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Integrating the Walk-In Clinic and Brief Therapy Processes to Enhance Treatment Outcomes: A 1 + 3 Session Intervention for Youth Presenting with Anxiety and Depression

Jazlyn McGuinty[1] | Alain Carlson[2] | John Nelson[3] | Joana Silva[4]

[1]Temerty Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada | [2]Faculty of Education, Nipissing University, North Bay, Ontario, Canada | [3]Independent Researcher, North Bay, Ontario, Canada | [4]RISE-Health, CINTESIS.UPT, Department of Psychology and Education, Universidade Portucalense Infante D. Henrique, Portugal

Correspondence: Jazlyn McGuinty (jazlyn.mcguinty@mail.utoronto.ca)

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ABSTRACT

This article describes a postmodern and integrative approach to walk-in clinic therapy and brief therapy for youth presenting with anxiety and depression. Externalising metaphors therapy (EMT) has the potential to enhance client outcomes through the integration of its two treatment models: a single-session model and a three-session model. The purpose of this article is to describe the integration of the walk-in clinic model (six-stage process) with the three-session model (15-stage process). The walk-in clinic process synergistically corresponds with and encapsulates the three-session treatment model. A combined treatment protocol is outlined in a case illustration and table format for the clinician practitioner. The model is based on qualitative and quantitative data, which provide preliminary support for the development of an integrative approach. A composite literature review was conducted within the scope of walk-in clinic psychotherapy and brief services psychotherapy in terms of process research and mental health research. The article also contains a more focused literature review on the proposed treatment model. Enhanced client outcomes is the primary goal of combining the walk-in clinic and three-session treatment model(s). Through this newly proposed model, youth engaging in mental health services may experience a scaffolding continuity of the therapy process that integrates these different treatment modalities. Youth experience the EMT treatment process at the walk-in clinic and may return to experience the model in greater depth during the subsequent three sessions.

1 | Introduction

Prevalence rates of symptoms of anxiety (20.5%) and depression (25.2%) for the global child and adolescent population were clinically elevated during COVID-19, according to a recent meta-analysis (Racine et al. 2021). Since the onset of the pandemic, other studies have highlighted prevalence rates of anxiety up to 40%, with transitional-aged youth disproportionately impacted (Kujawa et al. 2020). Unfortunately, a substantial proportion of anxiety disorders remain largely unrecognised and untreated (Bandelow et al. 2017).

Effectively addressing anxiety and depression within the youth population has become an international concern, particularly given the resource-intensive nature of traditional mental health treatment models. As part of the effort to fulfil this need, single-session/walk-in clinics have been trialled in Ontario, Canada, to reduce waitlist times and meet more client mental health needs

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Key Points

- Anxiety and depression are highly prevalent among children, adolescents and transitional-aged youth, emphasising the need for efficient, targeted mental health interventions.
- Externalising metaphors therapy offers a youth-centred, strengths-based approach that facilitates engagement through visual methods suited to paediatric populations.
- The model has clear applicability to community mental health settings, with implications for reducing wait times and improving access to care for youth.

(Sarmiento and Reid 2023). Schleider et al. (2020) also draw attention to the cost-effectiveness of the single-session model in the context of the United States. Indeed, the single-session model is becoming an increasingly common service delivery model (Hoyt et al. 2018; Hymmen et al. 2013).

One of the most rigorous and systematic evaluations of the single-session model draws on findings from 50 randomised controlled trials (Schleider and Weisz 2017). For this meta-analysis, the effects for youth depended upon the nature of the presenting problem. However, the results of single-session therapy were promising for anxiety and depression. A large-scale systematic review of 18 reports similarly indicates significant improvements in anxiety (Bertuzzi et al. 2021).

The single-session model falls within the family of brief therapy, which can be construed as encompassing a range of sessions, primarily from three to six counselling sessions. When youth engage in more than six sessions, they are moving towards a long-term therapy modality, which has different theoretical orientations, therapy structures and change processes. Single-session therapy has always existed in some form, as youth often attend only one session and discontinue services, depending on their psychotherapy needs, intrinsic/extrinsic motivation and other factors.

The single-session model is relatively new, and it is a model unto itself in many respects. It is typically 60–90 min long and offered through mental health walk-in clinics, either through pre-booked sessions or through impromptu walk-in visits. Mental health clinicians (and clinical social workers) offering the single-session model are either trained in a specific 'single-session model' or heavily rely upon their existing brief therapy training and use an integrated eclectic approach. Some clinicians combine both approaches.

There is a real disconnect, a lack of continuity, between the single-session model and the brief therapy model. This occurs not only when a youth attends the former with one mental health therapist and the latter with another mental health therapist, but also if the youth attends both therapy model(s) with the same mental health therapist. Should the youth receive single-session services with a cognitive behaviour therapist and then brief therapy services with a solution-focused therapist, they will experience two very different treatment approaches. Additionally, a mental health therapist using either of the above models will have to adapt an ad hoc approach to integrating the two service delivery models, which often translates to the youth repeating their single session, once again, in their 'first' brief therapy session. To the knowledge of this research team, no such integrative approach exists for the mental health therapist and youth seeking anxiety and/or depression treatment.

Perhaps with such a significant disconnect, inefficiencies in improving mental health outcomes exist for youth and related impacts upon increased waitlist times. Waiting for mental health services can intensify untreated anxiety and depression for youth, possibly requiring more intensive, long-term psychotherapy services. In both cases, the youth may end up retelling their story twice, slowing the therapy process and ultimately the change process. Youth traverse the change process in single-session, brief and long-term therapy models.

