Advanced Skills Workshop: Identity in Counselling

A Non-Pathologizing Perspective for Canadian Psychotherapists

Workshop Synopsis

Every client who walks into a therapist's office carries layers of identity — some chosen, many imposed. When therapy relies on a diagnostic frame, those imposed layers are often deepened: the client who came looking for themselves leaves with a new label that becomes a new cage. This workshop inverts that dynamic. Rather than asking *what is wrong with this person*, it trains psychotherapists to ask: *Who is this person, how have they been spoken about, and how do they want to be known?*

Built from the *Protest Language* textbook and grounded in the Canadian regulatory and cultural landscape, this is both a theoretical and applied workshop. It moves through philosophy, neurodevelopmental theory, narrative practice, intersectionality, decolonizing frameworks, and intensive skills exercises — offering practitioners a coherent architecture for identity work that is clinical, ethical, and genuinely non-pathologizing.

The Problem the Workshop Addresses

The medical model enters identity through three doors that this workshop names and closes. First, it pathologizes through **diagnostic totalization**: when a client is told they are anxious, depressed, or disordered, those words do not describe the problem — they become the identity. Michael White observed that people tend to ascribe truth to their problem, producing a totalizing effect in which the person is no longer someone navigating anxiety — they are an anxious person. Second, the medical model pathologizes through **moralization**: language like *maladaptive behaviours, poor coping, and unhelpful thoughts* tells clients, quietly but powerfully, that the way they have been surviving is wrong. Third, it pathologizes through **therapist authority**: positioning the clinician as the sole expert strips the client of narrative agency and renders their own experience secondary.

The legacy of these practices in Canada is not abstract. The historical use of clinical frameworks to pathologize and attempt to *cure* Indigenous, queer, and racialized identities — including conversion therapy, now prohibited under the federal Criminal Code — continues to shape how marginalized clients relate to mental health care. Mistrust of therapy, in this context, is not resistance; it is a rational response to history.

The Canadian Landscape

The workshop situates identity work explicitly within Canada's current professional and social context. The 94 Calls to Action of the Truth and Reconciliation Commission require clinicians to engage with Indigenous ways of knowing as legitimate and central — not peripheral — to healthcare. Canada's multicultural commitments shape the diversity of clients Canadian psychotherapists serve, including immigrant, refugee, and diaspora communities whose experience cannot be understood without attention to displacement, systemic racism, and cultural identity. And Canada's universal healthcare system, for all its strengths, relies heavily on diagnostic gatekeeping — meaning therapists regularly face the tension between administrative labels required by the system and the clinical language needed to protect client dignity. The workshop teaches therapists to navigate that tension transparently, rather than resolving it by defaulting to the medical model.

The Theoretical Architecture

The workshop draws on three interlocking bodies of theory that together build a comprehensive non-pathologizing account of identity:

1. The Non-Pathologizing Theory of Identity — Differentiation

Identity formation is not completed in adolescence; it is a lifespan process, continuously reshaped by the systems we enter and exit. Each time a client takes on a new role, loses a relationship, or moves through a life transition, they face the question: *Who am I now, and how do I want to be known here?* The workshop introduces **differentiation** — knowing who you are from the inside, regardless of what systems around you are naming you — as the clinical target of identity work.

This **Differentiation Formula** provides the clinical sequence: *Control → Safety → Vulnerability → Hope → Healing*. Control here means internal regulation and anchored self-knowledge — not power over others or circumstances. Once a client develops some sense of internal control, safety becomes possible; from safety, vulnerability can be chosen rather than forced; from chosen vulnerability, hope emerges; and from hope, healing follows. This sequence protects clients from being asked to go deeper than their foundation can hold.

2. Identity as Adjective, Not Label

Perhaps the most practically radical idea in the workshop is the distinction between **identity-as-label** and **identity-as-adjective**. Labels are role-based and system-derived: *I am a mother, a patient, an alcoholic, a trauma survivor*. They are tied to positions that can end. When the role disappears — through loss, transition, or changing circumstances — the label dies with it, and the person is left with no ground to stand on. Adjectives are different. They describe enduring qualities, values, and virtues: *I am compassionate, resilient, discerning, someone who shows up*

with integrity. These can travel through every transition and survive any loss. Drawing on Hermans et al.'s Dialogical Self Theory, existential psychology (Frankl, Yalom), virtue ethics, and narrative therapy (Michael White), the workshop grounds this distinction in multiple philosophical and theoretical traditions while making it immediately applicable to clinical conversation.

