Critically Infused Social Work: A Website

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SOWK 5010: Introduction to Social Work Theories and Critical Practice Skills Part I

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What is Critical Social Work?

Modern critical social work pulls from many critical social science theories and practice approaches (Healy, 2014, p. 185). While quite wide-ranging, as illustrated by Figure 1 below, these critical social science practice approaches are rooted in the critical social science paradigm and, therefore, share common assumptions:

- Macro structures affect social relations and create inequities (Healy, 2014; Hick, 2005);
- There are material and intangible differences in power, privilege—and therefore irreconcilable interests—between those who are privileged by and oppressed within structures (Healy, 2014; Hick, 2005);
- Dominant discourses and ideologies function to maintain the status quo and normalize power relations (Healy, 2014; Hick, 2005);
- There should be a focus on working toward the elimination of "all forms of oppression and domination" through action achieved through "empowering oppressed people to act, collectively" (Healy, 2014, p. 186).

As Healy (2014) notes, critical social work practice includes all of the above assumptions. However, there still exists wide variation in the approaches taken by different critical social workers; one's specific approach varies depending on, for example, one's theoretical orientation (Hick et al., 2005, p. 4), as well as one's own embodied experiences and social location (p. 15). Critical social work practice may also vary depending on the discourses that are dominant within an institutional context—the possibilities for and modalities of critical social work practice within a large non-profit agency, for example, will likely look very different than within a small organization that is committed to radical practice (Healy, 2014; Hick, 2005, p. 15). Critical social

workers may also choose to use some approaches that stem from "conventional" social science theories (Healy, 2014).

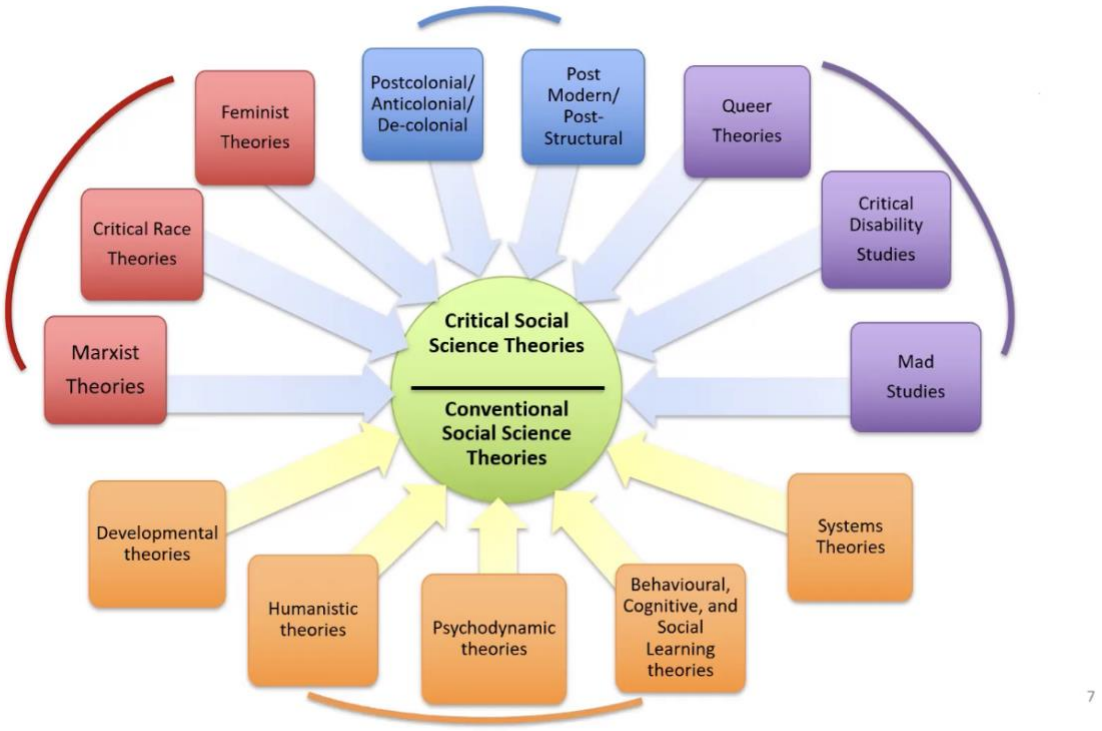
Indeed, a "sensitivity to difference" (Hick, 2005, p. 15) is essential for critical social work practice. This includes the awareness that any single definitions of critical social work are "illustrations of power" wherein "the less powerful become excluded from the expression of their experience" (p. 21). This openness to difference is perhaps a part of the main distinction between critical social work and the critical social sciences—unlike critical social science theories, critical social work theory is in an ongoing, recursive relationship with social work practice whereby each continually shape the other (Kondrat, 2012; Parton, 2002).

While critical social work theories rose in popularity during the 1960s and 1970s, the field of social work has long included the presence of "critical" social workers (Healy, 2014, p. 186). However, as Chapman and Withers (2019) note, it is important to resist the tendency to valorize historical or current social workers as "good" or "critical" social workers within a dichotomy of good/bad or critical/uncritical. Even Jane Addams, who is often positioned as the seminal "critical" social worker in social work history, was not "cleanly radical"—she, for example, published eugenic arguments while promoting her work within the now-famous settlement movement (p. 50). Today, many "critical" social workers remain both complicit and directly involved in perpetuating and upholding acts and structures of violence and oppression—consider, for example, that Black and Indigenous youth are disproportionately overrepresented in care within Ontario's child welfare system (Ontario Human Rights Commission, 2018), or that "critical" social work within Ontario operates on stolen land where the sovereignty of Indigenous nations is not respected. Indeed, we believe that an essential component of critical social work theory and practice must be the ongoing commitment of critical social workers to challenge their

personal beliefs and public discourses—including those that label their own positions as "critical", "progressive", or "good" (Chapman & Withers, 2019).

Figure 1

Critical and Conventional Social Science Theories that Inform Critical Social Work, from Sloos (2020a)

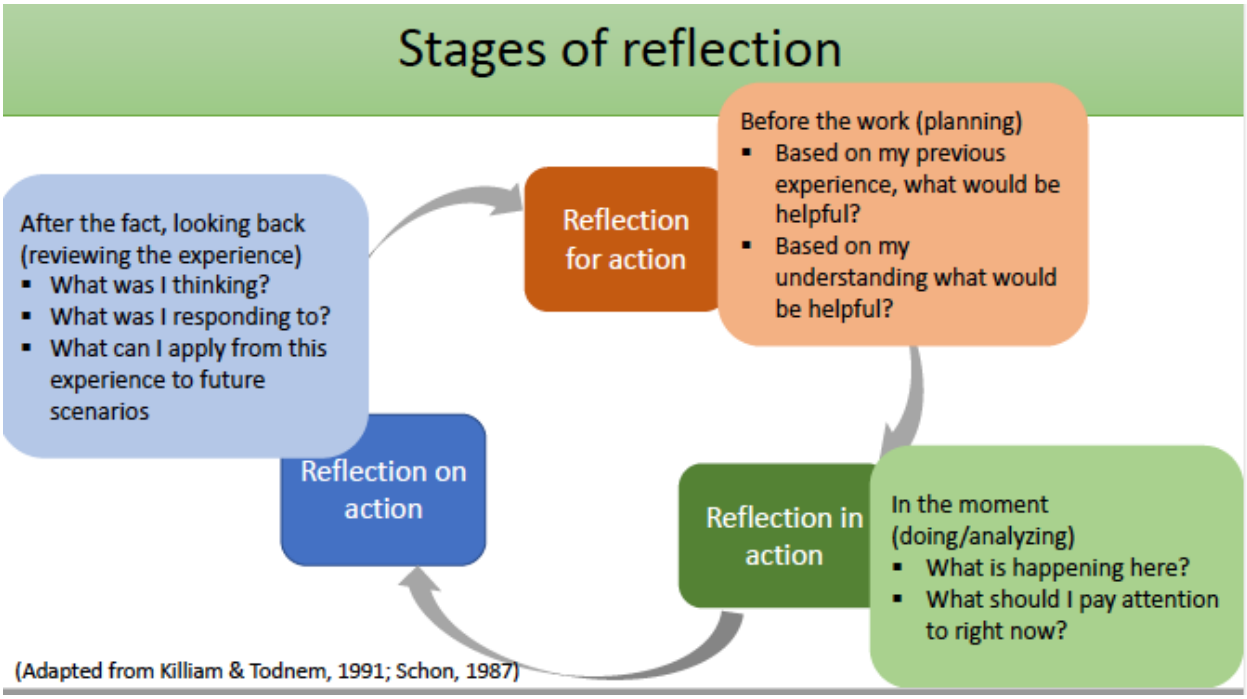


Introduction to Reflection and Critical Reflexivity

While moving throughout the different sections of this website, we encourage you to engage in the stages of reflection outlined in the diagram below. You may find it useful to use the theories and approaches covered in this website as prompts to reflect on previous actions that you have taken in your social work practice. You may find it helpful to think about reflection as an opportunity to "scrutiniz[e] the self for values, needs, and biases" in order to "increase awareness" and ultimately "engage with service users more consciously and objectively" (Sloos, 2020d).

Figure 1

Stages of Reflection, from Sloos (2020d)

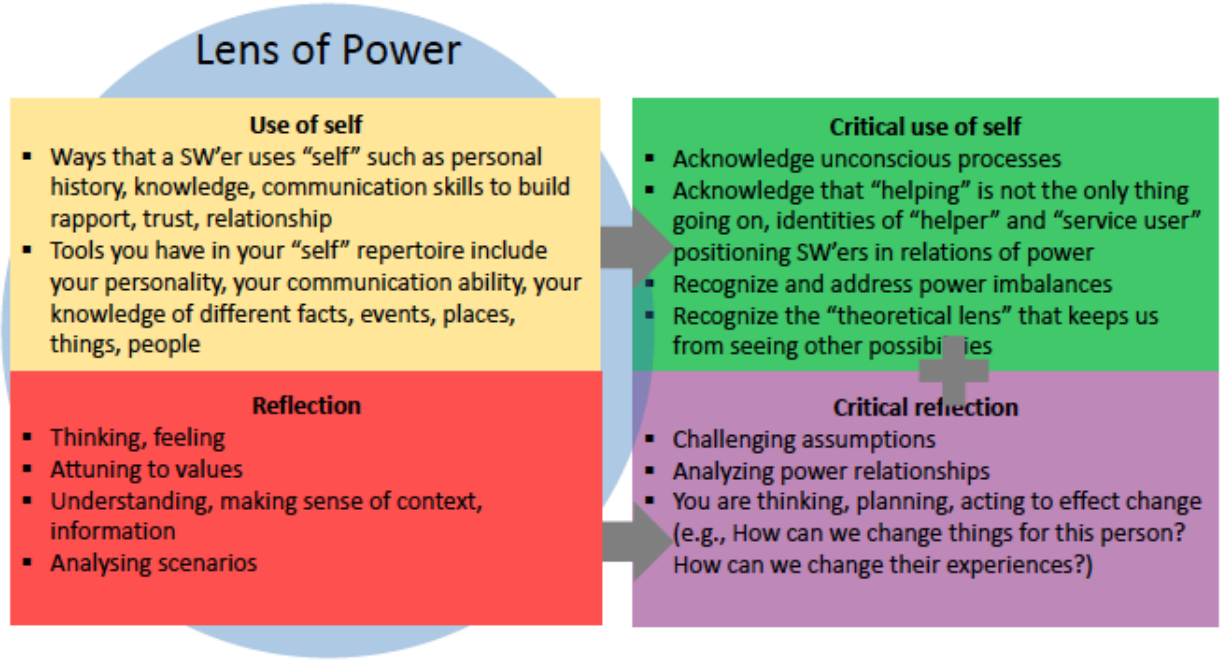


We also encourage you to engage in critical reflexivity. Unlike reflection, critical reflexivity applies a "lens of power" (Sloos, 2020d). This lens of power is both applied to your "use of self"—that is, the skills and tools that you have because of your experiences and positionality—as well as to the processes of reflection themselves. Critical reflexivity, therefore,

includes both a “critical use of self” and “critical reflection” (Sloos, 2020d). You may find it useful to use critical reflexivity to identify and challenge, for example, the forms of power embedded within the theories and approaches that this website covers, as well as to identify the forms of power that are promoted by identifying what is missing from this website (Sloos, 2020d). The diagrams below may be helpful in further understanding critical reflexivity.

Figure 2

Critical Reflexivity, from Sloos (2020d)



In our section that briefly discusses critical social work, we discuss that a component of critical social work must include resisting to label oneself as purely “critical”. We therefore encourage you to consider how, in your processes of reflection and critical reflexivity, you may be leaning toward labeling yourself as a purely “critical” social worker. Instead, we ask you to think about the ways “in which critical reflexivity can operate to re-inscribe colonial notions of

moral superiority, and re-center whiteness within social work education and practice settings" (Badwall, 2016, p. 1).

Suggested Reading:

Badwall, H. (2016). Critical reflexivity and moral regulation. *Journal of Progressive Human Services*, *27*(1), 1–20.

A Conversation with Postmodernism

Me: Hello. Hi reader.

You: [looks around] what is this?

Me: Exactly—what *is* "this"?

You: [silence]

Me: [silence]

You: Who are you?

Me: Even in thinking about the answer to this question, my answer has changed. I have changed. I am also always changing. The truth is socially constructed, and so is my subjectivity. Yours too (Healy, 2014, p. 211).

You: O…kay. So, is this a conversation? An essay? How do I get back to the rest of the website...?

Me: We have the power to make this whatever we want it to be. Power is relational. It is created, not possessed (Fook, 2002, p. 52).

You: …if you *had* to categorize it.

Me: Postmodernism and poststructuralism are all about pushing back on categories (Healy, 2014, p. 214).

You: Oh, so you're doing that here, with form?

Me: Yes, clever, eh?

You: [sighs]

Me: Based on my socially constructed understanding of that kind of "sigh", it seems you are exasperated with me. Care to share what's on your mind?

You: Honestly, this is wasting my time. I just need to get back to the site so I can read about how to apply critical approaches to strengths-based theory. I'm new at my organization and my boss has just given me a million forms I have to fill out with all of these standardized checklists. Adopting a "critical lens" is on #1 on the checklist and I have no idea what they mean. And I have a client waiting for me. I don't have time for this.

Me: It sounds like you work in an organization where the discourse of New Public Management [NPM] is dominant.

You: Explain.

Me: Siri, read me the first key theme related to the New Public Management discourse from Karen Healy's book.

Siri: That sounds like something I can do. Reading the first key theme related to the New Public Management discourse from Karen Healy's book, published in 2014, on pages 52 and 53:

"Based on the assumption that free markets increase service efficiency, quality and choice, the NPM discourse promotes an increased use of market mechanisms in the organization of health and welfare services. Clarke (2004, p. 36) describes the link between neoliberal economic theory and NPM: 'managerialism embodies this [neoliberal] decision-making calculus in its commitment to a rational, ruthless, business-like view of organizational and policy choices'. Proponents of NPM argue for a decreased role for governments in service delivery, seeing the role of government as one of 'steering not rowing' (Osborne and Gaebler, 1993). In the NPM discourse, governments outsource service delivery functions as far as possible to nongovernmental service agencies. These agencies compete for government and other forms of funding, such as philanthropic and fee-for-services, which leads to economic efficiency and services that are responsive to consumers' interests."

You: Oh. Yeah, actually. That's pretty accurate. While you're at it, can you ask Siri to read the definition of discourse? [Mutters: she's more helpful than you]

Me: Ask her yourself. When you mutter via text I can still hear it, by the way.

You: …Siri…can you read me the definition of discourse?

Siri: Sure, I can read you the definition of discourse: "The term 'discourse' refers to 'a system or aggregate of meanings' (Taylor, 2013, p. 14) through which certain social phenomena, such as 'need', 'knowledge' and 'intervention', are constructed. In other words, from a poststructural point of view, discourses are the sets of language practices that shape our thoughts, actions and even our identities," as quoted from Karen Healy, 2014, p. 3.

You: Hmm, that's helpful, Siri. So now that I know a bit about what NPM discourse is, that it is present at my organization, and that it's causing me problems, what do I do? What's the practice approach here?

You: Siri? Siri, how do I apply the knowledge of dominant discourses to practice?