Albeit not linear, youth move through a predictable change process that is significantly impacted by the factor of time. The therapist and youth relationship may have only 'one session' to therapeutically address anxiety and/or depression, or they may have '30 sessions'. The structure and change process within one session is very different from the structure and change process within 30 sessions.

Added to this complexity is that single-session models are delivered through a very generalist approach to the presenting concerns of youth. This means one size fits all. Existing single-session models are designed to be used for every presenting concern (anxiety, depression, interpersonal issues, behaviour/anger, school avoidance, social anxiety, suspension/expulsion, personal crisis and other issues), disregarding their varying complexities and differences.

To the knowledge of this research team, no single-session model has been developed specifically for a specific presenting concern like anxiety and depression (both treated as internalising disorders). Specially designed single-session therapy models need to carefully match the presenting concerns of youth. Furthermore, single-session models need to seamlessly integrate their structure and change process into the next stage of therapy (brief therapy) for the presenting youth. Such integrative treatment models have not been developed.

Thus, this literature review addressed prevalence rates for anxiety and depression within this clinical population. It also focused on the single-session model rather than brief therapy, which has been described in the literature. The proposed model integrates the walk-in model with the brief therapy model. What follows is a description of existing clinical research within the framework of the proposed model.

2 | Origins of an Integrative Treatment Model

A brief description of existing clinical research is now presented to better understand the development of the two treatment intervention models (both presenting specific concerns) and their proposed *integration* into a new service delivery model (1 + 3 sessions). Integrating the walk-in clinic process with the brief therapy process is the main goal of this new model.

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Externalising metaphors therapy (EMT) was initially created through a reflection on the change process within narrative therapy (externalising practices) and the purposeful use and manipulation of metaphors in psychotherapy. Externalising metaphors was initially suggested as a useful treatment strategy for children and youth presenting with anxiety on the autism spectrum. Since then, the EMT treatment intervention model has significantly developed, and its clinical evaluation began in Canada and Portugal, which is still in progress.

As briefly noted, EMT is largely based upon the externalising practices within narrative therapy (White 1989, 2007; White and Epston 1990), the purposeful manipulation of metaphors as evidenced in metaphor therapy (Kopp 1995) and the conceptual use of complex schemas/metaphors within schema therapy (Leahy 2002, 2011). More specifically, and as a result of their theoretical integration, two seminal articles describe and develop the newly formed psychotherapy: EMT (see McGuinty et al. 2012, 2014). EMT is strengths-based and client-centred and aims to assess, explore and shift the client's underlying and maladaptive emotional schemas through externalising problems and a metaphoric transformational process.

The EMT 2012 theoretical article addresses clients on the autism spectrum presenting with anxiety, and the EMT 2014 article develops a three-session treatment protocol (manualising its key clinical processes) for neurotypical children and youth presenting with dysphoria. To improve upon the EMT three-session treatment intervention, McGuinty et al. (2015) investigate and incorporate the structure and change process within brief psychotherapy itself. That research searches for a common change process within all brief therapies, including cognitive behavioural therapy, solution-focused brief therapy, narrative therapy and emotion-focused therapy. The research team identify a common process that children, youth and transitional-aged youth go through within the brief therapy treatment of anxiety and depression. This common process informs the EMT models.

This common process is defined as containing four stages that all brief therapies go through, which can be operationalised through five tasks within each of these stages. The four stages identified are: (1) defining and assessing the problem; (2) shifting the problem; (3) changing the problem; and (4) generalising and maintaining the change. A full description of the 20 tasks that represent this common process is detailed within previous research (McGuinty et al. 2023).

As the next developmental stage of EMT clinical research, McGuinty et al. (2017) evaluated the three-session model through a randomised controlled trial to examine its effectiveness with transitional-aged youth presenting with dysphoria. The quantitative data included 50 transitional-aged youth who participated from four student counselling centres in Ontario, Canada (Nipissing University, Laurentian University, Carleton University, University of Ottawa). Significant reductions in depression, stress and anxiety were indicated through pre-post measurements through the Depression, Anxiety and Stress Scale-21. Trait anxiety also decreased, as measured by the State–Trait Anxiety Inventory.

In terms of qualitative data, an online four-session model was created and clinically evaluated with four transitional-aged youth presenting with anxiety in a university in northern Portugal (see Silva et al. 2022). That EMT pilot study looked at therapists' descriptions and participants' perspectives on the process of change. It suggested putative mediators of change within its transformation process. Additionally, the EMT walk-in clinic model has been evaluated with 20 transitional-aged youth at a college student counselling service within Ontario (expected publication, 2025). This walk-in clinic pilot study relies upon post-session qualitative data.

The EMT individual treatment model was expanded to include a new 'treatment group format' for anxiety with neurotypical youth (see McGuinty, Bird, Silva, et al. 2018) and for those youth with an autism spectrum disorder (see McGuinty, Bird, Nelson, et al. 2018). The treatment group format strongly encouraged children, youth and transitional-aged youth to share their experiences and relationships with anxiety and depression in small groups with peers.