3. Identity in the Triage Model

The workshop locates identity and differentiation work as the **third stage of the non-pathologizing triage sequence** — following safety work and grief and loss work, and preceding trauma-focused intervention. This placement is clinically intentional: clients who do not yet have a differentiated sense of self are especially susceptible to the dominant narratives that attach to their presenting problems. Without an identity anchor, trauma work risks becoming destabilizing and re-pathologizing. Identity work first provides the ground from which trauma can be approached.

Protest Language as the Clinical Vehicle for Identity

The workshop teaches therapists to hear symptoms as protest — as the client's *no* to a description of self that does not fit their preferred identity. This draws on the **8-step protest language listening process**:

1. Establish a collaborative, not-knowing stance
2. Listen for the **Hero Narrative** — language of coping, overcoming, striving
3. Identify the **Exit Narrative** — language of withdrawal, giving up, seeking relief
4. Set both narratives aside — acknowledge them, then shift attention beneath them
5. Tune in to protest language — listen for the implicit *no*; ask: *What is the client saying no to?*
6. Validate and explore the protest without judgment
7. Support meaning-making through relational process questions
8. Identify preferred narratives and identity — listen for *I* statements that reveal who the client wants to become

When a client says *I used to be able to handle the pressure*, this is not nostalgia — it is a protest against who they have been forced to become. When a client says *I keep making mistakes*, this is not merely self-report — it is self-pathology that the therapist should pause and deconstruct: *What is being communicated to you that tells you that you keep making mistakes?* The therapeutic task is to stand beside the client while they hold up their protest sign, and help them hear what preferred identity that protest is pointing toward.

Amir's Case Study — Theory Made Visible

The workshop uses **Amir's case** as a sustained applied illustration. Amir is a 24-year-old Syrian refugee in Montreal who could easily be framed with a diagnosis of Social Anxiety Disorder. A non-pathologizing lens shifts the question: not *what disorder does Amir have*, but *what has Amir survived, and how do his current responses make sense in context?* His social withdrawal, vigilance, and hesitation in public spaces are understood not as irrational pathology but as survival strategies shaped by real experiences of violence, displacement, and the ongoing shadow of homophobia.

Through **externalization**, the therapist helps Amir name the problem as *the shadow of homophobia* or *the watchfulness that follows violence* — separating his identity from the distress he carries. As the therapeutic work continues, preferred identity language begins to emerge: rather than *disordered, fearful, avoidant*, Amir begins to inhabit words like *courageous, protective, discerning, deeply committed to surviving without losing himself*. Over six months, this approach contributed to a 40% reduction in distress symptoms alongside a strengthened sense of agency and identity — demonstrating that non-pathologizing work is not only more ethical but clinically effective.

Narrative Theory and Intersectionality

The workshop draws on four narrative therapy tools as the primary clinical language for identity work: **externalization** (separating person from problem), **double listening** (hearing both the problem story and the story of the client's responses, values, and resistance), **deconstruction** (examining taken-for-granted cultural narratives that produce inadequacy), and **re-authoring** (co-creating a preferred narrative organized around agency, values, and preferred identity).

These tools are then placed in an **intersectional frame**. Clients do not live single-issue lives — identities of race, gender, sexuality, class, migration status, faith, disability, and language interact in daily experience and shape both suffering and possibility. The workshop trains therapists to use intersectional mapping not as an academic exercise but as a clinical skill: understanding that what appears as an individual symptom is often an adaptive response to structural conditions, and that what looks like private distress frequently carries the weight of racism, transphobia, poverty, or displacement.

This connects directly to the workshop's **decolonizing stance**: identifying one's own social location and assumptions, unlearning Western-centric frameworks as the only legitimate way to understand healing, centering the client's cultural metaphors and knowledge traditions, and remaining accountable through ongoing supervision and consultation.