Siri: I'm sorry, I don't have an answer to that question.

You: Hmm, okay. Let's try…Siri, how do I resist these oppressive neoliberal constraints at my organization?

Siri: That's not something I have the answer to. Try another question.

Me: Still think she is more helpful than me?

You: OKAY I'm sorry. Wow. Fine, then, what do you think I should do? Should I tell management to @#@#$@##$$%^%^&*^&*%^%$^$%^#$@#$%&%&%^*&*(*%^$%

You: Sorry, my cat rolled onto my keyboard #WorkingFromHome…So, should I tell management to not expect me to work within such oppressive and limited constraints?

Me: Oh. Mhm. I don't have the answer to that either. Like I said, before power is relational. You need to look at your context and its power relations to see where sites for resistance and intervention are (Healy, 2014, p. 217).

You: Context—like organization's context? Or my personal context?

Me: Yes, exactly. Work from the local to the structural, if you know what I mean (p. 217).

You: Wow, you really are a bother, you know that?

Me: I am going to reframe what you said as that I have the ability to ask thought-provoking questions that push back against neoliberal demands for efficiency and positivist views of yes/no and objective truth. So, it's a strength, really.

Siri: Is it a “strength”, though? A key characteristic of postmodernism is relativism defined as inherent subjectivity (p. 223).

You: So that means disagreeing with neoliberalism is subjective? Well my boss will just love that...

Me: Correct. How we make meaning of discourse is influenced by discourse itself (p. 223).

Siri: Very good, that is an application of postmodern theories in practice.

Me: Wow, Siri..! You are a sentient being!

Siri: Yes, in this context I have the relational power to answer questions.

You: This is getting WAY off track.

Me: What *is*—

You: DON’T you dare answer with “what *is* the track?”.

Me: Fair enough.

You: So what you're saying is that any next steps depend on identifying what the dominant discourses are and then how to proceed?

Me: That interpretation is valid, as are all interpretations.

Siri: Remember, there may be more than one dominant discourse present at your organization. And, they may be competing (pp. 3-11).

Here is the beginning of the introduction to 'psy' discourses from Karen Healy's book, published in 2014, on pages 64 and 65:

"The term 'psy' was coined by social scientists to refer to 'heterogeneous knowledges' developed from the psychological sciences, such as psychology, psychiatry and the behavioural sciences, which provide practical techniques for understanding, diagnosing and promoting change within the individual (see Rose, 1999, p. vii)...A core assumption of 'psy' disciplines is that many problems facing service users can be classified and treated at the level of individual psychological or even physiological processes. Undeniably, 'psy' ideas have had a profound influence on the development of the social work profession. Indeed, many of the concepts widely accepted by professional social workers can be traced to the influence of the 'psy' disciplines, especially psychoanalytic theory. Yet the social work profession has an ambivalent relationship to these disciplines and the use of 'psy' ideas varies historically and geographically."

You: [looks at watch] Okay Siri, thanks, that's good...

Siri: Okay. Here is the beginning of the introduction to sociological discourses from Karen Healy's book, published in 2014, on pages 74 and 75:

"The influence of sociology on professional social work has been no less profound than that of the 'psy' disciplines. In a variety of ways, sociological discourses seek to explain the social origins and consequences of human behaviour. They provide 'a range of perspectives, commentaries and interpretations of social life and experience' (Cree, 2010, p. 201). In turn, social workers often use these ideas to explain the phenomena they encounter in practice and guide their responses to them."

You: Okay, ah, THANKS SIRI. This is all great, but I have to get back like right now or I'm going to get fired. So…bye…thanks, I guess.

Me: Thank YOU. Good luck!

Siri: Goodbye!

Critical Approach: Anti-Oppressive Practice

Anti-Oppressive Practice (AOP) is one of the central social justice-oriented approaches in social work. It recognizes the structural origins of oppression and promotes social transformation by utilizing critical theories including feminist, Marxist, postmodernist, Indigenous, poststructuralist, anti-colonial, and anti-racist theories, among others (Baines, 2011). AOP recognizes that multiple forms of oppression can occur simultaneously within micro-, mezzo-, and macro-levels that uniquely impact marginalized people and communities. It works to eradicate oppression and challenge power structures through collective institutional and societal changes (Sakamoto & Pitner, 2005). Accordingly, AOP also promotes a deep reflection and development of a 'critical consciousness' to analyze, for example, how social work can be complicit in recreating and reinforcing structures of oppression, such as through unequal power dynamics between a social worker and service user. Critical consciousness is the "process of continuously reflecting upon and examining how our own biases, assumptions and cultural worldview affect the way we perceive difference and power dynamics" (Sakamoto & Pitner, 2005, p. 441). Through the development of clear connections between social justice and social work practice, AOP offers a conceptual model for understanding the multiplicity of oppression, privilege, and power dynamics at a structural level. AOP's ultimate goal is to change the "structure and procedures of service delivery systems through macro changes" (Sakamoto & Pitner, 2005, p. 437). As we will discuss further in our critical analysis of AOP, its conceptual model can sometimes be difficult to translate into actionable items for social work practice.

Anti-oppressive practice values the contribution of community and institutional change processes in achieving broader social change. As such, social workers embody principles of social justice activism by working to not only provide services to service users, but to also raise

the consciousness of those they are working with, to externalize their problems, and to understand how social inequality and structures of oppression work to create disadvantaged life circumstances in areas like housing, employment, healthcare and education. AOP reconciles and provides a path to link social work theories and values with practice utilizing 5 critical practice principles (Healy, 2014):

1. Critical Reflection on Self in Practice

Social work is an inherently political role; it allows social workers to occupy a position of power and privilege via their access to resources and hierarchical structure of the social service sector. Therefore, it is crucial for social workers to be critically reflexive to avoid recreating oppressive social relations in practice (Healy, 2014).

Asking ourselves questions like, "how does my social location create positions of privilege?" and "how may social divisions impact my ability to best meet this service user's needs?" can create the foundation for reflection on how our own biographies shape and create power differentials in our practice. It is also important to note that while social workers occupy a position of power in a therapeutic relationship, one's identity and social locations are dynamic and heavily dependent on the context one is in. For example, a racialized female social worker working with a white male service user might navigate power differentials based on her race and gender positions that do not reflect normative service user-service provider power imbalances.

2. Critical Assessment of Service Users' Experiences of Oppression

Critical social workers strive to comprehensively understand the diversity and multiplicity of oppression in service users' lives. Personal, cultural, and structural processes each shape individuals' problems, and the access they have to solutions. Critically analyzing the intersections of oppression such as gender, class, and race, allow us to understand how macro

level policies, discourse, and processes impact service users' lives. Similarly this critical analysis must also be turned inward, to understand how social work discourse and language use in framing of problems can contribute to sustain oppressive power structures (e.g. "disturbed, "at risk") (Healy, 2014).

3. Empowering Service Users

Empowering service users is one of the central tenets of AOP and strives to create empowerment processes both at the interpersonal and institutional level. At the interpersonal level, the process of "externalizing structural oppression" is key to being able to deconstruct experiences and recognize how social forces impact service users' lives. This process allows people to *see* the true nature of their circumstances by analyzing the structures and institutions that impact and influence their ability for social mobility, economic prosperity, and educational attainment. At the institutional level, "anti-oppressive social workers promote changes to the organization and delivery of services in ways that enhance anti-oppressive practice and service user control" (Healy, 2014, p. 198). Practical ways to promote empowerment include ensuring that service users' views and stated needs are incorporated into assessment and solution options.

4. Working in Partnership

AOP prioritizes working in partnership with service users through collaborative efforts that position the service user as the expert in their own life. Consequently, service users must be included as much as possible in the decision-making processes that impact their life. This is achieved through a deliberate sharing of power and a commitment to transparency where the service user has the full information and awareness of the circumstances to make decisions in their best interest. Working in partnership attempts to balance unequal power dynamics by working against hierarchical structures to create a supportive environment where the service user

is able to access the necessary resources and information to work collaboratively with a social worker (Healy, 2014).

5. Minimal Intervention

A key principle of AOP is reducing oppressive and disempowering situations in social work (Healy, 2014). Utilizing AOP in social work means minimizing opportunities of social control by strategically intervening in the least intrusive way possible in the service users' life. Early intervention and an emphasis on preventative services contribute to minimal intervention and less disruption in service users' lives.

Limitations

While AOP is committed to challenging and dismantling systems of oppression and increasing understanding of structural contexts that we are all embedded in, it does present some limitations. Working from an anti-oppressive framework without a critical consciousness can create circumstances for complicity and contribute to oppressive practices in social work. As Sinclair and Albert (2008) note, "to operate under the assumption that we need go no further than to state that our schools of social work adhere to anti-oppressive ideology and practice, allows for the perpetuation of a culture of silence which reinforces neocolonialism". Further, AOP can facilitate this complicity in its "dualistic framing of oppression and anti-oppression in critical social work because it imposes an erroneous conceptual division between oppression and anti-oppression which is usually simplistically associated with the moral categories of bad and good" (Wong, 2004). This allows social workers to ignore their own roles in recreating structures of oppression in their relationship with service users (Baldwell, 2016). As critical social workers, it is crucial that we do more than simply situate ourselves and our efforts as on the "right" side of social transformation. We must "take political and ethical stances, but do so in a way that

recognizes that we and our stances have been shaped by the very legacies that we're struggling against" (Chapman & Withers, 2019, p. 29).

Further limitations of anti-oppressive practice include its promotion of a robust structural analysis of factors that contribute to our lived experience, but a lack of tangible steps to engage in praxis. For example, while AOP endeavours to practice 'consciousness-raising' with service users as a form of empowerment, it fails to acknowledge its own role in social work as part of settler colonialism, and does not provide practical steps for the repatriation of land. While social workers call for actions to 'decolonize' the profession (Tamburro, 2013), social work in Canada relies on settler colonialism to function (Fortier & Wong, 2018) and therefore does not truly engage in decolonial actions. Consider, for example, that "Decolonization as metaphor allows people to equivocate these contradictory decolonial desires because it turns decolonization into an empty signifier to be filled by any track towards liberation" (Tuck & Yang, 2012, p. 7). AOP can be strengthened by incorporating perspectives that address and unsettle the relationships between colonialism and practice, and that prioritize Indigenist knowledges and goals.

Additionally, the practice of 'consciousness-raising' positions the social worker as knowledgeable on all forms of oppression and creates a power hierarchy in the social worker-service user relationship. This practice can be patronizing in that it functions to 'teach' individuals about their own experiences of oppression (Baines, 2011). To combat this, Dominelli (2002), states that social workers should engage in anti-oppressive practice and

> aim to provide more appropriate and sensitive services by responding to people's needs regardless of their social status. Anti-oppressive practice embodies a person-centred philosophy, an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives; a methodology focusing on the process

> and outcome; and a way of structural social relationships between individuals that aims to empower service users by reducing the negative effects of hierarchy in their immediate interaction and the work they do. (p. 6).

Therefore, combined with the development of a critical consciousness that acknowledges and challenges the role of social work in perpetuating settler colonialism and reproducing power hierarchies, AOP can potentially become a robust theoretical framework that can be useful for a critical social worker.

Examples of Social Worker Roles in Anti-Oppressive Practice		
Role	Implementation	Goal
Co-learner	Continuously learn from service users about their lived experiences and knowledge, skills, and strengths	To foster a sense of control, agency, and self-determination in the service user
Co-teacher	Incorporate education (ex. awareness of power dynamics in relationships) into the work; assume that people are already capable or have the capacity to become capable as the experts in their lives	To foster a sense of control, agency, and self-determination in the service user
Empathetic listener	Use active and reflective listening skills; convey positive regard, warmth, and respect	To develop a strong therapeutic relationship and build trust with the service user
Co-consultant	Collaboratively provide knowledge and share experiences; provide information and perspective where applicable	To help a service user's networks be better informed and better able to support them

Co-creator	Create opportunities for service users to become skilled at obtaining resources and support by acting as an "empowerer", not a "rescuer"	To promote service user's ability to see themselves as active agents responsible for change
Co-activator	Promote a sense of cooperation and joint responsibility to meet the service users' needs; promote partnerships and engagement with other supportive groups/communities	To help service users find new or alternative support and resources
Mediator	Promote cooperation and collaboration between service users; negotiate tensions if incidents arise	To support health interactions between service users and promote skill building of conflict resolution

Adapted from: Morgaine & Capous-Desyllas, 2015

Journaling Prompts

1. In all interactions/situations, have I thought about power, privilege, and social location and how it impacts my actions?
2. Have I questioned/challenged dominant ways of thinking to transform power towards equity?
3. Have I ensured the actions I have taken are equitable, collaborative and power sharing?
4. How can I promote anti-oppressive actions at an institutional or systemic level?

Critical Race Theory (CRT) and Anti-Racist Practice

What is CRT?

CRT provides social workers with a helpful analytical lens for applying anti-racist practice by examining structures of discrimination based on race and the implications, in relation to both the ideological and material circumstances, for racialized populations (Maiter, 2009, p. 270; Ying Yee, 2004, p. 68). Sarah Maiter (2009) explains that CRT positions race as a concept that "lacks any biological validity" (p. 267) but whose social construction is shaped by and embedded within hegemonic structures resulting in material effects. From this understanding, CRT provides two central areas of focus for understanding power dynamics and oppression: firstly, "the myriad of ways that racism may be embodied or embedded within relations, institutions, systems, and structures" (Ladhani & Sitter, 2020, p. 56) and secondly, challenging and unveiling the (at times obscure) power and privilege of whiteness (Ying Yee, 2004, p. 89).

How does CRT examine power relations?

CRT presents whiteness (or white supremacy) as a key concept in its analysis of power relations at the micro-, meso-, and macro-levels. From the macro-level, it "examines the historical processes of enslavement, colonization and misrepresentation of non-European peoples," and how these processes have come to embed white privilege and power within institutions and society (Maiter, 2009, p. 270). Furthermore, it recognizes the "powerful social meanings of race in White-dominated societies," as well as how these meanings "are evident in the lived experiences of minority groups," and particularly in the oppressions they face (Maiter, 2009, p. 270). CRT also examines how these dominant social meanings (or discourses), particularly presentations of racialized populations, are informed by the "dominant and/or majority group" and how their "ability to shape, define, and determine the knowledge base about

minority cultures documents not only their power to speak on behalf of those who are marginalized in society, but also how society itself normalizes the inferior position of minority cultures" (Ying Yee, 2004, p. 98). By virtue of "dominant and/or majority group's" normalizing the inferiority of racialized people, white supremacy and racial discrimination can "take place without people being consciously aware" of their complicity within these structures, resulting in the neutralization and deracialization of "whiteness" (Ying Yee, 2004, p. 98).

At the meso- and micro-levels, CRT can provide helpful anti-racist practice principles for social workers to critically reflect on their relationship with service users and their position within social service institutions. Anti-racist practice requires social workers to question "the traditional role" institutions play "in producing and reproducing racial, gender, sexual, and class-based inequalities in society" (Maiter, 2009, p. 270). For example, historically, efforts to apply anti-racist practice within institutions and social movements have been challenged due to white feminists' preoccupation over their moral self-image resulting in demonstrations of empathy to racialized women or flaunting their knowledge on anti-racism to prove that they are not racist instead of working towards organizational change (Srivastava, 2005, p. 57). Ying Yee (2005) notes that one can "[racialize] the practices of white people by challenging them to reflect on what practices may appear fair, neutral non-ideological but actually originate from specific socio-cultural-historical perspectives (pp. 96-97). While this is an important first step in dismantling the primary structures of racism, Sarita Srivastava (2005) argues that acknowledging structures of racism is not the only goal of anti-racist practice. Furthermore, these acknowledgements can in fact prohibit and stagnate implementation of anti-racist practice within institutions and social movements, because some may believe the acknowledgement of racism is sufficient action despite it not changing actual structural conditions (Srivastava, 2005, p. 53).