The EMT single-session consultation model was created for walk-in clinic psychotherapy services, therapeutically addressing anxiety and depression (see McGuinty et al. 2021) with neurotypical youth. Later, an autism spectrum disorder–specific model (see McGuinty, Carlson, Nelson, et al., 2023) was created for emotional self-regulation within the walk-in clinic format. Lastly, McGuinty, Carlson, Nelson et al. (2023) developed a long-term psychotherapy model (eight sessions) for youth on the autism spectrum presenting with emotional self-regulation challenges. In conclusion, and for the current 1 + 3 model, the 2021 (walk-in) and 2014 (three-session) articles with treatment intervention protocols are most relevant to this current effort.

3 | Development of Current Model

Before going into a more detailed description of the 'walk-in clinic + brief therapy' combined and integrated treatment model with protocol, additional theoretical concepts are presented. These concepts should shed light on contributing factors to its mechanisms of change, impacting the change process itself.

As previously noted, both EMT treatment models use the process of externalising problems (anxiety/depression) for youth. Problems are separated and viewed as external to the self through the creation of metaphors that represent the problem state (anxiety metaphor/depression metaphor). This may induce a meta-position or observer position, which facilitates the multivocality of self, a sense of authorship of a youth's life and the realisation of psychotherapeutic change (Gonçalves and Ribeiro 2012; H. J. M. Hermans 2003). An external and visual anxiety/depression metaphor may promote a youth's relationship (internal dialogue) with it, themselves and others, including a co-constructionist relationship with the mental health therapist, which supports what Lawrence and Valsiner (2003) call a transformed personal sense.

New forms of meaning construction may support the emergence of more adaptive and flexible self-narratives through clinical techniques from a constructivist-narrative stance (Neimeyer 2006). The EMT models help the youth create new meaning through more adaptive self-narratives around their

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TABLE 1 | The treatment protocol: Integrating walk-in clinic and brief therapy services for anxiety and depression with youth.

Walk-in clinic (one session)	Brief therapy (three sessions)
Section 1 Setting the problem aside Eliciting strengths and strategies Involving other supportive members present **Section 2** Introduce a new way of thinking about problems The person is not the problem; the problem is the problem Externalising language: further separating the problem from self	**Session 1: Externalising the problem with the client** 1. Strengths, strategies and resources together with exploring client hopes, dreams, wants and wishes 2. Externalisation introduced 3. Influence/impact of the problem on the domains of sense of self, sense of others/relationships and sense of life (considering thoughts, feelings and actions) 4. Evaluation with posturing
Section 3 Heightening a near experience of the problem Problem definition Naming the problem **Section 4** Concretising affective states: anxiety/depression schemas Metaphor creation through mediums Verifying complex schema for appropriateness/fit	**Session 2: Developing the client metaphor** 1. Externalising concepts reviewed 2. Metaphor creation and development 3. Metaphor exploration on four domains (relationship between self and problem, sense of self, sense of others/relationship and sense of life) in reference to the three aspects (thoughts, feelings and actions) 4. Metaphor's view of hopes, dreams and wishes
Section 5 Transform metaphor with strengths and strategies Incorporation of strengths and strategies into metaphor Shifting metaphor with strengths and strategies providing feedback loop **Section 6** Summarise model for client and other supportive members present Explain roles/responsibilities after single session ends Anticipated change expressed through metamorphosis of metaphor(s)	**Session 3: Shifting the client metaphor** 1. Externalising concepts reviewed 2. Adjust/shift existing metaphor or create new metaphor and adjust/shift in four ways: (a) explore metaphor to see how it has evolved or changed, reflecting this back to client for meaning; (b) use client strengths to see if they changed metaphor; (c) use clientexamples of success to see if metaphor changed; (d) use the exercises taught to see if metaphor has changed 3. Metaphor exploration on four domains (relationship between self and problem, sense of self, sense of others/relationship and sense of life) in reference to the three aspects (thoughts, feelings and actions) 4. Create a plan of action

sense of self, sense of relationship with others, sense of life, and relationship between their self and anxiety/depression. Meaning construction is promoted more playfully, imaginatively and visually through creative metaphors rather than reliance upon traditional 'talk therapy'. This proposed model promotes the dialogical interchange between different self-positions, which has been described in the literature (H. Hermans 2001).

4 | EMT: An Integrative Treatment Protocol

The walk-in clinic session naturally comes first for the youth seeking mental health services. Sometimes the youth will experience one walk-in clinic session and end the services. Also, some youth may attend a walk-in clinic session and need to follow up with brief therapy services. Based upon the youth and clinician's clinical judgement, these clients may require three more sessions to work on anxiety and/or depression. This decision is based upon the severity of the presenting concern and the need for more sessions.

Youth who require further services are often referred to brief therapy services, which in the EMT treatment model is comprised of 3 one-hour sessions spread over approximately the same number of weeks. So, youth typically attend a walk-in clinic session (presenting with anxiety and/or depression) and wait approximately a month to begin brief therapy (focusing on the same presenting concerns).

The proposed treatment model integrates the six phases of the walk-in clinic, dovetailing them into the brief therapy treatment model. To this research team's knowledge, no other treatment model incorporates the single session into short-term psychotherapy. Sections 1 and 2 of the walk-in clinic model are integrated into the first brief therapy session. Sections 3 and 4 are integrated into the second brief therapy session. Sections 5 and 6 are integrated into the third brief therapy session. Because of this dynamic, the research team chose to describe the EMT models matching the six sections to the three sessions. Thus, Sections 1 and 2 of the walk-in clinic session will be described with Session 1 of brief therapy. The remainder of the sections and sessions sequentially follow in order. A description of the treatment protocol is delineated below in Table 1.