Workshop Exercises

The workshop includes eight applied exercises organized around three modalities — self-reflection, skills practice in pairs or triads, and case analysis:

1. Adjectives, Not Labels — participants answer *Who am I?* and *How do I want to be known?* using only adjectives, then circle the three that feel most chosen rather than inherited. Debrief explores the distinction between survival identity and preferred identity.

2. Fixed vs. Fluid Identity — participants rewrite fixed identity statements (*I am an anxious person*) into fluid language (*I have been living under anxiety's influence lately*), practicing the core non-pathologizing move away from totalized self-description.

3. The Sequence Map — participants map the Formula for Success (control, safety, vulnerability, hope, healing) and reflect on where they habitually begin change work, and whether they tend to press toward healing before sufficient safety is established.

4. Safety Before Depth — using case vignettes, participants assess whether a client primarily needs more control, more safety, or is ready for deeper vulnerability work — reinforcing the triage logic that identity exploration requires a foundation.

5. Listening for Protest — participants receive a set of symptom-heavy statements and identify the hidden *no* in each: what is the person protesting, what are they saying no to, and what preferred identity might live underneath?

6. Symptom to Preferred Identity — participants take a single symptom statement and develop three possible preferred-identity words beneath it (e.g., *I'm always on edge → calm, grounded, secure*), practicing reading symptoms as agency-rich protest.

7. Externalizing Interview — in triads (counsellor, client, observer), participants practice externalizing language with a case vignette, asking 6–8 structured questions that separate the person from the problem. The observer tracks moments of either successful externalization or slippage into identity-saturated language.

8. Mapping Intersectionality — using a four-ring visual tool (identities → relationships/communities → institutions/systems → dominant narratives), participants map a case to show where power, privilege, exclusion, and protection operate, then produce a one-sentence reframe: *Rather than seeing this as a disorder within the client, we can understand it as a response shaped by __, __, and __.*

A ninth applied exercise — **Decolonizing the Intake** — invites small groups to audit a standard intake form using three questions: *Why do we need this information? Who does this question serve most — the client, the institution, or the clinician? Could this question invite shame, surveillance, or premature pathologizing?* Items that assume deficit, diagnosis, compliance, or Western norms of health are identified and rewritten collaboratively.

Four Practice Commitments

The workshop closes with four direct clinical commitments that participants carry into their practice:

1. Always look for the preferred story alongside the problem story
2. Separate distress from identity — the client is never reducible to their diagnosis, symptom cluster, or presenting concern
3. Map intersectionality — locate the client's experience within relational, social, cultural, and structural context
4. Question Western assumptions about health, normalcy, and how healing is supposed to look

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Learning Outcomes

By the end of this workshop, participants will be able to:

- Define identity formation as a lifespan, fluid, and relational process, and critique how the medical model pathologizes identity through diagnosis, moralization, and therapist authority
- Distinguish between external identity (labels), survival identity, and preferred identity (adjectives), and apply this distinction in clinical conversation and documentation
- Explain the Differentiation Formula and use the triage sequence to place identity work appropriately within the clinical process — after safety and grief, before trauma
- Apply the 8-step protest language listening process to hear symptoms as protest and move toward preferred identity and preferred narrative
- Use narrative therapy tools — externalization, double listening, deconstruction, re-authoring — as primary clinical instruments for identity work
- Map intersectionality and apply a decolonizing stance to case formulation, intake processes, and clinical language
- Recognize moral identity as a legitimate dimension of clinical exploration and remove therapist moralization from the clinical space
- Implement immediate, sustainable changes to clinical language, intake processes, case formulations, and presentations

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CHCPBC and Regulatory Standards Addressed

This workshop directly addresses the CHCPBC **Indigenous Cultural Safety, Cultural Humility, and Anti-Racism** standard — specifically the requirements for self-reflective

practice, building knowledge through education, anti-racist practice, and strengths-based and trauma-informed care. It also addresses the **Anti-Discriminatory Practices** standard, the **Person-Led Care** principle, and the broader ethical requirement to practice in a manner that preserves dignity and does not impose the practitioner's values on the client's identity, choices, or life narrative.