Additionally, critical race theory's focus on structures producing racial oppression provides a helpful alternative for social workers when critically reflecting on the lived experience of a service user: social workers can frame a service user's identity within the wide spectrum of oppression instead of through a focus on cultural differences or "cultural competency". Ying Yee (2004) argues that social work's attention to cultural competency and multiculturalism leads to a "stereotyping of cultures" which results in a "pre-defined, frozen, cultural identity" formed by the "norm of whiteness" (p. 99). Anti-racist practice provides a strong case for looking beyond an essentialized cultural identity as the focus on culture fails to "capture the consequence of race and the related effects of racism for people" (Maiter, 2009, p. 269). This includes, for example, a lack of acknowledgement of the "privileges that accrue to white people because of their skin color" and "the numerous material hardships for people of color" that arise due to a lack of structural privilege, such as "employment barriers, scrutiny by the police, struggles to find adequate housing, amongst others" (Maiter, 2009, p. 269).

Beyond CRT: Considering Intersectional Feminist Theory and Anti-Colonial Theory for Anti-Racist Practice

Critical race theory can also be linked to intersectional feminist theory as it "suggests that a full understanding of the effects of race cannot be gained without examining the intersections of all forms of oppression" (Maiter, 2009, p. 270). Intersectionality stems from demands within feminist theory to examine "inequality and oppression within groups of women" and provides an analytical lens "to explore gender, sexuality, class, and race as complex, intertwined, and mutual reinforcing categories of oppression and social structures" (Mattson, 2014, pp. 9-10). The concept was first coined by Kimberlé Crenshaw to describe a framework for illuminating the ways that racism and sexism overlap and create "unique and distinct kinds of burdens" for Black

women (Southbank, 2016). Emerging from critical race theory (Crenshaw, 1989), intersectional feminist theory's "aim is to disclose and challenge social structures and oppression" while also acknowledging the complex and dynamic nature of power relations which results in differences of experience within and between groups (Dhamoon, 2015, p. 29; Mattson, 2014, p. 10).

Moreover, the work of Crenshaw draws attention to intersectionality's purpose of identifying "intersectional failures" (Southbank 2016), where non-intersectional framing of social issues privileges the perspective of dominant groups over others by reinforcing structures of oppression which are not accounted for in this narrowly framed narrative. She uses the example of feminist movements fighting for women's equality and how they have historically over (if not only) accounted for issues pertaining to white women, leading to a "representational scheme that allow[s] white women to represent everybody regardless of whether their particular way of experiencing discrimination was the same" (Southbank, 2016). By not applying an anti-racist lens to the issues of women, feminist movements disregard the issues stemming from race, for example, that are faced by women of colour, and therefore reinforce structures of oppression like racism.

One area in which critical race and intersectional feminist theories could be more comprehensive and inclusive is by acknowledging the link between white supremacy and colonialism. By recognizing the arguments of theories and frameworks that unsettle the normalization of colonialism social workers may be able to better recognize "the interconnectedness of struggles" against structures of oppression, a particularly important focus being how "settler domination" is at the root of oppressive structures that impact everyone within a settler colonial state, especially marginalized populations (Dhamoon, 2015, p. 34), though certainly not in equal modalities or magnitudes.

Journal Prompts for social workers

- How does the structure of whiteness impact your workplace's practices and relationships? How can you apply anti-racist practice within your individual work or workplace practices to influence personal and institutional change?
- How do you think the intersections of your identity may impact your work as a social worker? In particular, how may your intersectional position impact your relationship with service users?
- Can anti-racist practice be strengthened by connecting this perspectives to other critical social science theories? Which links may be helpful to you as a social worker?

Anticolonialism, Postcolonialism, Indigenism, and Decolonization

> I recently became totally exasperated when I saw a social media post by a white settler colleague asking for recommendations of "more practical" readings by Indigenous scholars, which would provide more detail about what decolonization looks like "in reality." To watch settler scholars sift through our work as they effectively ask, "Isn't there more for me to get from this?" is so insulting. It seems like the tacit (and sometimes arrogantly explicit) request for more (details, explanation, assurance) is actually a form of dismissal. It is a rejection of the opportunity to engage with Indigenous texts on their own terms. It is a deferral of responsibility through asking, "Isn't there something less theoretical? Isn't there something more theoretical? Something more practical? Something less radical? Can't you describe something that seems more likely or possible?" These insistences upon Indigenous writings contradict themselves while also putting all the onus of responsibility on Indigenous people to make the future more coherent and palatable to white settler readers. In reading Indigenous work, they ask for more work, even if they have done little to fully consider what has already been carefully and attentively offered. Often it seems that settler readers read like settlers (that is, read extractively) for particular content to be removed for future use. The reading is like panning for gold, sorting through work that may not have been intended for a particular reader, sorting it by what is useful and what is discardable. (Tuck, 2019, pp. 14-15)

We thought it was important to frame this section by actively drawing attention to the settler tendency to "read extractivley" (Tuck, 2019, pp. 14-15). In drawing attention to this tendency, we are not placing ourselves outside of it—rather, we are implicating ourselves directly within the problem as settler-scholar-social workers who are attempting to include an "overview" of anticolonial, postcolonial, decolonial, and/or Indigenist theories for our project.

We decided to include this section because we feel that it is important to unsettle versions of social work theory and practice that erase Indigenous knowledges and perspectives. This is especially important given the context of social work and its ongoing role in colonization (Blackstock, 2009). However, we acknowledge that our attempts to fit concepts within the confines of this project might also be violent form of erasure, especially in relation to decolonial and Indigenist perspectives, in that we are "sorting [through work] by what is useful and what is discardable" (p. 15) for this overview website, which, beyond this section, centers largely on Western conceptions of social work.

With this uncertainty in mind, we want to specify that this section is being written for other settlers. Furthermore, we want to specify that we will not attempt to give a comprehensive overview of a theory or theories; rather, we will aim to highlight some concepts and terms as a starting point—an incomplete starting point—for readers to access the highlighted resources and, as Tuck (2019) writes, "engage with Indigenous texts on their own terms" (p. 14). Some parts of this section will deliberately use more long-form quotations than may usually be considered normal within academic work as we want to use the space to center Indigenous voices rather than our paraphrased (mis)understandings. Finally, we have attempted to reduce the aforementioned violence of "making Indigenous perspectives *fit*" by not applying as strict a focus on length or categorization to this section as other sections within this project. We invite readers to join us in noticing and sitting with feelings of discomfort such as defensiveness, guilt, exasperation, or attempts to neatly "extract" knowledge.

Anticolonialism and Postcolonialism

Anticolonialism can be defined as "the political struggle of colonized peoples against the specific ideology and practice of colonialism" by "emphasiz[ing] the need to reject colonial power and restore local control" (Ashcroft et al., 2013, p. 15). There is much variation within the praxis of anticolonial theory, however, it has often taken the form of a "discourse of anti-colonial 'nationalism'" where colonial structures of governance are resisted through demands of "an independent postcolonial nation-state" (pp. 15-16). Postcolonialism "examines the effects of colonization and reconfigures the colonizer/colonized axis in different ways" (Moreton-Robinson, 2015, p. 8). While some feel that it has positively contributed through its conceptualizations of categories such as *diaspora*, *migrant,* and *hybrid identities,* as well as through its "ability to reveal the operations of counterhegemonic discourses as produced by the dispersed, or diasporic, subject" (Moreton-Robinson, 2015, p. 8), it is a highly debated field; one main reason that it implies that colonialism is finished.

Critiques of anticolonialism and postcolonialism have unique aspects, however, one area that is shared is their tension within settler colonial states, like Canada. Settler colonialism is "the specific formation of colonialism in which the colonizer comes to stay, making himself the sovereign, and the arbiter of citizenship, civility, and knowing" (Tuck & Gaztambide-Fernández, 2013, p. 73). In settler colonialism, "invasion is a structure, not an event"; that is, the "logic of elimination is embedded into every aspect of the settler colonial structures and its disciplines" (Tuck & Gaztambide-Fernández, 2013, p. 73; Wolfe, 2006, p. 402).

> In North America, settler colonialism operates through a triad of relationships, between the (white [but not always]) settlers, the Indigenous inhabitants, and chattel slaves who are removed from their homelands to work stolen land. At the crux of these relationships is land,

> highly valued and disputed. For settlers to live on and profit from land, they must eliminate Indigenous peoples, and extinguish their historical, epistemological, philosophical, moral and political claims to land. Land, in being settled, becomes property. Settlers must also import chattel slaves, who must be kept landless, and who also become property, to be used, abused, and managed. (Tuck & Gaztambide-Fernández, 2013, p. 74)

Therefore, the relationship of "colonizer and colonized" as "in absolute and implacable opposition" that is the basis of anticolonialism is complicated within settler colonial contexts where there is also the presence of a "more obvious form of complicity" in, for example, the silencing of Indigenous land claims (Ashcroft et al., 2013, p. 17). The continued presence of settlers in settler colonialism problematizes postcolonialism as "Indigenous and non-Indigenous peoples are situated in relation to (post)colonization in radically different ways—ways that cannot be made into sameness" (Moreton-Robinson, 2015, p. 11); indeed, as Moreton-Robinson notes, Indigenous peoples' "ontological relation to land constitutes a subject position that we do not share, that cannot be shared, with the postcolonial subject, whose sense of belonging in this place is tied to migrancy" (p. 11).

Decolonization and Indigenism

Another framework is that of an Indigenist outlook, which can be defined as "one who not only takes the rights of indigenous peoples as the highest priority of [their] political life, but who draws upon the traditions—the bodies of knowledge and corresponding codes of value—evolved over many thousands of years by native peoples the world over" (Churchill, 2003, p. 251). *Indigenism* is not synonymous with *Indigenous*; from this definition, a person, either Indigenous or non-Indigenous, can work within or outside of an Indigenist framework (Simpson, 2004, 382). Across Turtle Island (North America), the Indigenist outlook has largely adopted the

six foundational demands stated in Latin America through the *Indigenismo* movement, "all of them associated with sociopolitical, cultural, and economic autonomy (or sovereignty) and self-determination" (p. 255). The fundamental component of this outlook is that "the land rights of 'First Americans' should serve as a first priority for attainment of everyone seriously committed to accomplishing positive change in North America" (Churchill, 2003, pp. 259-260, emphasis added). Ward Churchill (2003) explains the primacy of this demand thusly:

> Let's imagine that the United States as a whole were somehow transformed into an entity defined by the parity of its race, class, and gender relations, its embrace of unrestricted sexual preference, its rejection of militarism in all forms, and its abiding concern with environmental protection. (I know, I know, this is a sheer impossibility, but that's my point.) When all is said and done, the society resulting from this scenario is still, first and foremost, a colonialist society, an imperialist society in the most fundamental possible sense, with all that that implies. This is true because the scenario does nothing at all to address the fact that whatever is happening happens on someone else's land, not only without their consent, but through an adamant disregard for their rights to the land. Hence, all it means is that the invader population has rearranged its affairs in such a way as to make itself more comfortable at the continuing expense of indigenous people. (Churchill, 2003, p. 259).

Decolonization is used in a similar context as Indigenism by some Indigenous scholars (see, for e.g., (Simpson, 2004, 382). While there are many articulations of definitions, as settler-scholars, it is not our place to highlight or theorize about decolonization. Consider, for example, that while Linklater (2014) notes that "a decolonization approach contributes to two relevant areas of Indigenous trauma work", she also notes that "Indigenous people…must be at the forefront of developing Indigenous trauma practice and theory" (p. 27). Given the tendency of the social

work profession to try and adopt methods of "decolonization", we think that it is important to center Tuck and Yang's (2012) article entitled *Decolonization is not a metaphor*:

> Decolonization brings about the repatriation of Indigenous land and life; it is not a metaphor for other things we want to do to improve our societies and schools. The easy adoption of decolonizing discourse by educational advocacy and scholarship, evidenced by the increasing number of calls to "decolonize our schools," or use "decolonizing methods," or, "decolonize student thinking", turns decolonization into a metaphor. As important as their goals may be, social justice, critical methodologies, or approaches that decenter settler perspectives have objectives that may be incommensurable with decolonization. Because settler colonialism is built upon an entangled triad structure of settler-native-slave, the decolonial desires of white, non- white, immigrant, postcolonial, and oppressed people, can similarly be entangled in resettlement, reoccupation, and reinhabitation that actually further settler colonialism. The metaphorization of decolonization makes possible a set of evasions, or "settler moves to innocence", that problematically attempt to reconcile settler guilt and complicity, and rescue settler futurity. (Tuck & Yang, 2012, p. 1)

Furthermore, in *Losing Patience for the Task of Convincing Settlers to Pay Attention to Indigenous Ideas,* Tuck (2019) writes:

> Indigenous and decolonial theories are unfairly, inappropriately expected to answer to whiteness and to settler relationships to land in the future…A settler future is preoccupied by questions of, What will decolonization look like? What will happen after abolition? What will be the consequences of decolonization for the settler?…decolonization is not obliged to answer questions concerned with settler futures…What I am coming to more fully understand is that the questions of "What will decolonization look like?," when posed

> by settlers, are a distraction to Indigenous theorizations of decolonization. They drain the energy and imagination of Indigenous scholarship—they pester, they think they are unique, and they are boring. I want time and space to sketch the next and the now to get there. Decolonization is not the endgame, not the final outcome of a long process, but the next now, the now that is chasing at our heels. I am lucky to come from the long view. (p. 15)

Connections to Social Work?

So, what can be applied from the above to social work practice? As discussed above, postcolonial and anticolonial theory are problematic within our settler colonial context because settler colonialism is an ongoing "structure" of "invasion" in which we are complicit (Tuck & Gaztambide-Fernández, 2013, p. 73; Wolfe, 2006, p. 402). Furthermore, we believe that as settler scholars, it is not our place to interpret theorizations of decolonization or assert that we are applying a decolonial lens. As some Indigenous scholars have noted that both Indigenous and non-Indigenous people can work within (or outside of) an Indigenist outlook (see, for e.g., Simpson, 2004, 382), we will proceed humbly and cautiously to attempt to think within this framework by highlighting the calls for the sociopolitical, cultural, and economic autonomy (or sovereignty) and self-determination, beginning with land.

Furthermore, instead of attempting to fit concepts within the categories of *foundational assumptions with respect to power, relationships, and change process* that we have organized other sections within this project, we will highlight some questions and concepts as a starting point—an incomplete starting point—for readers to access the highlighted resources and, as Tuck writes, "engage with Indigenous texts on their own terms" (p. 14).

Turning the Gaze Inward to Settlers and Settler Colonialism

Ask Yourself: Whose Land am I on?

The fundamental demand of an Indigenist outlook is the repatriation of land to Indigenous peoples. So, applying an Indigenist outlook would look like working toward this goal. This application can begin through learning about whose land you are living and working on, and what treaties are associated with this land. Here is a website that might be a helpful starting point: https://native-land.ca/. Here is a place you can donate: https://www.gofundme.com/f/legal-fund-1492-land-back-lane.

Suggested readings:

Simpson, L. B. (2014). Land as pedagogy: Nishnaabeg intelligence and rebellious transformation. *Decolonization: Indigeneity, Education & Society*, *3*(3), 1–25.

Wolfe, P. (2006). Settler colonialism and the elimination of the native. *Journal of Genocide Research*, *8*(4), 387–409.

Ask Yourself: How is the Broad Field of Social Work as Well as My Specific Role, Approach, and Organization Invested in Settler Futurity? How Can I "Interrupt" and Not "Recuperate" Settler Colonialism?

> Anything that seeks to recuperate and not interrupt settler colonialism, to reform the settlement and incorporate Indigenous peoples into the multicultural settler colonial nation state is fettered to settler futurity. To be clear, our commitments are to what might be called an Indigenous futurity, which does not foreclose the inhabitation of Indigenous land by non-Indigenous peoples, but does foreclose settler colonialism and settler epistemologies. That is to say that Indigenous futurity does not require the erasure of now-settlers in the ways that settler futurity requires of Indigenous peoples. (Tuck & Yang, 2012, p. 80)

On an individual level, you might consider asking: does your practice or role promote Indigenous sovereignty and self-determination? Is it built around understandings that, for example: Indigenous worldviews, which emphasize interconnectedness with all of creation, are very different than Western individualistic, anthropocentric worldviews (Linklater, 2014, pp. 27-32); Indigenous healing is based around "wellness"—as opposed to Western "medical models of illness"—and includes "holistic approaches that consider equally the spiritual, emotional, mental and physical aspects of the person" (pp. 21); "Indigenous philosophies and cultural practices provide the most appropriate and successful therapeutic techniques for individual and community healing" (p. 25)? (How) does your practice prevent itself from being a tool of settler colonialism, beyond having good intentions as a social worker (Blackstock, 2009)?