Table 1. The Treatment Protocol: Integrating Walk-in Clinic and Brief Therapy Services for Anxiety and Depression with Youth.

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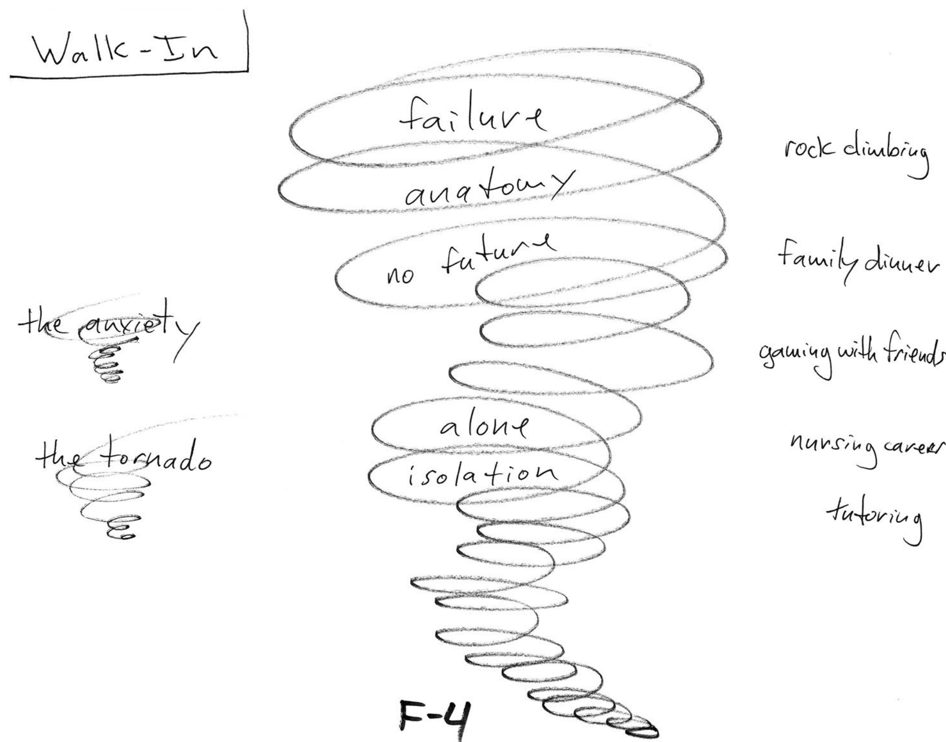

FIGURE 1 | Walk-in clinic.

4.1 | Walk-In Clinic (Sections 1–2) and Brief Therapy (Session 1)

In Section 1 of the walk-in clinic, the clinician asks the youth (and others present) to set the problem aside so that the clinician can get to know the youth and their strengths better. Often, problems dominate identity claims, and so it is important to create space for personal strengths that may be reactivated. The youth is asked directly to share their own strengths. Other members present may also contribute their perspectives on client strengths. The clinician may share their initial impression of client strengths in general that the client may align with (i.e., 'courage' for attending counselling). The same process occurs for client strategies, where the clinician asks the youth (and others present) to share those that have and have not worked against the presenting problem previously (Figure 1).

In Section 2, the clinician introduces a new way of thinking about problems. The catchphrase 'The person is not the problem; the problem is the problem' is commonly used to begin 'separating problem from self and externalising it from self'. Often, clients view anxiety and/or depression as part of who they are—an identity claim. The clinician further separates the problem from self by engaging in externalising and posturing language around the problem. The clinician inserts the article (the) before anxiety/depression, referring to the problem as 'the anxiety' or 'the depression'. Comparing the syntax differentiation is useful in this process, where 'I am anxious' or 'I am depressed' becomes 'The anxiety …' or 'The depression …'. Noun usage (Anxiety is … Depression is …) and personification (Anxiety grabs me … Depression holds me down …) are common ways that clinicians and clients may separate the problem from self. And pronouns may be used as placeholders for problems, such as it, its, they, them, their and the like. These all collectively contribute to the externalising of the problem.

In Session 1 of brief therapy, the process content from the walk-in clinic session (Sections 1 and 2) is purposefully reintroduced and integrated into this one-hour session. The client and others present will have had less than one month to consider and possibly practice their existing strengths/strategies and continue to separate the problem from their sense of self. Client strengths and strategies are reviewed together with resources (community, familial, school, financial, etc.) that the youth and others present have access to that may help the youth. With the problem still put to the side, the youth is encouraged to discuss their hopes, dreams, wants and wishes, which may include intimate relationships, friendships, family, peers, careers and life goals.

'Externalising and separating the problem from self' is reintroduced, and the client is asked to explain these concepts together with their current understanding. Often, visual descriptions of 'the anxiety' and/or 'the depression' are provided by clients, as they further develop a creative relationship with these problems. The problem is invited into the room, where its influences or impacts on the client are developed according to the youth's sense of self, sense of relationship with others and sense of life. The client is asked what the anxiety and/or the depression says about their sense of self. What does the anxiety and/or the depression say about their relationships? And what does the anxiety and/or the depression say about the youth's life? Implications for client thoughts, feelings and actions are reflected upon and reflected back to the client within this conversational territory.

