. The deep client-centred and safe space (trauma-informed environment) foundations/architecture at the clinic help to provide physical and emotional sanctuary to our clients.

CRITICAL CLINICAL INTERVENTION: POLITICIZING OUR PRACTICE

Samantha, a 56-year-old woman, was referred to the clinic by Mental Health Services in our community after going to the emergency department feeling suicidal during one particularly difficult night. After completing an intake appointment at Mental Health Services, it was determined that she did not qualify and was not at immediate risk; she was provided with community resources and referrals, the clinic being one of them. During her intake appointment with the clinic, she identified that she was seeking counselling because she was having "episodes" and was feeling unsure how to move forward in her current situation. During her "episodes," she described feeling like "she could not breathe" and "feeling an overwhelming sense of dread." Samantha reported an inability to sleep, nightmares, and feeling anxious most of the time. She described her current situation as existing in an "unhappy relationship" where she was experiencing emotional and verbal abuse on a regular basis. She seemed ambivalent about whether or not to remain in her current situation. Samantha is retired and has a fixed income, which would make it somewhat more challenging to live on her own. (It is not uncommon for women in unsafe or detrimental situations to be hesitant to leave due to financial constraints.) Samantha stated that although the night she went to the emergency department she was feeling suicidal, that was the first time she had experienced those feelings and she has not felt that way since. She also reported strong family bonds with siblings and her daughter, as well as friendships outside of the relationship (protective factors).

Using critical feminist, empowerment, and narrative approaches, in the beginning it was important to unpack Samantha's dominant stories about herself to better understand the distressing symptoms she was experiencing

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(panic, anxiety, and sleep disturbances). The work together was collaborative and involved a process of sharing knowledge (Brown, 2007). In promoting agency and power in the therapeutic relationship, Samantha determined what was most important to discuss and what she was hoping to get out of each meeting (Turner & Maschi, 2015). In telling her story, Samantha recounted feeling most anxious and overwhelmed after negative interactions with her current partner (he would yell, call her names, belittle her, and/or ignore her). She stated that it reminded her of her parents' relationship and hearing them argue when she was a child. As Samantha told her story, she described a few experiences of trauma through sexual and/or physical violence that occurred in her young adulthood. Part of exploring these pieces was asking about how her experiences have made her feel about herself; how she thought her past experiences have influenced her current relationship as well as her expectations of other people; what has been helpful in the past; what has helped her manage her feelings and emotions; how has she been able to manage so well throughout her life despite these experiences; and were there times when things did not seem as bad, and what was happening during those times. Through this exploration, Samantha was able to identify that her current relationship was triggering feelings from other experiences of abuse and violence. She found that "things do not seem so bad" when her partner is away for work. Through this exploration, Samantha made a decision to end the relationship and move in with her sister.

Throughout the therapeutic process, Samantha expressed feelings of guilt, shame, and self-blame around her experiences. She stated that she did not understand why she was feeling the way she was feeling or why she felt it was getting worse. A large part of our discussion in the beginning sessions was around normalizing and contextualizing her feelings given her history and life experiences. Instead of individualizing and pathologizing her "symptoms," we discussed how she was experiencing normal reactions to trauma and that the distressing thoughts, emotions, and feelings she was experiencing made sense (Brown, 2017; Worell & Remer, 1992).

Working with women experiencing shame and self-blame, Brown (2013) suggests that "unless women's stories are unpacked, the self-blame and helplessness within dominant or privileged narratives are simply reconstituted" (p. 24). If we accept the idea that therapeutic interactions are inherently a political process, then they are not exempt from the "politics of gender, class, race and culture" (White, 1994, p. 1). Part of our counselling work at the clinic involves having a socio-political analysis, which provides an avenue to begin having conversations about mitigating dominant stories and privileging alternative ones.

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Although a significant piece of the work with Samantha involved highlighting unique outcomes where she demonstrated strength, resilience, and resistance, it also involved challenging unhelpful stories about herself. Dominant discourses about women, gender norms, and rape culture often result in "negative identity conclusions" for women (Brown, 2007, p. 4; 2017). Samantha would often engage in self-blame by making statements such as "Well, I should not have said that to him," "I should not have been there," or "I shouldn't have gotten into the car with him." Covert and overt messaging about women's roles, behaviours, and bodies begins as soon as we start to gain knowledge and understand the world around us. Socially constructed cultural norms related to victim blaming were ingrained in how Samantha viewed herself. Engaging Samantha in discussions about rape culture and societal attitudes toward women and reframing the discussion away from "her choices" and "her behaviour" and toward patriarchal attitudes and behaviours of men that lead to the violence she experienced supported a re-engagement with her own history (White, 2000). During the sessions with Samantha, she would often say, "Well, I never thought of it that way." Samantha was not changing or revisioning her history, rather she was able to "re-engage with [her] personal history on new terms" (White, 2000, p. 36). In this case, challenging patriarchal assumptions focused on women's roles in society and reinforcing alternative stories about women's experiences allowed for stories of manipulation and victimization to become ones of empowerment and resistance.

CONCLUSION

We have much to celebrate at the clinic: its community development roots, its social justice framework, its critical and anti-oppressive emblems, and its accompaniment philosophy. While indeed a work in progress, the clinic signals a social work initiative that can embrace an interprofessional lens, be a bridge between the worlds of community and university, focus on meeting the needs of our marginalized communities, and provide thoughtful and meaningful practice education experiences for emerging health professionals. We are continually working to balance our clinical and case management service delivery platforms with true community development and advocacy orientations of critical and anti-oppressive social work practice. We work hard to maintain our critical lens and engage with our communities to advocate for a more just and equitable society. We are diligent in our efforts to maintain our unique philosophy and offer transformative opportunities for our staff, students, and clients.

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