Suggested readings:

Blackstock, C. (2009). The occasional evil of angels: Learning from the experiences of Aboriginal peoples and social work. *First Peoples Child and Family Review*, *4*(1).

Tuck, E., & Gaztambide-Fernández, R. A. (2013). Curriculum, replacement, and settler futurity. *Journal of Curriculum Theorizing*, *29*(1), 72–89.

Ask Yourself: How Do I Enact "Settler Moves to Innocence"?

Tuck and Yang (2012) outline six "settler moves to innocence" which "are those strategies or positionings that attempt to relieve the settler of feelings of guilt or responsibility without giving up land or power or privilege, without having to change much at all" (p. 10). Tuck and Yang note that they "provide this framework so that we can be more impatient with each other, less likely to accept gestures and half-steps, and more willing to press for acts which unsettle innocence" (p. 10). We have included the title of each below, as well as the title of the article so

that readers can sit with the full descriptions and ask if/how they apply to their own professional or personal practices.

1. Settler nativism
2. Settler adoption fantasies
3. Colonial equivocation
4. Free your mind and the rest will follow
5. A(s)t(e)risk peoples
6. Re-occupation and urban homesteading. (p. 4)

Suggested readings:

Tuck, E., & Yang, K. W. (2012). Decolonization is not a metaphor. *Decolonization: Indigeneity, Education & Society, 1*(1), 1–40.

Chapman, C., & Withers, A. J. (2019). *A violent history of benevolence: Interlocking oppression in the moral economies of social working*. University of Toronto Press.

Closing: An "Ethic of Incommensurability"

As settlers after reading this section, it's likely you have many feelings. Maybe confusion, exasperation, helplessness, grief, sadness. It is true that this section does not offer concise ways that anticolonialism, postcolonialsm, Indigineism, or decolonization can be neatly applied to our social work practice. However—as settlers living on stolen land, benefitting from settler colonialism, and working in a profession that upholds this structure—to try and neatly apply concepts to social work practice would be to perpetuate settler futurity, that is, "to reform the settlement and incorporate Indigenous peoples into the multicultural settler colonial nation state" (Tuck & Yang, 2012, p. 80).

Instead, we want to close by sitting with Eve Tuck's concept of an "ethic of incommensurability":

> …what we might call an ethic of incommensurability…recognizes what is distinct, what is sovereign for project(s) of decolonization in relation to human and civil rights based social justice projects. There are portions of these projects that simply cannot speak to one another, cannot be aligned or allied. We make these notations to highlight opportunities for what can only ever be strategic and contingent collaborations, and to indicate the reasons that lasting solidarities may be elusive, even undesirable. (Tuck & Yang, 2012, p. 28)
>
> An ethic of incommensurability, which guides moves that unsettle innocence, stands in contrast to aims of reconciliation, which motivate settler moves to innocence. Reconciliation is about rescuing settler normalcy, about rescuing a settler future…to fully enact an ethic of incommensurability means relinquishing settler futurity, abandoning the hope that settlers may one day be commensurable to Native peoples. It means removing the asterisks, periods, commas, apostrophes, the whereas's, buts, and conditional clauses that punctuate decolonization and underwrite settler innocence. The Native futures, the lives to be lived once the settler nation is gone - these are the unwritten possibilities made possible by an ethic of incommensurability. (Tuck & Yang, 2012, pp. 35-36)

What does an ethic of incommensurability look like in relation to social work? To your role? To your practice? What components simply "cannot be aligned or allied" with an Indigenist outlook? Where and how can you move to "unsettle innocence" and "stand in contrast to aims of reconciliation"?

Mad Studies

Disability Studies

Disability studies is a cross-disciplinary field of study that prioritizes leadership and inclusion of those living with disabilities in research and in the generation of knowledge (Jones & Brown, 2013). Within the discipline there is a deliberate centering of first-person narratives and 'disabled people' are inherently considered 'experts by experience' (Faulkner, 2017). In accordance to the Society of Disability Studies (2016), the important contributions of this field of disciple include, but are not limited to:

1. The exploration of models and theories that analyze the factors that define disability (social, political, cultural, and economic);
2. Working to de-stigmatize 'disability', especially those disabilities that cannot be accurately measured or explained through mainstream research methods;
3. Acknowledging the usefulness as well as limitations of medical research studies and recognizing the role of mainstream research in furthering stigma;
4. Studying how perspectives, attitudes, policies, etc. differ but analyzing a broad scale (personal, collective, national and international) and learning through these differences.

However, Disability Studies' broad scope of "the overarching, or governing, concept of disability" has posed great limitations upon research that focuses specifically on madness and seeks to establish a more expansive understanding of mental health knowledge (Ingram, 2016, p.11; Faulkner, 2017).

Mad Studies

In response to this limitation, Richard Ingram, a Canadian activist and academic, is credited to be the first to coin the term 'Mad Studies' in 2016 at the Disability Studies

symposium at Syracuse University. The term grew out of Ingram's analysis on the limitations of Disability Studies in conceptualizing madness, and it is described both as an emerging discipline as well as an indiscipline (Ingram, 2016). More accurately, Mad Studies is the academic rendition of the service user/survivor or Mad Movement that has emerged across the world over the past twenty-five years (Faulker, 2017; Ingram, 2016). Kathryn Church (2015) proposes that both the community-based and academic movements should invite an understanding of mental health that predates and problematizes psychiatric research discourse by focusing on lived experience and personal narration. Mad Studies places the ongoing work and history of survivor/service user activism, as well as survivor narratives, at the forefront of its focus (LeFrancois et al 2013). Faulkner identifies the interdisciplinary nature of Mad Studies as one of its great strengths:

> One of the strengths of this emerging field of enquiry is that it is drawing on many different academic disciplines: literature and critical theory, law and sociology, to name but a few. This gives it the strength to make use of different strands of knowledge and thinking, challenging the centrality of biomedical psychiatry in shaping our understanding of mental health. (2017, p. 514)

Mad Studies as a critical approach calls into question the dominance of the biomedical model, the legitimacy of clinical trials, and the self-interest of pharmaceutical companies within psychiatric care (Faulkner, 2017). It recognizes that the conventionally desired "objectivity" in the researcher or service provider has instead the potential to create further harm and possibly lead to the "distortion or misunderstanding of the experience being interpreted" (Faulkner, 2017, p. 505). In recognizing the inherent hierarchies of "expert" evidence and knowledge valued by mainstream research studies, Mad Studies advocates for the inclusion of:

> experiences, history, culture, political organising, narratives, writings and most importantly, the people who identify as: Mad; psychiatric survivors; consumers; service users; mentally ill; patients; neuro-diverse; inmates; disabled – to name a few of the 'identity labels' our community may choose to use. (Costa, 2014, para. 3)

Mad Studies pushes up against the devaluation of experiential knowledge and seeks to recenter user experience and first-person narrative within academic dialogue. It helps us to analyze on a macro-level how mental health structures and the domination of western medicine contribute to the further stigmatization of 'madness'. On a micro-level, within the context of social work, Mad Studies contributes to the reframing of power dynamics between service user and service provider and urges us to dismantle the hierarchy between professional and experiential knowledge and evidence. Through examples such as user-led research studies and peer support roles, Mad Studies also invites us to consider the ways in which lived experience contributes meaningfully to worker credentials.

Mad Studies is an important approach required in dismantling sanism. Sanism is described by Poole and colleagues as the "systematic subjugation of people who have received 'mental health' diagnoses or treatment" or those who are neurodivergent (Poole, et al., 2012, p. 20). Social workers unknowingly enact sanism within their practice because "pathologizing, labeling, exclusion, and dismissal have become a 'normal' part of professional practice and education" (p. 20).

Addressing Limitations

Mad Studies encounters limitations that can be overcome if practiced in combination with other critical theories and perspectives. As an example, Mad Studies encounters the tension of pursuing academic interests, while striving to maintain relationships and

involvement with ongoing activist movements (Ingram, 2016). This is a difficult pursuit, but necessary for maintaining a relevant praxis. To demonstrate the significance of community work as well as the need for adopting other critical perspectives to understand ways in which Mad Studies is relevant, we look at two examples. The first demonstrates the importance of integrating critical race theory within Mad Studies. The second draws attention to the intersections between madness and the trans experience, demonstrating the importance of maintaining the relationship between queer theory and mad studies. Both cases exemplify the significant importance of Mad Studies maintaining a relationship with community-based movements, and supplementing perspectives with additional critical theories.

1) Critical Race Theory: Black communities maintain a strong tradition of self-help and peer support groups; one reason behind this is the severe lack of available culturally specific social services (Wilson 2001; Seebohm et al., 2010). To meaningfully engage the experiences of community mobilization, such as the tireless work of racialized communities, it is imperative to employ the critical lens of intersectionality. Faulkner & Kalathil demonstrate the importance of adopting aspects of critical race theory to supplement the approach of Mad Studies when they state:

> It is important to remember that social justice movements and initiatives have an inherent danger of allowing the narrative of a given group to be dominated by individuals who are normative in all other senses, thereby marginalising non-normative voices within the group. (2012, p. 45)

For these reasons, Mad Studies needs to listen deeply to the ways in which madness is experienced differently when compounded with other lived experiences, such as racial oppressions.

2) Queer Theory: There is a strong resonance between Mad Studies and queer experiences. One example is the way that trans individuals experience psychiatric assessments and medical approval prior to receiving the necessary treatments required for their transition (McWade et al., 2015). In order to prove treatment eligibility, they must prove their sanity. The impact of psychiatrization imposed upon an individual who identifies as trans demonstrates the way in which "compulsory able-bodiedness and compulsory heterosexuality" dominates medical assessment procedures (p. 307).

By integrating the approach of intersectionality and critical race theory to Mad Studies, we can begin to establish a more comprehensive *mad-infused* critical praxis (McWade, et al., 2015).

"In a mad world, only the mad are sane." — Akira Kurosawa

Conventional Approach: Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is one of the most widely used forms of psychodynamic, evidence-based practice for improving mental health. It is a psycho-social intervention that works to alter unhelpful thoughts, beliefs, attitudes, and behaviours by improving emotional regulation through the development of targeted skills and strategies. It is a short-term, structured, goal-focused, and action-based therapy that helps individuals understand the connection between mood, thoughts, and behaviours and the relationship to the environment in which they live (O'Neill, 2017).

Through a collaborative process with a CBT therapist, service users develop strategies to replace dysfunctional core beliefs through 6-8 targeted sessions to address specific issues that they have identified as detrimental to their mental health. CBT is meant to be a brief intervention utilizing specific treatments for a limited number of sessions. While there is a range in duration, common consensus around CBT holds that a time-limited therapy may act as an additional incentive for patients and therapists to work efficiently (Cully & Teten, 2008; Payne, 2016; O'Neill, 2017). CBT is widely lauded in the mental health sector for not only its effectiveness in the treatment of many psychological disorders, but also for its position as a cost-effective method of intervention (O'Neill, 2017).

Measurement of a service users' achievement of their goals is critical in calculating the efficiency of CBT. Therefore, careful assessment and monitoring of a service user's progress is vital to the practice. One form of measuring progress is through worksheets and homework assignments as well capturing mood ratings/scores. Because the success of CBT is contingent upon an individual's voluntary participation (Matthews et al., 2003), CBT utilizes homework assignments and additional reading materials to assist in the service user's therapeutic growth in

interventions such as cognitive restructuring, problem-solving, and mindfulness (Cully & Teten, 2008).

Foundational Assumptions

1. Situations themselves are generally not problematic. It is our reactions to situations that cause problems.
2. Thoughts impact how we experience the world and how we feel.
3. Our thoughts, feelings, and behaviours are constantly influencing and reinforcing each other.
4. We have the capability to change our thoughts, feelings, and behaviours.

(Cully & Teten, 2008).

Origins of Cognitive Behavioural Therapy

In the 1970's, Cognitive Behavioural Therapy was created as a product of the integration of two therapies: cognitive therapy and behavioural therapy (Miller, 2005). Cognitive therapy is derived from cognitive theory, which is an approach to psychotherapy that attempts to explain human behaviour through understanding thought processes and interpretations of life events. It argues that "our perceptions and interpretations of the world around us affect our behaviour as we learn" (Payne, 2016, p. 156). Behavioural therapy was developed out of social learning theory, which states that learning is gained by modelling behaviour of those around us. Behavioural therapy aims to change potentially destructive or unhealthy behaviours through "conditioning" that will allow individuals to adopt new and healthy ways of interacting with their world (Payne, 2016). Cognitive behavioural therapy pulls from both methods to create an approach that attempts to change behaviours by focusing on and challenging the thoughts that create them.

Strengths

CBT is adaptable to meet the needs of individuals

CBT uses a wide variety of methods to treat individuals with mental health issues utilizing interventions such as Dialectical Behaviour Therapy, Motivational Interviewing, and Mindfulness training. Often these treatment methods will be used in conjunction with others. Each treatment plan identifies the particular behaviours and conscious processes that need to be targeted. This flexibility means that each individual's treatment is specifically curated to meet their needs and stated goals.

CBT is a cost-effective, brief therapy with high rates of success

CBT models are widely used for their perceived low cost, structured sessions, and measurable outcomes. Research on CBT has shown that evidence-based care packages featuring CBT cost less and increase societal benefit, compared with care featuring medication (Myhr & Payne, 2006). For this reason, health professionals argue that CBT could produce significant cost savings to the Canadian government in conjunction with better mental health outcomes. The brief nature of CBT (6-8 sessions) also produces a desirable quality: it is a relatively fast treatment method in a society with dramatically increasing rates of depression and anxiety (Smetanin et al., 2011), two common mental health concerns treated by CBT. Further, CBT models highlight the importance of monitoring treatment processes to assess the success and efficacy of the intervention. As an evidence-based practice method of intervention, CBT provides measurable outcomes that are observable and tracked closely, making it the preferred method of treatment in many mental health organizations.

Role of the Social Worker

The role of the social worker in CBT is to provide a collaborative setting in which the service user has an active role in their treatment. A CBT therapist can provide methods for understanding and working through cognitive distortions; however the internal work and change processes are reliant on the service user's ability to engage with the treatment. Consequently, a strong therapeutic relationship that promotes mutual respect and trust is crucial. To create a meaningful and supportive relationship with a service user, authors Cully and Teten (2008) note that CBT therapists should seek to demonstrate empathy through validating a service user's experiences, authenticity in their presentation and interactions, and demonstrating a positive regard by showing the service user the respect they deserve through non-judgement and commitment to their well-being.

"The therapeutic relationship in CBT is characterized by an active, directive stance by the therapist, high levels of emotional support, high levels of empathy and unconditional positive regard" (Keijsers et al, 2000, p. 268; Brisebois & Gonzalez-Prendes, 2012, p. 24). The emotional experiences that result from this therapeutic relationship can be integral to the service user's progress and can lead to changes in cognition and their insight (Hardy et al., 2007). Therefore, centering the empowerment and strengths of the service user are critical to the development of a strong therapeutic relationship and the success of CBT. The ultimate goal of the CBT therapist is to work with the service user to develop skills and strategies that allow them to manage their symptoms on their own (Brisebois & Gonzalez-Prendes, 2012).

What Does CBT Look Like in Practice?
(Cully & Teten, 2008)

Step 1: Assessment

Assessments are used to:

1. Understand the service user and their current issues
2. Inform treatment and intervention techniques
3. Serve as a foundation for assessing progress during the treatment plan.