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As a final step to this first of three brief therapy sessions, the youth is asked to evaluate what the problem wants for them and their life. Are they okay and in line with what the anxiety and/or the depression wants for them, for their relationships and for their life? The client (and possibly others present) has previously indicated their own hopes, dreams, wants and wishes. How do these fit with what the anxiety and/or the depression wants for them? These influences and impacts need to be addressed in terms of continuing with them or the client making a decision to ultimately take a position against the problem. Such highlighting, contrasting and intentional posturing between the two positions provide important information for the youth. Also, these dimensional qualities can be explored in terms of the client's past, present and future.

4.2 | Walk-In Clinic (Sections 3–4) and Brief Therapy (Session 2)

In Section 3 of the walk-in clinic, the clinician elicits a near experience of the problem with the youth. The reason for heightening a recent experience of the anxiety and/or the depression is to assist the client in defining and naming the problem. The problem is invited into the room, and the clinician asks the client for a more vivid description of the problem. Often, a very recent experience of the problem brings the youth in closer touch with the anxiety and/or the depression. Once the problem is more present, the client may begin naming the problem itself. The anxiety may become 'the monkey on my back', or the depression may become 'a looming rain cloud'. Clients may have already come up with a creative name and metaphor over the past month since their walk-in clinic session. If not, then time is spent getting to know a more visual, imaginative and concrete representation of the problem.

In Section 4, the concretising of affective states continues through the development of the client complex schema (metaphor). The anxiety schema or depression schema are organised cognitive categories of learned experiences throughout the youth's life, interacting with the world. The very definition of anxiety or depression is client-specific, as all youth have their own concepts of such problems. The client creates (or may have created in the walk-in clinic session) a metaphor as a natural extension of naming the problem through a variety of preferred, client-centred mediums (vision, audition, olfaction, gustation, taction). As a last step, the clinician ensures appropriateness in terms of its fit for severity. A mild-to-moderate presenting concern would have its corresponding visual representation (strong wind) that closely matches the anxiety or the depression. Likewise, a more severe presenting concern would have a complex schema (Level 5 tornado) that matches its severity level.

In Session 2 of brief therapy, the process content from the walk-in clinic session (Sections 3 and 4) is further reinforced through metaphor exploration across four domains. The continued development of the metaphor is the main focus of the second brief therapy session. Before this begins, the clinician reviews the externalising concepts of separating problem from self. However, this is done with the client teaching the clinician about such concepts. The clinician asks the client about the anxiety metaphor or the depression metaphor since the walk-in clinic session and the first brief therapy session. A metaphor check-in may occur should the client have developed one and continue to use it.

The clinician and youth embark upon a metaphor exploration across the four domains: (1) sense of self; (2) sense of relationship with others; (3) sense of life; and (4) relationship between the client's self and the problem. The externalised anxiety and/or depression metaphor is given space in the session. The clinician asks the client about their sense of self from the complex schema's perspective. What would the anxiety metaphor (Level 5 tornado), for example, say about who you are as a youth? What would the anxiety tornado say about your relationships with others? And what would it say about the youth's life in general? The relationship quality between the youth and the problem is also explored. What is the very nature or dynamic of the relationship? This process may provide client insights into their relationship with the problem.

The second brief therapy session ends with interviewing the metaphor in terms of its view of the client's hopes, dreams, wants and wishes for their life. What does the anxiety metaphor truly want for the client? What does the client hope for, dream of, want and wish for? These positions are often contrasted in stark opposition to what the problem wants for their life. The anxiety and/or the depression may have undisclosed covert plans for a youth's life in many regards, and it is useful to have them made known, brought to the forefront for clearer examination and investigation. In essence, their true nature and plans for the client.

4.3 | Walk-In Clinic (Sections 5–6) and Brief Therapy (Session 3)

In Section 5 of the walk-in clinic, the clinician helps the youth shift and transform the metaphor through their strengths, strategies and resources. The clinician reflects upon and holds up the strengths, strategies and resources to the metaphor to see their impact when incorporated into the metaphor. As a client gains personal strength, learns a new coping strategy or has greater access to a resource or support, this may impact the anxiety metaphor or depression metaphor. The youth's dynamic relationship with the metaphor may change proportionately as well. These changes may provide an immediate feedback loop of information for the youth and clinician, and as a result, may continue to change and shift the anxiety metaphor or depression metaphor.

In Section 6, the clinician reviews the steps thus far, including the following: creating strengths, strategies and resources; separating problem from self; naming the problem; developing a client-centred metaphor (complex schema); and integrating the strengths, strategies and resources into the ever-shifting metaphor. The client (and other members present) are assigned roles and responsibilities for the continuation of the metamorphosis of metaphor long after therapy has ended. One of the main goals is to keep this newfound knowledge, expressed through an interactive evolving metaphor, close to the youth and others. The youth is instructed to anticipate ongoing change in terms of the anxiety metaphor and/or depression metaphor, as they are mirrored images of the client problem. The youth leaves the walk-in clinic session with the plan of continuing to use the metaphor in managing anxiety and/or depression in their life.

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In Session 3 of brief therapy, the process content from the walk-in clinic session (Sections 5 and 6) is reviewed, and the final concepts are developed with the youth. Separating problem from self through externalising language and eventual metaphor development is discussed between the clinician and client. The youth is asked whether this externalised experience (including metaphor creation and use) altered their interpretations and experiences of the anxiety and/or the depression. The client is asked whether their metaphor has shifted from the previous session. If so, then the clinician continues with the session. If the metaphor has not been useful, then the client may create another metaphor and continue with this last session. Metaphoric change is the primary goal of this third session.