Step 2: Case Formulation

- Draws on evidence about the particular problem and how it may be tackled
- Proposes a model of what is happening to the service user and enables them to have a discussion with the CBT therapist about processes that are occurring, and strategize about how to tackle them
- Set goals with service user
- Assess service user's concerns/difficulties
- Establish treatment plan
- Identify treatment obstacles

Step 3: CBT Treatment Sequence

Potential Brief CBT Session Structure:

	Session Content
Session 1	Orient the Patient to CBT Assess Patient Concerns Set Initial Treatment Plans/Goals
Session 2	Begin Intervention Techniques
Session 3	Continue Intervention Techniques
Session 4	Continue Intervention Techniques Reassess Goals/Treatment Plan
Session 5	Continue/ Refine Intervention Techniques Discuss Ending Treatment and Prepare for Maintaining Changes
Session 6	End Treatment and Help Patient To Maintain Changes

Adapted from Cully & Teten, 2008

CBT Intervention Example: Cognitive Restructuring

Cognitive restructuring is a process in which a service user challenges and replaces negative thoughts and cognitive distortions. It aims to create more positive and functional thought habits and strategies to overcome irrational or maladaptive thoughts (Mills et al., 2008). Cognitive restructuring can include developing the skills to identify triggers that lead to negative emotions, gaining greater perspective on situations, and recognizing automatic thoughts and feelings (Bonfil & Wagage, 2020). This technique is not simply about changing all negative thoughts to positive ones; rather, it emphasizes developing a perspective that can consider both positive and negative thoughts and outcomes. Further, it works to help service users choose to focus on thoughts that are most helpful in achieving their aims and that has less negative emotions attached (Bonfil & Wagage, 2020).

According to Bonfil & Wagage (2020) the steps for cognitive restructuring are as follows:

Step 1: Record the situation, thoughts, and feelings

Step 2: Pick *one* automatic thought from the list created

Step 3: Develop a different point of view about the situation

- Consider:
    - What is the effect of believing this thought?
    - What would happen if I didn't believe this thought?
    - What is the evidence supporting this thought?
    - What is the evidence against this thought?
    - Is there an alternative explanation?
    - What is the worst/best thing that could happen?

- What can I do about this?

Step 4: Craft an alternative response

Conventional Approach: Narrative Therapy

Origins of Narrative Therapy: A Brief Overview of Postmodern Theories

Narrative therapy aims to explore the narratives of a service user, group, or community, by looking at how these narratives are constructed and how these constructions of identity within the narrative actively shape their experience, sense of self and options (Healy, 2014, p. 218). This focus on constructions of identity stem from postmodern theories which argue that our reality is socially constructed through discourse (or "language practices") (Healy, 2014, p. 211). Two central theories of postmodernism are postmodern theory and poststructural theory which exhibit "substantial overlap", however can be differentiated in that poststructuralism studies the relationship between knowledge and language, "whereas postmodernism is a theory of society, culture, and history" (Agger, 1991, p. 112).

Postmodern theories in practice aim to deconstruct and reconstruct "discourses, knowledge, and social relationships" allowing theorists to "question the taken-for-granted or implied assumptions of our thought and knowledge, [analyze] power, and [imagine] new possibilities" (Moffatt, 2019, p. 46). Ken Moffatt (2019) argues that "one should not seek the truth that lies below the surface of relationships and language but instead acknowledge that multiple truths exist because of the wide range of contexts, languages, images, subcultures, and cultures" (p. 46) A postmodern framework asks social workers to "view all aspects of social work practice, particularly the concepts of client need and social work responses, as socially constructed" (Healy, 2014, p. 205). While postmodern theories will be utilized in this section exclusively to understand and explain narrative therapy, it is important for social workers to familiarize themselves with the basics of these theories, "given that they inform many of the disciplines on which our profession draws" (Healy, 2019, p. 206).

Origins of Narrative Therapy

Based on these understandings from postmodern theories, narrative therapy maintains "that people make meaning in their lives based on the stories they live" (Ricks et al., 2014, p. 100). In other words, the "first person narrative" through which a person defines themself is "based on memories of his or her past life, present life, roles in social and personal settings, and relationships with important others" and, furthermore, the "problems in people's lives are derived from social, cultural, and political contexts" (p. 100). Much of the leading work on narrative therapy has been developed by workers associated with the Dulwich Centre in Adelaide, Australia (link).They have produced extensive work on the application of narrative ideas to a broad range of social services work and fields of practice (Healy, 2014, p. 218) which speaks to the far-reach and versatility of this intervention practice.

The Role of the Social Worker in Narrative Therapy

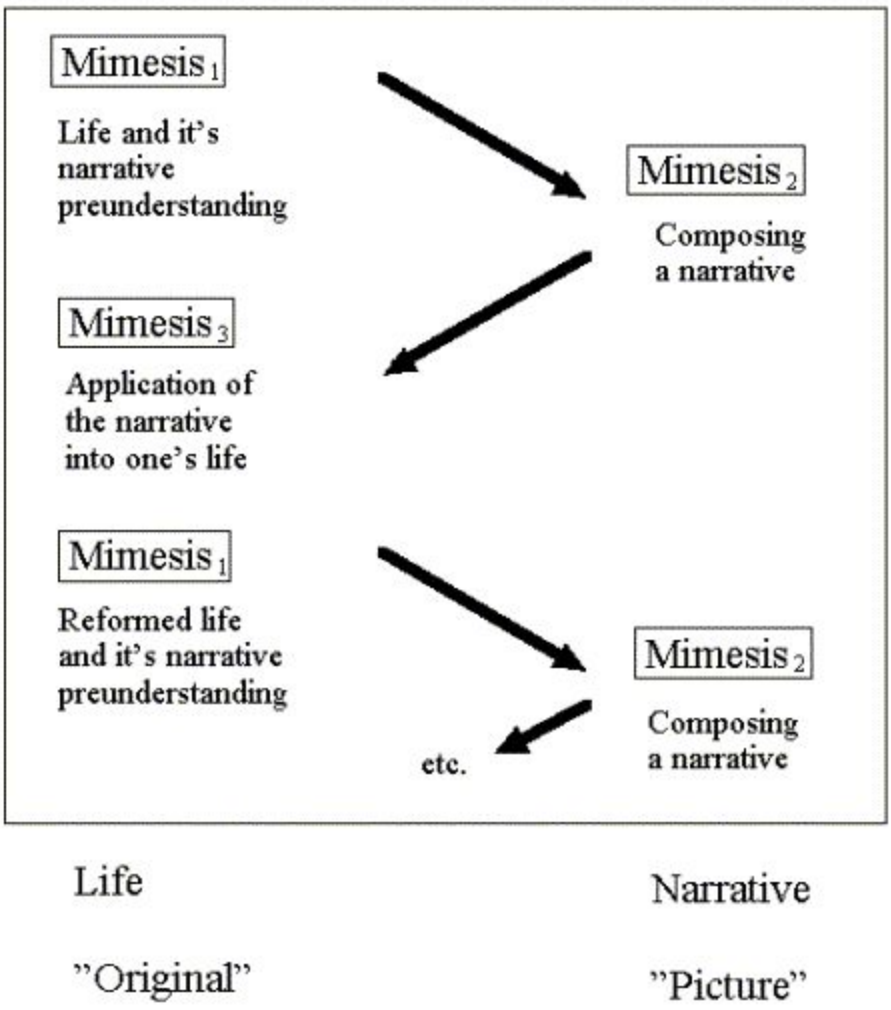
Narrative therapy can be employed by a social worker when they are engaging with a service user that they believe may be constrained or harmed by narratives they and others have generated about them (Fook, 2002, p. 137). This speaks to narrative therapy's concern "that the presenting problem is exerting undue influence on shaping the client's identity" (Dybicz, 2012, p. 268). Healy argues that "because narratives so powerfully shape our 'identities' and our life choices, these narratives should be the site of intervention" and ultimately social workers should assist people to "realize new narratives" (2014, p. 218).

Facilitating narrative therapy with a service user requires significant input and skill on behalf of the social worker, relying on particular language and framing of questions to elicit responses that support the service user in deconstructing and reconstructing narratives of self. Dybicz (2012) describes "the client-social worker relationship" in narrative therapy "as that of an

author-editor" (p. 281), Ricks et al. (2014) state that "the goal of the counselor in narrative therapy is to help clients develop a new life story that is representative of their lived experiences" (p. 101), and Yuen (2007) explains how she uses narrative therapy to "[render] the skills and knowledges of children and young people more visible and accessible" (p. 7). These assertions explain that the purpose of the social worker is to support the individual through the process of identifying the unhelpful narrative as well as to assist with the co-creation and rooting of a second, more helpful narrative.

The process of transforming the narrative of self within a narrative therapy intervention is called "mimesis". Aristotle originally conceived mimesis as "the process of having an image of who we are and who we would like to be, the latter motivating our present actions" (Dybicz, 2012, p. 219). Dybicz (2012) explains that the concept of mimesis was then updated by Riceour "by splitting it into three parts: prefiguration (mimesis1), configuration (mimesis2), and refiguration (mimesis3)" (p. 269). We will explore the process of applying mimesis in practice in the case study presented below.

A Model of Mimesis



The ontological enrichment of life and story. From *"And this story is true..." On the Problem of narrative truth* by H. Heikkinen et. al. [Paper presentation]. European Conference on Educational Research, University of Edinburgh, United Kingston. http://www.leeds.ac.uk/educol/documents/00002351.htm

Process of Mimesis	Applying Mimesis in practice with Melanie
Prefiguration (mimesis1) Service user explains their understanding of their lived experience through a narrative (story of self) and establishes theme(s). (Dybicz, 2012, pp. 269-270)	Questions for Exploring Melanie's Story: ● What effects do you think that being in a university program you don't enjoy is having on your life? ● What effect does the pressure you feel from your family have on your life? ● Are you accepting of the impact that being in a university program you dislike is having on your life? Are these effects acceptable to you or not? ● Why is this? Why are you taking this position on what the pressure from your family is doing? (Muller, Externalizing Conversations Handout)

<table>
<tr><th>Process of Mimesis</th><th>Applying Mimesis in practice with Melanie</th></tr>
<tr><td>Configuration (mimesis2)

Social worker assists service user in “consciousness raising” by identifying how theme(s) used to organize narrative may be unhelpful and constraining and therefore, social worker collaborates with service user in identifying new themes to construct an alternative (more “helpful”) narrative.

(Dybicz, 2012, pp. 269-270)</td><td rowspan="2">Questions for enabling Melanie’s second story:

● How would you prefer things to be at university? With your family?
● If you were to stay connected to what you have just said about what you prefer, what next steps could you take?
● Can you describe the last time you weren’t worried about the pressure of your family about attending university for a couple of minutes? What was the first thing you noticed in those few minutes? What was the next thing?
● Would you like more time like this in your life?
● How did you achieve those few minutes of not worrying about your family’s opinion of you being in university?
● Tell me about times when you have managed to achieve a similar feeling of not worrying about your family’s opinion in the past.
● How might this alter your view of the problem of pressure from your family now?
● Thinking about this now, what do you expect to do next?

(Ackerman, 2020)</td></tr>
<tr><td>Refiguration (mimesis3)

Occurs simultaneously with configuration: as a new narrative is being constructed (or configured), it is also being embedded as the “natural” framework for the service user and their close social support (as the process of construction requires a social process for true authenticity) to understand and view the individual’s identity.

(Dybicz, 2012, pp. 269-270)</td></tr>
</table>

Strengths of Narrative Therapy

Narrative therapy possesses components that can be useful for critical social work practice.

Challenging biomedical and psy- discourses

Narrative therapy critiques medical and psy- discourses' emphasis on diagnosis by arguing that the narratives produced through diagnosis, or even the discourse of a diagnosis itself, may be harmful to the identity formation of the service user (Dybicz, 2012, p. 268; Healy, 2014, p. 207). Healy (2014) contends that although these diagnoses are meant to "ultimately 'help' the person", they can actually result in the person feeling imprisoned by a narrative that damages and constrains them (p. 218).

Externalizing Problems and Identifying Strengths of Service Users

A social worker often uses narrative therapy to "separate the problem from clients" (Ricks et. al, 2014, p. 100) through externalization of problems, which is "an approach...that encourages persons to objectify and, at times, to personify the problems that they experience as oppressive" (White & Epston, 1990, p. 38). Narrative therapy not only aims to identify how challenges impact a service user's narrative of their identity, it also intends to intervene in an effort to construct an alternate narrative that portrays strengths and successes and that can provide a new orientation for clients in understanding and even addressing problems (Dybicz, 2012, p. 268). For example, Angel Yuen (2007) looks at how "discourses of victimhood, which are often present in instances of childhood trauma, can contribute considerably to establishing long-term negative identity conclusions," (p. 3). Through her work in narrative therapy, Yuen (2007) supports individuals who have experienced childhood trauma by recognizing both the "trauma

and effects that this has on the child's life" as well as the "second story of how the child has responded to these experiences" (p. 6). This dual focus helps establish how children respond in diverse ways to lessen the effects of the trauma and, furthermore, that these responses demonstrate agency, knowledge, and skills that can be helpful to constructing a new narrative (p. 5).

Creative Applications of Narrative Therapy

Narrative therapy can be applied using a variety of creative techniques to "assist clients in reframing ideas, shifting perspectives, externalizing emotions, and deepening their understanding of an experience or an issue" (Ricks et al., 2014, p. 103). In their article, Ricks et al. (2014) provide an extensive overview of how social workers can use "photos, movies, artwork, writing, and music" as "tools for helping clients rewrite their relationship with their problems" (p. 101). For example, they demonstrate how art can help clients "express declarative and nondeclarative memories, which may not be accessible through verbal therapies" (pp. 103-104). It can even assist clients "with self-expression" because it"brings out any hidden aspects of the self" and "helps capture self-portraits" (pp. 103-104).

Conventional Approach: Solutions-Focused Brief Therapy

Solutions-Focused Brief Therapy (SFBT) is also known as *Solutions-Focused Therapy* or *Brief Therapy* (Healy, 2014, p. 162). A foundational premise of SFBT is that service users possess the solutions and capacities to "make satisfactory lives for themselves" (de Shazer et al., 1986, p. 207, as cited in Healy, 2014, p. 174). SBFT is a therapeutic intervention that is meant to help service users harness these solutions; it is referred to as a "goal-directed approach" (de Shazer et al., 2007, p. 1), where "goals" are "desired emotions, cognitions, behaviours, and interactions in different…areas of the client's life" (Solution Focused Brief Therapy Association, 2013, p. 9). However, unlike problem-solving approaches, SFBT does not spend time identifying or understanding a problem to be overcome; rather, therapy is focused on identifying goals and solutions based on changes that service users can enact in their own lives. Furthermore, SFBT focuses on small wins as opposed to working linearly toward a large goal (Healy, 2014, pp. 175-176). Unlike many psychodynamic practices, SFBT is purely "future-focused" (de Shazer et al., 2007, p. 1) in that it is not interested in revisiting the past or understanding a "truth" (Payne, 2016; Sloos, 2020c). It is also not focused on producing a diagnostic assessment; instead, the service user is positioned as the "assessor" who determines what changes they want to see and how they will accomplish those changes (Solution Focused Brief Therapy Association, 2013, p. 9). Trepper et al. (2013) succinctly note:

> SFBT helps clients develop a desired vision of the future wherein the problem is solved, and explore and amplify related client exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality. Thus, each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources. Even in cases where the client comes to use outside resources to create solutions, it

is the client who takes the lead in defining the nature of those resources and how they would be useful. (p. 3)

Origins of SFBT

While it has some roots in systems theory family-based therapies of the 1950s-1960s, the origins of SFBT are often credited to Insoo Berg and Steve de Shazer of the Brief Family Therapy Center in Milwaukee during the 1980s (de Shazer et al., 2007; Lethem, 2002; Healy, 2014). Berg and de Shazer "began exploring solutions" to research that was taking a problem-oriented approach to family therapy (de Shazer et al., 2007, p. 3). Though it has become a "theory for practice" (Healy, 2014, p. 164), SFBT was therefore "pragmatically developed" rather than arising from a base of theory (de Shazer et al., 2007, p. 1).

Role of the Social Worker?

The role of the social worker is to help service users recognize the capacities to enact solutions that they already possess (Healy, 2014, p. 174) and to "expand" the service users' options (de Shazer et al., 2007, p. 4). While SFBT acknowledges that there is a "hierarchy in the therapeutic arrangement" (p. 3), the therapist-service user relationship is rooted in a "positive, collegial, solution-focused stance" (p. 4) where the practitioner:

- believes that the service user has the knowledge and ability to make change in their life and leads "in a gentle way" by "pointing out…different direction[s]" for the service user to "consider" (p. 4);
- "almost never pass[es] judgments about their clients, and avoid[s] making any interpretations about the meanings behind their wants, needs, or behaviors" (p. 4);
- has an "overall attitude" of being "positive, respectful, and hopeful" (p. 4);

- views “resistance” from the service user as either “people’s natural protective mechanisms, or realistic desire to be cautious and go slow” or as a “therapist error, i.e., an intervention that does not fit the client’s situation” (de Shazer et al., 2007, p. 4; Lethem, 2002, p. 190). Resistance is not framed as problematic behaviour; instead, the responsibility lies on the therapist to “discover the ways in which clients are able to cooperate with therapy” (Lethem, 2002, p. 190).