The previous or new metaphor is adjusted or shifted in the following three ways: (1) explore metaphor to see how it has evolved or changed, reflecting this back to the client for meaning; (2) use client strengths to see if the metaphor shifted; and (3) use client examples of successful strategies that have worked to evaluate metaphoric change. Future-oriented questions may also be asked to imagine how the metaphor might change should the youth: (a) continue to use their strengths, strategies and resources; (b) continue to view the problem as external and separate from themselves; and (c) take further posturing stances on what they want for their life versus what the problem wants for them.

The metaphor is once again further explored in terms of the four domains (sense of self, sense of relationship with others, sense of life, and relationship between self and problem metaphor). The clinician listens and integrates the aspects of thoughts, feelings and actions into the above domains as the client further unpacks their knowledge and experiences.

Lastly, the clinician helps the youth create a plan of action for using the metaphor as this final session ends. The client now has a complex schema metaphor embodying their understanding of anxiety and/or depression, with its impact upon their life. The metaphor is embedded with client strengths, strategies, resources and a new understanding of the self-problem relationship. The affective states of anxiety/depression have been externalised, separated from self and visually concretised. The client may continue to use the metaphor now that the brief therapy experience has ended.

5 | Case Illustration

5.1 | Walk-In Clinic (Sections 1 and 2)

Sage is a 19-year-old first-year college student enrolled in a nursing program in Ontario, Canada. He is from the province of Alberta, Canada, and has left behind the support of his parents, sister, high school friends and recent ex-girlfriend. Sage presents at the college walk-in clinic for mental health counselling services near the end of November, a month away from the beginning of examinations.

As the walk-in clinic session begins, the clinician immediately asks Sage to introduce himself from a strengths-based position around his personal strengths, thus putting the problem momentarily and purposefully aside. Sage shares that he has a close family connection with both parents, his younger sister and two close high school friends. He loves the rock climbing terrain of Alberta and indicates some pride in getting into the nursing program. The clinician shares the pioneering courage that all out-of-province students must have in leaving home and challenging themselves to grow. The clinician also highlights his bravery in seeking out mental health support through attending counselling services. Then, the clinician evokes strategies that Sage used in managing his mental health in high school, which mainly include rock climbing and hanging out with his girlfriend and friends.

The clinician introduces Sage to a new way of thinking about problems that separates them from himself. This is done because students often internalise and identify themselves with these mental health problems. The clinician tells Sage that 'the person is not the problem, rather the problem is the problem'. The clinician provides some common mental health examples of externalising through calling anxiety and/or depression 'the anxiety' and/or 'the depression'. 'I am anxious' becomes 'The anxiety …'. The clinician also uses its noun usage 'Anxiety is …'. This syntax posturing makes these mental health concerns more concrete and creates space between Sage and the problem. The clinician purposefully introduces pronoun placeholders (it, they, them, their) when referring to problems.

(*20 min*)

5.2 | Walk-In Clinic (Sections 3 and 4)

The clinician now asks Sage to invite the problem into the conversation and counselling room. Sage shares that he has been feeling increasingly anxious with December examinations fast approaching and a current failing grade in anatomy. Relatedly, he feels anxious because he has not really made any new friends at the college. Sage indicates that he is in a single dormitory room and keeps mostly to himself. He feels isolated and disconnected from past supports. In defining and naming the problem, the clinician asks Sage to get an immediate sense of the anxiety he experiences by describing the most recent example. Sage heightens his experience of anxiety by recalling failing the anatomy test yesterday. He worries that he will fail the course, be sent back to Alberta and have no career path in life. The clinician asks Sage to name this experience by labelling the problem. Sage names it simply: 'the tornado'.

In further externalising the problem, the clinician gets Sage to develop the tornado metaphor by unpacking its description. Sage describes the common Albertian metaphor as spinning all around himself and feeling caught in the middle with nowhere to go. He indicates that the speed of the tornado is rapidly increasing with its deadly impact upon his life. Sage feels alone, isolated and trapped inside the storm with no way out. He feels socially anxious about not having made new connections and being disconnected from existing family and friends back home. Living in a single dormitory room, all alone, confirms this solitary fact for him. Though his previous relationship break-up was mutual, he mourns not having such a close relationship this academic year. And lastly, the anatomy

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course is much more difficult than he had anticipated with the amount of memorisation involved. The clinician checks for appropriateness regarding the metaphor selection in terms of its matching his lived experiences of the presenting problem. Like a tornado, Sage indicates that it is dynamic and not static in that it can quickly change in terms of wind and damage. Sage shares the F-Scale with the clinician, indicating six levels: F-0, F-1, F-2, F-3, F-4 and F-5. He also indicates that he had expected college life to be difficult, tornado-like, but not this difficult. The clinician and client agree that the metaphor's shifting intensity and damage closely match his experiences of anxiety and agree to use this client-centred metaphor. Sage draws a picture of the metaphor to further externalise and concretise this presenting problem as an 'F-4 Devastating Damage Tornado (330-410km/h)'.