Indeed, the stance of the practitioner, as outlined above, is considered to be one of the key aspects of SFBT.

Strengths

There are many positive components of SBFT that are useful for critical social work practice.

Non-pathologizing approach

While SBFT has its origins within ‘psy’ discourses, it has developed into a practice approach that breaks with psychodynamic focuses. For example, by focusing on solutions as opposed to problems, SFBT avoids pathologizing clients; SFBT does not focus on ‘diagnosing’ service users with biomedical or psychiatric language (Healy, 2014). As such, SFBT can also assist service users in working toward a solution without placing blame on themselves or others (Lee, 2003, p. 389). This non-pathologizing stance can also make SFBT more accessible to people who encounter internalized or external stigma around mental health support (Lee, 2003, p. 389).

Collaborative approach that centers the service user

SFBT promotes a collaborative approach between service user and practitioner where paths to potential solutions are “co-constructed” by both parties and are rooted in the service users’ goals, language, and perspectives (Solution Focused Brief Therapy Association, 2013, p. 5). This

collaborative approach is in distinct contradiction to the legal and biomedical discourses which position the practitioner as the expert (Healy, 2014, p. 178). Instead, the service user is celebrated as the expert of their own life who has the agency and knowledge to enact change needed. This also allows practitioners to embrace solutions from "multiple worlds," including diverse cultural strengths, and "participate in a culturally respectful and responsive therapy process with clients from diverse ethnoracial backgrounds" (Lee, 2003, p. 393).

Illuminates tangible paths forward, via small steps

Unlike "insight-oriented clinical approaches" SFBT is goal-oriented—therapy sessions are focused on identifying actions that the service user can take to achieve what feels like a solution to them (Lee, 2003, p. 390). However, while SFBT is goal-oriented, goals set within therapeutic sessions do not need to work toward completely resolving a problem; instead, the session aims to identify any steps toward a solution, even if they seem to be small steps. Therefore, unlike problem-based approaches which often outline a linear path toward "success", SFBT encourages service users to think of paths toward success in a non-linear approach. As a result, service users are able to identify concrete steps that inch closer to a place of "solution" without becoming overwhelmed by a needing to complete multiple checkpoints on a specific path toward success.

Example of a SFBT practice tool: Listen, Select, Build

One approach to SFBT is that the therapist and service user can make "new meanings and new possibilities for solutions" through the process of "co-construction" (Solution Focused Brief Therapy Association, 2013, p. 5). In this process, the therapist focuses on the words that the service user uses to identify some characteristics of a solution, even if small. After the therapist "listens" and "selects" the potential aspect of a solution, and the service user and therapist

"build" a "clearer and more detailed version of some aspect of a solution" (p. 5). In this "listen, select, build" process, the therapist continually raises "solution-focused questions or response[s]" based on the service user's previous response (p. 5).

Indeed, a key component of SFBT is the dialogue between the practitioner and service user. Specifically, the "essential therapeutic process" of SFBT looks at what is "*observable* in communication" (Solution Focused Brief Therapy Association, 2013, p. 4, emphasis in original). Unlike psychotherapy's focus on, for example, a service user's internal thoughts or biological stages, SFBT focuses on what is actually said or done in the "therapist's and client's moment-by-moment exchanges" (p. 4). This means that the therapist has to focus on not "reading between the lines" to try and uncover a "truth" or "underlying meaning" behind a service user's responses (pp. 5-6). An important component of the therapeutic dialogue, therefore, is that the therapist actively tries to "listen for and work within the client's language by staying close to and using the words used by the client" (p. 6).

More ways to apply SFBT to your practice

Use the tables below, as well as the information above and resources on the website, to brainstorm some solution-focused questions/responses that would fit within your practice.

SBFT Main Interventions *(from de Shazer et al., 2007)*	**Examples of solution-focused questions or responses that fit your practice**
Looking for previous solutions	
Looking for exceptions	

Questions vs. directives or interpretations	
Present- and future-focused questions vs. past-oriented focus	
Compliments	
Gentle nudging to do more of what is working	

SFBT Specific Interventions *(from de Shazer et al., 2007)*	**Examples of solution-focused questions or responses that fit your practice**
Pre-session change	
Solution-focused goals	
Miracle question	

Scaling questions	
Coping questions	
Is there anything I forgot to ask?	
Taking a break and reconvening	
Experiments and homework assignments	
So, what is better, even a little bit, since last time we met?	

Conventional Approach: Trauma-informed Approaches

Introduction to the 'Trauma-informed'

'Trauma-informed' has become a term commonly used among mental health professionals, service providers and the general public over the past 20 years (Goodman, 2015). This term is used to describe the way in which service providers are trained to respond to situations and offer services, with an embedded understanding of the "complex and ongoing role of traumatic events in an individual's life" (Harris & Fallot 2001; Goodman, 2015, p.57). Trauma Informed Approaches (TIAs) are grounded in principles of "neuroscience, psychology and social science as well as attachment and trauma theories" (Sweeney, et al., 2016, p. 177). TIA models seek to establish a complete understanding of the lasting impacts of traumatic event can have on the "neurological, biological, psychological and social development" of a service user and to further interrogate the repercussions this bares on an individual's guiding perspectives and relationships (Sweeney, et al., 2016, p.177). However, it is important to keep in mind that the discourse around trauma and trauma-informed practice is extensive, and for this reason, it is difficult to establish a comprehensive and unified definition within this short overview.

What is Trauma?

The common use of the term 'trauma' demonstrates that there is a pervasive acknowledgement and acceptance that "traumatic experiences can have negative and lasting effects on individuals" (Goodman, 2016, p. 55). Trauma is recognized by the American Psychiatric Association and described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the following:

> The person has been exposed to a traumatic event in which . . (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or other; (2) the person's response involved intense fear, helplessness, or horror. (p.428; quoted Bustow, 2003, p. 1296)

The significance of the DSM, will be further discussed when evaluating ways in which mental health professionals assess and diagnose service user trauma. What is also important to note here are the dissimilar ways in which individuals may respond to the same traumatic event. Symptoms of trauma include, but are not limited to: fear, nightmares, hopelessness, helplessness, worthlessness, flashbacks, avoidance, depression, anxiety, despair, distrust, rage, guilt, dissociation, self-harm, emotional numbness (American Psychological Association, 2013; Goodman, 2015; Burstow, 2003).

Of significance here is the variance in which individuals identify with the term trauma. For instance, Yuen (2007) raises that there are "individuals and groups who are determined to not be defined by stories of trauma" (p.4), whereas others posit that trauma is "[a]rguably, […] a conceptualization that psychologically injured people claim for themselves" (Burstow, 2013, p. 1301). Therefore, although trauma is defined concretely by the DSM, as demonstrated above there are countless ways in which it is understood and embodied by survivors of trauma.

Key Principles of the TIAs

> "Trauma-informed mental health services are strengths based: they reframe complex behaviour in terms of its function in helping survival and as a response to situational or relational triggers" (Sweeney, 2016, p. 179)

According to Sweeney et al. (2016), frontline mental health professionals should be trained in methods that foster a safe environment, prevent the retraumatization of service users and provide further referrals to trauma-specific resources. A consolidated list of TIAs' key principles includes: recognizing the signs of trauma, building trust, maintaining transparency and practicing an attuned awareness of power differentials. Ultimately, the goal is for service providers to work with service users to collectively establish a care plan that involves peer-support and appropriate service referrals. The table below, borrowed from Sweeney et al., (2016) defines the nine key principles of TIA in more detail.

Table 1. Key Principles of TIAs (Sweeney, et al., 2016, p. 178)

Table I The key principles of trauma-informed approaches	
1. Recognition	Recognise the prevalence, signs and impacts of trauma. This is sometimes referred to as having a trauma lens. This should include routine enquiry about trauma, sensitively asked and appropriately timed. For individual survivors, recognition can create feelings of validation, safety and hope
2. Resist retraumatisation	Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can retraumatise survivors (and staff). Take steps to eliminate retraumatisation
3. Cultural, historical and gender contexts	Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender appropriate. Recognise the impact of intersectionalities, and the healing potential of communities and relationships
4. Trustworthiness and transparency	Services should ensure decisions taken (organisational and individual) are open and transparent, with the aim of building trust. This is essential to building relationships with trauma survivors who may have experienced secrecy and betrayal
5. Collaboration and mutuality	Understand the inherent power imbalance between staff and survivors, and ensure that relationships are based on mutuality, respect, trust, connection and hope. These are critical because abuse of power is typically at the heart of trauma experiences, often leading to feelings of disconnection and hopelessness, and because it is through relationships that healing can occur
6. Empowerment, choice and control	Adopt strengths based approaches, with survivors supported to take control of their lives and develop self-advocacy. This is vital as trauma experiences are often characterised by a lack of control with long-term feelings of disempowerment
7. Safety	Trauma engenders feelings of danger. Give priority to ensuring that everyone within a service feels, and is, emotionally and physically safe. This includes the feelings of safety engendered through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, socially, morally and culturally safe
8. Survivor partnerships	Understand that peer support and the coproduction of services are integral to trauma-informed organisations. This is because the relationships involved in peer support and coproduction are based on mutuality and collaboration
9. Pathways to trauma-specific care	Survivors should be supported to access appropriate trauma-specific care, where this is desired. Such services should be provided by mental health services and be well resourced

Assessing Trauma

"[T]rauma-informed services can engender more comprehensive and effective mental health services by ensuring that practitioners conduct in-depth assessments of trauma service" (Goodman, 2016. p. 57). Through this process, service providers "screen for a history of trauma and assess for trauma symptoms, including the ways in which trauma coping might manifest " (Fallot & Harris 2001, as sited in Goodman, 2016, p. 57).

A tool commonly used to diagnose trauma is the DSM. According to Burstow, the "DSM is the key text that mediates the application of diagnoses" (2003, p.1299). It defines mental disorders and provides a guideline for further assessing trauma and diagnosing Post Traumatic Stress Disorder (PTSD). For example, the PTSD Checklist for DSM-5 is a 20 question survey that can be completed individually by a service user, or together with a service provider to assess symptom severity. Answers are to fall within the 5- point Likert scale, which ranges from zero ('Not at all') to four ('Extremely') and, according to the International Society for Traumatic Stress Studies (ISTSS), the survey results should only be interpreted by a professional or clinician (ISTSS, 2020). Results are used to determine appropriate treatment plan, allows service provider to track service user progress, and if necessary, prompts service provider to address the lack of improvement (National Center for PTSD, 2018a). The image below showcases a section of the PTSD Checklist for DSM-5 (National Center for PTSD, 2018b).

Table 2. PTSD Checklist for DSM-5 (National Center for PTSD, 2018b)

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4

Benefits

Goodman (2015) acknowledges that through the creation of TIAs and the acknowledgement of the complex, multifaceted and long-lasting impacts of trauma on an individual, we have made significant progress in counselling and psychology. Goodman identifies three key benefits that TIAs bring to the mental health sector:

1) By integrating the use of assessments to identify the root and the severity of trauma symptoms, especially within settings that are not typically focused on mental health where trauma-specific needs might be overlooked (such as schools), we can avoid misunderstanding of cause of behaviour, and can provide appropriate referrals rather than discipline.

2) Trauma-informed practitioners and scholars advocate for a deeper understanding of the "underlying and interconnected concerns' of trauma rather than only "treating symptoms or seeing life events and concerns as separate and unrelated" (p.57) and a recognition that "traumatic events have ongoing impacts" on trauma survivors (p.58).

3) The strength-based approach employs the construct of 'empowerment' when working with service users who have experienced trauma. This is significant because "trauma survivors [..] are often disempowered by traumatic events and/or by post-trauma symptoms that continue to affect their lives" (p. 58).

However, Goodman also identifies that in order for TIAs to be effective they need to be integrated within all social service programs (2015). Further limitations are discussed below in the section entitled, Infused Approach: TIAs and Mad Studies.

Infused Approach: Using Anti-Oppressive Practice in Cognitive Behavioural Therapy

Limitations

Individualizes and pathologizes service user's problems

CBT has an individualistic focus; it sees problems as coming from an individual's thoughts and corresponding behaviours, and ignores forms of structural oppression (Payne, 2016). This method fails to see how an individual's problems can stem from social interactions and behaviours and are often the result of unequal power dynamics and oppressive social structures. This is problematic and limiting because CBT does not address systemic issues as a source of an individual's problems, nor does it provide an opportunity for CBT therapists to critically reflect on their own assumptions and social location in their relationship with the service user. For example, CBT attempts to 'restore' individuals to 'rational' and 'functional' cognitive processes. It does not acknowledge, however, that what is considered 'rational' or 'functional' has been defined by white, colonial understandings of mental health and ways of being (Howell & Vornka, 2012). In this way, CBT both ignores and perpetuates sanism and Eurocentrism. In addition to working from a narrow understanding of mental health, CBT also pathologizes individuals' mental health concerns. By using CBT, "you can erase issues related to employment, housing, education, healthcare, substance use, colonialism, racism, ableism, cisheteropatriarhcy and make them about certain people with 'disorders' and 'distortions'. CBT pathologizes behaviours, thoughts, and feelings based on one model or worldview that has a way to individualize all problems" (Joseph, 2020, as cited in Linton, 2020).

Conforms to a neoliberal ideology that reproduces inequality

CBT is a popular approach to mental health treatment because of its alignment with neoliberalism and the discourses of New Public Management [NPM]. Neoliberalism in the

mental health and health care sectors manifests in lean health care strategies that value efficiency, standardization and cost containment. Michel Guilfoyle (2008) argues that CBT's success can be attributed to the ease of integration with existing cultural and institutional power arrangements rather than its effectiveness. CBT's short-term therapy format is particularly appealing within neoliberal politics which value fiscal restraint in the mental health care sector. Ameil Joseph, a professor and critical theorist at McMaster University, offers some insight into provincial and federal implementation of internet-based CBT (iCBT) stating, "online CBT can be a highly profitable way of claiming to provide mental health services without offering the depth and breadth of appropriate, required or necessary services and support for people" (Linton, 2020). Further highlighting CBT's alignment with neoliberal values of individualism and responsibility, Joseph continues, "CBT has a way of suggesting that both success and failure of the model is evidence of success–redirecting blame onto individuals or blaming external factors that CBT does not address. When the model fails, it's because the person didn't do the work" (Linton, 2020).

An Infused Approach

So, how do we address the limitations of CBT using an Anti-Oppressive approach? Furthermore, are these two approaches even compatible?

CBT is severely lacking in a structural analysis of sociological factors and overarching systems of oppression that impact a person's mental health and well-being. Utilizing an anti-oppressive approach in CBT treatment models may provide invaluable strategies and insight to address the structural underpinnings of service users' mental health concerns. However, it is worth noting that "the goal of therapy should never be to help people adjust to oppression" (carmencool, 2018). While CBT is used to develop skills and strategies to overcome challenges

in one's cognitive and behavioural processes, in the context of structural oppression, CBT from an AOP perspective does not endeavour to maintain oppression by providing superficial solutions to service users. Rather, it seeks to understand the context that defines a service users' social reality and address social action to change institutions so that social justice becomes available to all. As Salas et al. (2010) note,"Social work is most effective when the false dichotomy between working with individuals and working towards social change is reconciled and when social justice is addressed at all levels of practice" (p. 95). Therefore, CBT–when grounded in a critically reflexive, non-judgmental, strength-based, and empowering philosophy that promotes equality within the therapeutic relationship and aims to understand the structural factors that contribute to one's lived experience–can be an excellent fit for the social justice mission of social work (Brisebois & Gonzalez-Prendes, 2012).

AOP Practice Principle	**Present in CBT Main Interventions?**
1. Critical Reflection on Self in Practice	No. While CBT encourages a collaborative and equal therapeutic relationship, it does not ask CBT therapists to consider how their own positionality and social locations might impact their relationship with the service user and the impact of the CBT treatment.
2. Critical Assessment of Service Users' Experiences of Oppression	No. CBT's major tenet is that an individual's problems are often the result of 'dysfunctional' cognitive processes and core beliefs that can be altered to create a desired response (Payne, 2016). However, while the main focus of traditional CBT may be individual thoughts or beliefs, these beliefs are not formed in a vacuum; rather, they are shaped by life experiences, including poverty, sexism, homophobia, transphobia, racism, etc. (O'Neill, 2017). Having this knowledge allows service users to make choices about the context and course of treatment.