(*20 min*)

5.3 | Walk-In Clinic (Sections 5 and 6)

The clinician and Sage discuss his previous strengths, strategies and resources that he can reactivate and build into the tornado's path. Sage loves rock climbing and is encouraged to join the college rock climbing club, though it would be different, perhaps less interesting than his Alberta experiences. Joining such a club could expand his social network, where he may make friends through this common interest. He also has great confidence in his rock climbing abilities, so the activity itself will be very easy for him.

The clinician and Sage plan to further develop his prior social network through Sunday night family FaceTime dinners with his parents and sister. Sage agrees to connect back with his parents for the family support he relied upon in high school. He also plans to reconnect and schedule a multiplayer gaming group with his old high school friends. Lastly, Sage indicates he will attend an after-class tutoring service to help with his anatomy course.

A feedback loop of information is provided to the client as he begins to use these strengths, strategies and resources while paying close attention to the tornado metaphor. Now, he can know which ones are more effective and under which circumstances he may use them. As the session ends, the clinician reviews the steps taken in the walk-in clinic session. The clinician draws attention to anticipating ongoing change for Sage with respect to the tornado metaphor, as it will continue to shift like the weather. The client leaves the session with a plan to use the metaphor that encapsulates both the problem and the strengths, strategies and resources that Sage can use.

(*20 min*)

5.4 | Brief Therapy (Session 1)

As Sage begins brief therapy, the clinician purposefully reintroduces and summarises the walk-in clinic content from a few weeks ago. Together with Sage, the strengths, strategies and resources are highlighted once again. The clinician checks in to see if Sage reconnected with family and friends, joined the rock climbing club and sought academic support services from the college's student success office. In addition to this, Sage is encouraged to share his hopes and dreams for his immediate life and future plans. He shares a vision of himself returning to Alberta for the winter vacation, having passed the first academic term and having befriended a few fellow students at the rock climbing club.

The clinician asks Sage to explain his understanding of separating problems from self through externalising them. Sage uses the externalised tornado he drew and developed in the walk-in clinic session. He identifies reflecting upon the named problem, 'the tornado', during the past two weeks, where he consciously tracked it and reflected upon it during his daily student life. The clinician asks Sage to describe its influence on his sense of self, sense of relationship with others and sense of life. Sage indicates that the tornado makes him feel less confident and lowers his self-esteem, which leads to greater isolation and feelings of sadness. Sage expresses that the tornado has cut him off from family and friends, as it gets in the way of relationships. Lastly, it is on a destructive path towards destroying the kind of life he wants to lead (e.g., independent living, marriage, children and a rewarding career helping others). The clinician ties the impacts of the tornado to Sage's thoughts, feelings and actions/inactions. The influences of the tornado are far-reaching, and its general message conflicts with Sage's life purposes. The tornado is about destruction, isolation and failure, according to Sage.

The clinician asks Sage to evaluate (1) what the tornado wants for Sage's life and (2) what Sage wants for his life. They evaluate and contrast these two positions. Sage compares the two as almost opposites, especially in terms of how it impacts his self-concept, close and newly developing relationships, and career in nursing that will successfully lead him into the adult life he envisions. Sage is encouraged to look for tornadoes in his recent past (final year of high school), present (current tornado) and projected future (once college ends and he returns to Alberta). The clinician helps Sage view the tornado from these dimensions as he has had successes with anxiety in the past, has some current successes and can plan for better managing anxiety in his future. If the client had previously developed a metaphor that represents the problem, then the clinician can check in on that metaphor to see if and how it has changed. Sage indicates that he has just noticed it showing up in relationships and his academic struggles with anatomy.

(*60 min*)

5.5 | Brief Therapy (Session 2)

As in the first brief therapy session, the clinician and Sage review the separation of problem from self through externalising. It is Sage's responsibility to teach the clinician these concepts, with the clinician asking questions for clarification and consolidation, with Sage using his own examples. Once the clinician feels Sage can clearly convey these ideas, Sage is asked to give an account of the tornado since the walk-in clinic and the first brief therapy session. Sage indicates a shift in the metaphor that now includes twin tornadoes—a smaller one representing his

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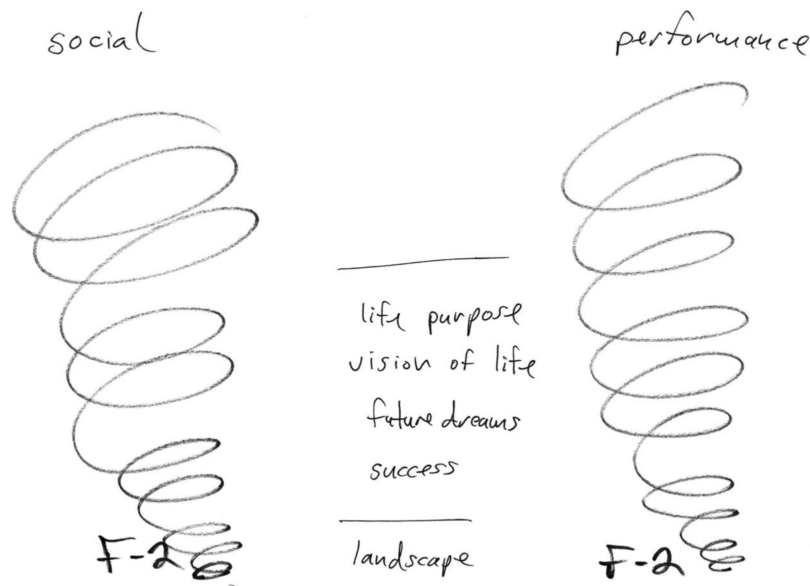

FIGURE 2 | Brief therapy: session 2.

experiences of social anxiety and another smaller one representing his experiences of performance anxiety. Each metaphorical tornado has decreased in terms of its magnitude. For Sage, the splitting of the tornadoes makes sense in that the strengths, strategies and resources he has been using since starting therapy now impact the original tornado differently. Thus, he indicates they have split into two different ones, responding uniquely to his attempts to decrease their influences on his life (Figure 2).