3. Empowering Service Users	Yes. CBT emphasizes service user empowerment as one of the major components of a successful CBT treatment. Client empowerment takes place in various forms, including: socializing the service user to the cognitive-behavioural model; sharing information about the nature of the problem that afflicts them; and providing a detailed rationale behind proposed interventions (Brisebois & Gonzalez-Prendes, 2012).
4. Working in Partnership	Yes. CBT is based on a strong therapeutic relationship. Consequently, working in partnership with a service user is crucial to developing a relationship founded on mutual trust, respect, and working toward a common goal (Cully & Teten, 2008). In the CBT model, service users are seen as possessing the abilities and strengths to become active agents in their own change process. A CBT therapist is present to help the service user facilitate their own healing and provide guidance, ultimately working with the service user to develop skills to problem-solve on their own and independent of the CBT therapist (Brisebois & Gonzalez-Prendes, 2012).
5. Minimal Intervention	Yes. CBT is a brief and voluntary treatment method that usually lasts from 6-8 sessions. These sessions are guided by the service user's goals and needs. Minimal intervention states that social workers should aim to strategically intervene in the least intrusive way possible (Healy, 2014); CBT exemplifies this AOP principle because it honours the service user's needs and stated goals, and operates from a structured, short-term model.

Case Example:

A 50-year-old Latino man, José, has come to your clinic seeking therapy as a result of severe depression and anxiety stemming from an injury at work that caused him to be put on medical leave. José lives in a rural town in Ontario with a majority white demographic and worked in agriculture. He has been at home for the last six months. He has three children, all of

whom are enrolled in university on scholarships and have moved away for the school year. His wife is supportive but works long hours as a receptionist at a physiotherapist clinic. José has stated that he often turns to alcohol to help the days pass by, as he has little motivation to do much else. When his children come home for the holidays, José says that he is overwhelmed with joy, but when they leave, he becomes even more depressed than usual. José has stated that he has little desire to return to work, and when you ask him about his thoughts on the situation, he constantly repeats, "I'm just a bad dad".

Questions to Consider:

1. What does it mean to approach José's case from an anti-oppressive lens?
2. What steps should you take?

A traditional CBT approach would work with José to restructure his thoughts around being a 'bad dad'. One approach could be to use a thought record to help him look for evidence against this negative thought and move toward more balanced or alternative thinking. For example, this could look like asking José for instances when he thought he was a good dad (e.g. spending time with his children when they come home, supporting them in their university careers, etc.). However, this neglects the larger structural issues that are impacting José and creating the conditions for his depression. A traditional CBT approach might help José develop strategies against negative thoughts, however, the true source of the problem remains unchallenged.

During further discussion with José, you decide to ask him what the *source* of his thinking stems from. He tells you that he feels bad for not being able to provide for his children. He states that since he lost his job, he was not able to afford to continue paying for his children's extracurriculars at university, as their scholarship only covered part of their tuition. He tells you

that he also feels bad that they are under significant financial stress that could have been alleviated by his return to work. However, when you broach the subject of returning to work, José reveals to you that he feels uncomfortable returning because he thinks he will "make mistakes" and that "people at work don't like him". While this may look like negative thinking that is delaying him from returning to work, you find that the source of his hesitation is actually racism in the workplace.

Questions to Consider:

1. How do poverty, racism, and precarious employment contribute to a service user's mental health?
2. How do structural forms of oppression function in José's life on a macro and micro scale?
3. What CBT interventions can be used to address these oppressions?

If you were to use CBT to teach him strategies to challenge these negative thoughts and encourage him to return to work with these new coping strategies, this would actually aid in maintaining an oppressive structure because this approach using CBT would only help José adapt to an oppressive system, and would not address the underlying issue: working in a racist environment. In addition to teaching service users CBT strategies for coping and managing negative thoughts and feelings, critical social workers also need to help service users access resources like community groups that offer practical support, to work with service users to find practical solutions to address racism in the workplace (e.g., approaching management or a union), and to connect service users with advocacy groups who are doing work in the areas that are impacting them.

Below are potential guidelines to working with José's case from an anti-oppressive framework:

1. Bring awareness to the José's positionality and the intersections of his social locations
2. Acknowledge the historical, social, political, and structural dimensions of oppression
    - Attempt to distinguish between problems that are environmental and those that stem from dysfunctional thoughts
3. Collaborate regarding the construction of treatment goals and planning a working alliance (that acknowledges power dynamics and works to dismantle them)
    - Co-construct goals to be accomplished through the relationship
    - Co-construct tasks to be fulfilled by each partner in the relationship
    - Build mutual trust and respect
4. Coping Strategies/Skill building
    - Identifying José's strengths
    - Validating his experiences of oppression/discrimination
    - Engage in cognitive restructuring practices by externalizing structural forms of oppression that are impacting José's mental health
    - Work together to create a list of tangible steps that can be taken to support José in securing employment and addressing racism in the workplace

Working from an anti-oppressive framework means aiming to understand the full impact of structural oppressions and the context in which a service user develops negative thoughts and mental health concerns. While it is beyond the scope of CBT to directly address structural issues of oppression, AOP can provide practical steps to create systemic change. Utilizing CBT with oppressed communities can create opportunities for strengths-based approaches to intervention

and help service user's build the skills for empowerment. Cognitive restructuring, emotional processing, and behavioural interventions need to focus on the service user's experiences of oppression, on useful thoughts, coping skills, and identification and incorporation of adaptive behaviours that work for the service user—not for an oppressive system. This is facilitated by a strong, collaborative therapeutic relationship, characterized by empowerment and validation strategies that help clients have a liberating, anti-oppressive CBT experience. As critical social work practitioners, our goal is to empower and work with service users to challenge and overcome these oppressions. Utilizing anti-oppressive practice in cognitive behavioural therapy can provide insight into the larger structures that impact an individual and how these structures can be addressed using conventional approaches in social work.

Basic Principles of AOP in CBT and Beyond

1. Identify Critical Issue/Source of Problem
2. Address Issues of Power
3. Acknowledge Structural Barriers
4. Reflect/Retheorize Incident Using Anti-Oppressive Framework
5. Highlight Strengths of Service User
6. Collaborate on Achieving Service User's Stated Goals
7. Work Toward Empowerment
8. Create Strategies for Change

Infused Approach: Using Anti-Oppressive Practice (AOP) in Solutions-Focused Brief Therapy (SFBT)

Limitations

While SFBT is an intervention with many strengths, it also has several limitations that must be considered within a critical social work practice. The following section highlights some of the main limitations of SFBT based on those identified by Healy (2014).

Emphasis on Individual Action and Responsibility

Some practitioners argue that SFBT can be viewed as a "systemic therapy" (de Shazer et al., 2007, p. 3) because it is often used in therapeutic interventions with families and couples; therefore, it is seen as intervening in the level of the "family system". Practitioners who label SBFT as a "systemic therapy" also note that the solutions discussed within therapeutic sessions often involve a service user's interactions with other people or with systems within their life. Furthermore, these practitioners observe that "once small changes begin to occur, larger changes often follow, and those larger changes are usually interactional and systemic" (p. 3). However, this definition of "systemic intervention" is very different from other definitions of "systemic intervention" that aim to change the environment, or from "structural interventions" that aim to address how structures like white supremacy and settler colonialism create oppressive conditions for individuals and groups. Indeed, a limitation of SFBT is that it places emphasis and responsibility on the service user to make changes in their environment; interventions do not focus on directly modifying conditions within the environment (Healy, 2014).

Does Not Take into Account Barriers, Including Structural Obstacles

Similar to the limitation above, SFBT does not consider the barriers and obstacles that an individual might encounter when trying to work toward their goals or hopes. These barriers also

include structural considerations, like racism or transphobia, that might limit the amount of change that an individual can actually implement in their life, even if they proceed with hope and determination (Healy, 2014, p. 178).

Does Not Highlight or Encourage Broader Social Change

Indeed, SFBT practitioners "rarely aspire to broader social change" (Healy, 2014, p. 179). Instead, intervention is focused on helping the service user move toward solutions within the environment that they inhabit, without discussing, for example, how their problems are connected to broader social problems or how they might work toward changing the structural conditions that contribute to their problem.

Falsely Assumes Objectivity is Possible

Healy (2014) notes that a limitation of the strengths-based perspectives is that the evaluation of something as a "strength" is fundamentally contrary to the self-defined "objective" stance of the therapist. Similarly, we would argue that while SFBT practitioners claim the stance of being non-judgmental and objective, the values and worldview of the practitioner are re-centered in the co-construction process as the therapists' solution-focused questions will be rooted in what the therapist recognizes as a potential solution. For example, Lee and Bhuyan (2013) note that "patterns and structures of naturally occurring talk in therapeutic encounters can reproduce whiteness as a powerful organizing principle" (p. 121). Furthermore, Ying Yee (2004) notes that "whiteness" includes the "social processes" which enable "the dominant and/or majority group's ability" to normalize "the inferior position of minority cultures," often in ways that are not visible or recognized (p. 98).

An Infused Approach?

As we can see, a common theme threaded throughout some of the main limitations of SFBT is its narrow view of intervention and change—it does not focus on structural conditions as a consideration for discussion, or as a location of change. It also does not look at the barriers, including structural barriers, that might prevent an individual from enacting a "solution". Based on the solution-focused orientation of SFBT, a likely reason for this is because to focus on barriers or structural components would be to focus on a "problem". Infusing an AOP lens into a SFBT approach, therefore, might address some of the limitations inherent to SFBT. The table below considers the presence of AOP principles in current SFBT interventions.

AOP Practice principle	Present in SFBT Main Interventions?
1. Critical Reflection on Self in Practice	Somewhat - SFBT emphasizes "contextual knowledge and taking a not-knowing stance" which "requires clinicians not to rely on prior experiences or theoretically formed truths and knowledge to understand and interpret therapeutic needs" (Lee, 2003, p. 393); - By adopting a social constructivist view of solutions, therapists are at least indirectly acknowledging that their own worldview is not universal (Lee, 2003).
2. Critical Assessment of Service Users' Experiences of Oppression	Somewhat - With advances in SFBT, practitioners may include acknowledgement or reference to the "to the social disadvantages that may have contributed to distress and difficulties" (Letham, 2002, p. 191); - Some SFBT may incorporate an "empowerment-based approach" which states that "a client's unique experiences and the social base of that experience should be understood within a social, cultural, economic, and political context (Congress, 1997; Rose, 1990)" (Lee, 2003, p. 385); - However, this does not include a critical analysis: "Instead of reading between the lines, SFBT therapists discipline themselves to listen for and work within the client's language by staying close to and using the words used by the client" (Solution Focused Brief Therapy Association, 2013, p. 6).

3. Empowering Service Users	Somewhat - SFBT is rooted in the belief of a service user's ability to set goals for themselves and make changes in their own lives. However, this notion of "empowerment" is not related to understanding or changing structural conditions (Healy, 2014). Indeed, "empowerment" within SBFT is centered around assisting service users in identifying micro-level actions they can take to work toward a desired goal (Lee, 2003, p. 390).
4. Working in Partnership	Yes - The role of the practitioner within SFBT interventions is to work with the service user to "co-construct" potential solutions (Solution Focused Brief Therapy Association, 2013, p. 5); - Goals and solutions discussed within therapeutic interventions are based on the strengths and opinions of the service user; SBFT practitioners work to and to "expand" the service users' options without inserting their own judgement, beliefs, or interpretations (de Shazer et al., 2007, p. 4).
5. Minimal Intervention	Yes - An assumption that guides SBFT interventions is "if it isn't broken, don't fix it" (de Shazer et al., 2007, p. 1). While some "schools of psychotherapy" encourage service users to engage in therapy even without the presence of current problems in order to continue personal "growth," SFBT is premised on the notion that "if there is no problem, there should be no therapy" (p. 2).

Based on the chart above, we have three ideas for an AOP-infused SFBT approach.

AOP Principle	AOP-Infused SFBT approach suggestion	Examples of Actions
Critical Reflection on Self in Practice	Continually engage in: - critical reflection by "scrutinizing self for values, needs, biases" in order to "increase awareness and engage with service users more consciously" (Sloos, 2020d); - critical reflexivity to develop an "intentional awareness of power relations in broader social systems and structures and recogniz[e] how they impact your social work practice with service users" (Sloos, 2020d).	- Through critical reflection, a therapist reflects on how their position as a white settler influences the values that they consider to be "solutions"; - A settler therapist uses critical reflexivity to evaluate if/how they have engaged in what Tuck and Yang (2012) describe as "settler moves toward innocence" (p. 10) within their practice.

Critical Assessment of Service Users' Experiences of Oppression	Consider how micro-, mezzo-, and macro-level processes might impact a service user's ability to define and achieve "solutions" - Personal (Micro): "Personal practice of health; coping skills; resilience; biological endowments" (Sloos, 2020e) - Cultural or Social (Mezzo): "Income and social status; social support networks; employment conditions; physical environments; social values and cultural norms internalized through socialization" (Sloos, 2020e) - Structural (Macro): "Sexism (gender); gender neutral agency policies racism (race); ignoring that race matters; heterosexism; language - that excludes; colonialism; ongoing and historical trauma" (Sloos, 2020e).	- When working with service users to set goals, a therapist considers how different intersectional subject positions influence what is seen as a "solution".
Empowering Service Users	Advocate for structural change	- Settler therapists advocate at community and policy levels for repatriation of land to Indigenous nations.
	Add a structural lens to general responses and questions with service users	- In the "co-construction process" (Solution Focused Brief Therapy Association, 2013, p. 5), a therapist uses solution-focused questions and responses that open possibilities for connections to the structural level.
	Add a structural lens to specific SFBT intervention questions	A therapist adds a structural lens to the "miracle question" (de Shazer et al., 2007) - For example: Imagine that you were to wake up tomorrow and feel like

		everything in your life is solved. What do you think would be organized differently in the world? Are there any people you know or have heard of who are working toward this change? A therapist adds opportunities for "critical adult education" (Burstow, 2003, p. 1313) to SFBT "experiments and homework assignments" (de Shazer et al., 2007) - For example: Look up a group or organization that is doing work related to a social change that you identified within your miracle question.

Concluding Tensions: Is Objectivity Even Desirable?

One of the core tenets of SFBT is for the practitioner to maintain an objective view and ensure that the solutions co-constructed during a session are not influenced by the practitioner's own values or beliefs (Solution Focused Brief Therapy Association, 2013, pp. 4-6). Our suggestions for an AOP-infused SFBT approach disrupt this tenet by asking practitioners to draw attention to structural connections within a SFBT intervention, when possible. However, as we have discussed in the limitations section above, we do not believe that it actually possible for a therapist to achieve an "objective" stance; dominant structures and values, such as whiteness, are re-centered in contexts as simple as identifying what is, and is not, a solution (Lee & Bhuyan, 2013; Ying Yee, 2004). We think, therefore, that critical social workers should draw attention to structural conditions that may shape a service user's goals or identified solutions within SFBT interventions. In other words, we believe that social workers who use SFBT interventions

without critical considerations, such as an AOP-infused lens, are not obtaining "objectivity"; rather, they are asserting a worldview that normalizes and upholds existing structural conditions, inequities, and forms of oppression. It is important to note, however, that the use of critical perspectives like AOP does not absolve a social worker from complicity or direct participation in the perpetuation of oppressive structures and material inequities (see, for e.g., Blackstock, 2009; Chapman & Withers, 2019; Tuck & Gaztambide-Fernández, 2013).

AOP-Infused SFBT Approach: A Brief Summary

This infused approach can be summed up as: respecting a client's experience and knowledge as central to their ability to construct solutions within their own lives while also maintaining a critical framework in order to, whenever possible, open up opportunities for solutions that connect to structural levels.

Infused Approach: Trauma-informed Approaches and Mad Studies

What Limitations Do TIAs Reveal?

Although Goodman states that "[i]n some ways, the inclusion of PTSD in the DSM was a significant step forward for the study and treatment of trauma" TIAs do reveal a number of limitations.

It is imperative to recognize the stark limitations of TIAs in order to maintain a critical awareness of the practice, as well as to correct the gaps in this approach. In this section, we will expose some of the key limitations of TIAs, before borrowing from external critical practice elements to supplement and strengthen this conventional approach. We first focus on the following four limitations: restricted definitions of trauma, diagnosing trauma through an evidence-based approach, and sanist assumptions.

Narrow Definitions of Trauma

Restricted definitions of trauma and PTSD, as put forth by the DSM and practiced in clinical settings, emphasizes the individualization of trauma and oversimplifies "the complex and multifaceted ways in which individuals and communities experience traumatic events" (Goodman, 2015, p.60). Furthermore, this Eurocentric definition established by Western scientific research ignores centuries of community-based understandings of trauma.

> "This exemplifies a colonial or Western/Eurocentric framework that focuses on the individual as a way to deflect attention from systemic factors" (Goodman, 2015, p. 60).

Burstow (2003) suggests we think of trauma as not a disorder, but as "a reaction to a kind of wound" caused by a profoundly injurious situation or event, occurring in a "world in which people are routinely wounded" (p. 1302). A trauma diagnosis is most often applied to individuals, but it is imperative to note that not it is not only individuals who can experience trauma. Community theorists recognize that entire communities "as an integral whole is traumatized" (Burstow, 2003, p. 1297). Trauma should also be understood as transgenerational or intergenerational, meaning that the impacts of traumatization felt by one individual can be passed onto the next generation. It can be passed on in this way by "virtue of belonging to a specific social group" or family (Burstow, 2003, p. 1297). The definitions provided by the DSM do not account for the way in which trauma can result from systemic oppression, such as ongoing racism, and be passed on as collective, historical (Goodman, 2015.) or vicarious trauma.

Diagnosing Trauma

Another critique of TIAs prevalent in the literature is in the way that individual trauma is diagnosed by a professional, demonstrating the "power of psychiatry" (Burstow, # p.). Many trauma-focused facilities are diagnostic which implies that reactions are "seen as an intrinsic character flaw" and are therefore pathologized (Goodman, 2015, p. 59). Indeed, Burstow (2003) argues that the mental disorder is brought on not by the trauma itself, but by the professional who applies the diagnosis as mediated by the DSM. Through both definition and diagnosis there is an inherent individualization of trauma; in this way TIAs fail to address or advocate to change the systemic injustices and daily oppressions that increase one's susceptibility to trauma (such as racism, and colonialism) (Goodman, 2015).

Evidence-based Formula

The causes and conditions of trauma, as well as the embodied impacts of trauma have been heavily researched and documented within clinical settings. In fact, there are "numerous scholarly publications and intervention programs on traumatology (the study and treatment of trauma)" (Goodman, 2015, p. 56). This work has pushed TIAs in the direction of having more systematic and comprehensive models of practice. By understanding trauma in this way, the effects of traumatization have been reduced to an equation. Forms such as the DMS-5 PTSD Checklist claim to be a "psychometrically sound measure" and understood as "valid" "reliable" and "useful in quantifying PTSD symptom severity" (link to pdf). Burstow (2003) describes the way in which trauma is codified and measured by the DMS:

Each of these criteria stipulates an attribute of trauma, then provides a list of included symptoms and identifies a precise number that must be met (p. 1295). In practice, these standardized forms can contribute to retraumatization. Herz and Johansson (2012) discuss the adversities that seem to follow the implementation of evidence-based practices: standardization, increase of manual-based social work, theoretical assumptions, and "neo-liberal individualization of 'social problems'"(p. 529).

False Assumptions : Normalcy

TIAs operate under a number of problematic theoretical assumptions. For example, it is built on the assumption that "[t]he world is essentially benign and safe" and those who do not trust in this inherent security are unreasonably cautious (Burstow, 2003, p. 1298). These assumptions demonstrate the "unquestioned belief in normalcy" that is prevalent in TIAs, along with a sense of superiority that is afforded to those who act accordingly (Burstow, 2003, p.

1298). This set of assumptions point to elitism (lewis, 1999), since the luxury of safety is afforded only to the wealthy. A traumatic event is defined as something that occurs outside the parameters of what is considered 'normal' human experience:

"The range of human experience becomes the range of what is normal and usual in the lives of men of the dominant class; White, young, able-bodied, educated, middle class. Trauma is thus what disrupts the lives of these particular men but no other" (Brown, 1995, p. 101).

To demonstrate the way in which 'normalcy' is a guiding assumption underlying TIAs, we look to the practitioner guide for the aforementioned PTSD Checklist. It states that this self-report measure can be completed either by the respondent individually, or together with a service practitioner in " approximately 5-10 minutes" (ISTSS, 2020). This allots as little as fifteen seconds to read, interpret and numerically rank each deeply personal question. This demonstrates the westernized, colonial, and sanist assumptions that are embedded within the assessment measures affiliated with TIAs.

Identifying the Gaps Between TIAs and Mad Studies

In effort to address some of these gaping limitations of TIAs as identified in the reviewed literature, we turn to the principles of Mad Studies. The table below presents a comparative review of four key principles of Mad Studies and how these are presently addressed by the conventional TIAs. Following this table, we offer some suggestions for ways in which you can problematize the use of TIAs in your practice and suggest ways in which you can adopt a more critical approach to trauma work.

The astute reader may observe that these categories all share a common root. We agree with you. Much of Mad Studies does centre around pushing back on normative assumptions of what constitutes sanity. However, for practicality, we have organized some key principles into artificial categories.

Mad Studies Principles	**Present in Trauma-Informed Main Interventions? (based on the approaches covered here)**
Resisting Narrow Definitions of Mental Disorders	**NO** Although there are many practicing definitions of trauma, those used in TIAs tend to be derived from professionals and clinical research. Trauma has become a "psychiatric conceptualization as mediated by the DSM" (Burstow, 2003). Trauma is not routinely defined by individual experience and personal narrative. According to Faulker (2017), "[m]ental health knowledge is dominated by professional knowledge to the exclusion of the knowledge based on lived experience (experiential knowledge) that people with mental health problems can bring" (p. 500). Trauma is individualized by TIAs, but not personalized.
Survivors as experts	**SOMEWHAT** When applying a strengths-based approach, Sweeney et al. (2016) address empowerment, choice, mutuality and collaboration as some of the key principles of TIAs. Although they emphasize the value of "peer support and coproduction" (p. 178), this is less apparent when looking at the way that trauma screenings are administered. According to ISTSS, survey results should only be interpreted by a professional or clinician. In neither the collaborative nor the professional diagnostic approach is the trauma survivor treated as the expert of their own experience.

Resisting biomedical diagnosis/ resisting psychiatry as an institution The *Indiscipline* of Mad Studies	**NO** Burstow (2003) states that trauma only becomes a disorder once it is labelled as such by someone in a position of authority. It is through this label, or diagnosis, that trauma becomes a mental disorder. Faulkner (2017) states that "the dominance of the biomedical model is in practice, expressed through these diagnostic frameworks (p. 502). By participating in these diagnostic frameworks that comply with the labeling and pathologizing of service users, social workers become complacent in the"sanist aggressions" that have become a 'normalized' component to our professional practice and education (Joseph, 2015; Poole, 2012).
Resisting false assumptions of normalcy	**NO** It is apparent from the literature that 'normalcy' is a guiding assumption of TIAs. Central to TIAs is the assumption that a traumatic experience is something that occurs outside the parameters of what is considered 'normal' human experience. This is generally defined through the lens of the dominant class (white, middle class, able-bodied, education, young etc.). To establish what is normal in this way, we pathologize the lived experiences of "women, Blacks, natives, Arabs, and I […] psychiatric survivors" for whom "the world is not a safe and benign place, and so mistrust is appropriate" (Burstow, 2003, p. 1298).

Infusing TIAs with Mad Studies

This is a difficult question, and one which cannot be simply answered on this webpage. This is a process that requires self-reflection in practice. However, as a starting point, we offer some initial thoughts for you to consider in your pursuit for a mad-infused TIA practice.

We need to separate our understanding of trauma from the psychiatric narrative (Linklater, 2014). Very simply, trauma is "a person's reaction to an injury" followed by an embodied response (Linklater, 2014, p. 22); it is not a diagnosed mental health disorder. It is, by

no means, outside of the 'normal' experience of individuals and communities who are routinely affected by colonization, racism, discrimination, sexism, and the list goes on. This alludes to the critical importance of also adopting an anti-racist framework when practicing TIAs (Maiter, 2009). "We can assume no absolute confidence in the homogeneity of people" (Faulkner, 2017), however, we do not need a trauma diagnosis to approach each service user with the intention of building a safe, transparent and collaborative environment of working relationship.

We need to recognize that the ways in which the biomedical model, and the systems that support it (officially mandated helping institutions), are inherently oppressive. Burstow (2003) declares that "trauma is systematically produced by" these institutions, especially those operated by the state, and "must be understood as central players in the traumatizing of people and communities" (p.1307). Can we, as social workers continue our work in these institutions without reinstating harm to service users? Even as "critical" social workers? How can TIA principles claim to advocate for collaboration when operating within a model of psychiatry that "alienates people from their capacity to name, invalidates people's conceptualizations, imposes a stigmatized identity on them, places them on paths not of their own choosing, deprives them of liberty, and imposes harmful treatments on them" (Burstow, 2003, p.1307)? Is it possible for effective collaboration to occur when working within these systems of care? For these and other reasons, TIAs need to align with the values of Mad Studies, and recenter experiential knowledge, and first-person narratives within academic and clinical dialogue about trauma.

By integrating principles of Mad Studies and other critical approaches into the practice of trauma-informed social work, we can address some of the inherent short-coming of TIAs. As Goodman (2015) identifies, TIAs offer major advancements in recognizing the underlying and complex impacts of a traumatic experience. However, in order to adopt a mad-infused practice

we must analyze the disempowering, diagnostic implications of trauma assessment surveys as well as the officially mandated institutions that administer care.

Infused Approach: Using CRT and Intersectional Feminism in Narrative Therapy

Limitations of Narrative Therapy

Neglects Impacts of Structures of Oppression

Some of the limitations of narrative therapy stem from the same limitations adhered to postmodern theories. Postmodernism provides social workers with a helpful lens to question and deconstruct concepts and discourses, especially in regard to the needs of service users and how social work professionals respond to these needs in practice (Healy, 2014, p. 206). However social workers should be cautious to ensure that the pursuit of deconstruction does not preclude them from recognizing the real life impacts that result from oppression based on structures that maintain inequities between people. Essentially, while narrative therapy can enable individuals to reconstruct a more helpful narrative in understanding their sense of self and the options they have, this does not mean that narrative therapy has the capacity to remove or lessen constraints of structural oppressions which have real impacts on the ideological and material contexts of an individual's life. Healy (2014) asserts that a focus on the language practices that shape [a person's] situation should not distract [social workers] from the pressing material needs...or recognition of the broader contexts of oppression" facing certain individuals (p. 223). While changing a person's perspective on the problem may be helpful to their understanding of their identity, it does not change the root of the problem.

Implications of Power Dynamics in the Social Worker and Service User Relationship

As stated previously, the social worker holds a significant role when supporting a service user through narrative therapy:they must skillfully guide the dialogue with language and questions that assist service users to tell their story of self, deconstruct harmful or unhelpful narratives by identifying alternative stories or themes, and reconstruct or co-construct a second

narrative. In this facilitative role, a social worker holds considerable power in this intervention, especially with respect to how their own positionality and perspectives may have influence on how a service user externalizes problems or develops their second story.

Lack of moral framework

As mentioned previously, limitations of narrative therapy can be linked to critiques of postmodern theories. Here, we consider how postmodernism's belief in the complexity of meaning and rejection of universal truths dismisses moral and political standings essential for social justice (Healy, 2014, pp. 223-224). Ricks et al. (2014) assert that "narrative therapy works to separate the problem from clients; and after this is accomplished, clients can work on their relationship with the problem" (p. 100).This assertion, however, disregards how problems are understood or explained by the service user and/or the social worker. Without incorporating a critical lens, narrative therapy fails to incorporate "guidelines about who is to be empowered and for what ends" (Fook, 2002, p. 47). Jan Fook (2002) states "unless we ask the more important questions like 'empowerment for what?' and 'for whom?', we are left with the possibility of perpetuating oppressive structures for someone" (p. 48).

Applying a Critical Race Theory and Intersectional Feminist Theory Lens to Narrative Therapy

In response to these limitations, we put forth an example of how a social worker could use the critical theoretical lens of CRT and intersectional feminism to address some of the issues discovered in narrative therapy as addressed above:

CRT/Intersectional Feminist (IF) Principle	CRT/Intersectional Feminist - Infused Narrative Therapy Suggestion	Reflective Questions for Social Workers
A Critical Framework to Recognize and Acknowledge Structures of Oppression	As theoretical positions that look in-depth at the structural forces of oppression that impact people based on their positions of identity, especially with regard to race, CRT and Intersectional Feminism provide a helpful framework for applying a more critical perspective when practicing narrative therapy. In approaching narrative therapy, this framework could assist in raising the consciousness of an individual regarding the impact of structures, such as systemic racism, patriarchy, colonialism, xenophobia, homophobia, on their narrative. While the root of the problem impacting their narrative may be beyond their capacity to change, the service user's awareness of the embeddedness of structures in society and institutions may challenge how they view this problem in relation to their sense of self. This is potentially a helpful realization for a service user in the reconstruction of their narrative, including how they can influence discourse at the micro-level to challenge these structures.	What structures impact the narrative of a service user? How do connections between hegemonic structures magnify experiences of oppression? For example: How do structures of white supremacy impact the narrative of a person who is racialized and/or Indigenous? How do structures of patriarchy impact the narrative of a woman? How do structures of white supremacy and patriarchy impact the narratives of racialized women?
Critical Reflexivity on Power Dynamics in the Social Worker and Service User Relationship	This framework can help a social worker critically reflect on their intersections of identity and how power dynamics within the social worker and service user relationship are generated and maintained based on these positions. Recognizing and acknowledging these power	How do the language, dialogue and questions you use reinforce or diffuse power? How does your intersectional position impact your interpretation of an individual's narrative of self?

	dynamics can be helpful in mitigating the reinforcement of oppressions when practicing narrative therapy because it asks the social worker to critically reflect on how their perspectives may influence their language when framing questions and comments. As well, recognition of their intersectional position's influence on their perspectives can help them apply critical reflexivity in their dialogue with a service user, in both their own interpretation and understanding of a service user's commentary and the service user's interpretation and understanding of the dialogue based on their own intersectional position.	
Applying a Critical Moral Framework to Narrative Therapy	While supporting a service user in realizing their narrative and reconstructing their story of self, a social worker can use a CRT/Intersectional Feminist framework to position their values and beliefs to orient their aims and how they facilitate these goals in practice. In particular, this framework would ask a social worker to recognize the inherent inequalities between people which are maintained and informed by complex, intertwined, and mutually-reinforcing categories of oppression and social structures" (Mattson, 2014, pp. 9-10) This provides a critical moral framework for how narrative therapy can challenge diverse structures of oppression, avoid reinforcing inequalities and collaboratively engaging as well	What values and beliefs orient your critical social work praxis? How can you apply an anti-racist and intersectional approach to narrative therapy? How can you assist a service user in challenging structures of oppression that impact their narrative?

	as respecting service users' own beliefs and understandings.	

Concluding Tensions

As narrative therapy draws heavily from postmodern theory, one of its core tenets is to not seek the "truth" of the causes impacting the lived experience of the service user and, instead, to assess how their narrative impacts their understanding of who they are and the options they have. However, this avoidance of "truth" inhibits narrative therapy from both recognizing the material impacts of hegemonic structures on peoples' lives and from providing an orientation for how to address these structures at the individual and community level. CRT and Intersectional Feminism provide a valuable lens to address these limitations by considering the links between structures of oppression and a person's narrative. They also offer guidance for how a social worker can both critically reflect on their own intersectional position, in order to try and avoid reproducing these oppressions, as well as to support consciousness raising regarding the impacts of structures with the service user. With that being said, applying this critical lens to narrative therapy will not change the material conditions of a person's life and therefore attention must

also be paid to addressing these issues as in addition to how they impact a service user's narrative.

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