The clinician repeats the process of the first session in terms of asking questions about the influences of anxiety on sense of self, sense of relationship with others and sense of life. An additional quality is added, which highlights the relationship between client and problem. Sage deepens his understanding of the influences of the anxiety metaphor on these areas. He also notices the impact of using his strengths, strategies and resources on the anxiety metaphor. Through actively engaging in using these, the splitting of the tornado has resulted in two tornadoes with less intensity. Sage draws the metaphor that has shifted and labels them as 'F-2 Significant Damage Tornadoes (180-249km/h)' or 'The Twin Tornadoes'. He deepens his understanding by showing their influences on his life, but also his influences on the twin tornadoes. As he grows stronger, the twin tornadoes grow weaker, and as he grows weaker, the twin tornadoes grow stronger. Sage measures their strength and his own strength in relation to them. He can transform and shift them, which demonstrates that their potential to affect his life is completely modifiable.

The nature and dynamics of the relationship between Sage and the twin tornadoes are further explored in terms of what they want for his life, hopes and wishes. In a sense, the continued course of the twin tornadoes is evaluated. Looking at their past, present and future relationship with the client can provide him with the answers to many of these questions. The twin tornadoes' agendas for Sage are those of typical tornadoes; they do not come out of nowhere, and certain conditions need to be present for them to arise. He explores further what circumstances in his life have given rise to these tornadoes, then draws the two shifted tornadoes while labelling them.

(*60 min*)

5.6 | Brief Therapy (Session 3)

As in the first two brief therapy sessions, the clinician and Sage review the 'separating of problem from self' through externalising language and its concretisation through client-centred metaphors. The clinician checks in to ensure that the strengths, strategies and resources are still being implemented and incorporated into the metaphor. Sage evaluates his shifting understanding and interpretation of anxiety and his relationship with it as an externalised entity. Sage indicates that 'the twin tornadoes' has been a useful metaphor (Figure 3).

The clinician encourages further shifting of the metaphor and the relationship between the client and metaphor. The clinician notices that the splitting creates a path to different management strategies for each tornado. Across social versus academic settings, Sage identifies that he prepares himself and responds to these anxieties differently. The immediate and long-term courses of the tornadoes give meaning to Sage as their destructive paths zigzag through all facets of his life without regard for his hopes, dreams and wishes. The clinician and Sage hold up each strength, strategy and resource to see how it impacts each respective tornado. For example, Sage and family have

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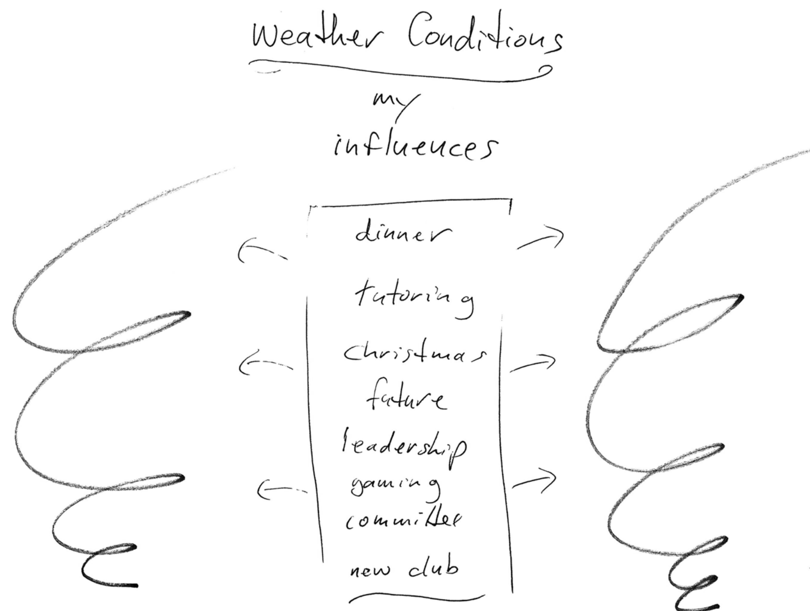

FIGURE 3 | Brief therapy: session 3.

developed a Sunday night dinner ritual where they eat together virtually. Sage shares and unpacks his week with his mother, father and sister, something he looks forward to earlier in the week. This planned change has lessened the magnitude of the social anxiety tornado. Sage also attends regular peer tutoring to pass his upcoming anatomy examinations. He feels more on track, especially with improved memorisation efforts and scheduling regular study times outside of peer tutoring. The path of the performance anxiety tornado seems to be shifting away from destroying his grades in this course and possibly his entire academic year. The clinician employs some future-oriented questions around what the tornadoes will look like in weeks, months and years if Sage were to continue using his strengths, strategies and resources. Sage expresses more hope in his future through projecting the weather he creates for himself.

The clinician returns to an exploration of Sage's shifting sense of self, shifting relationships with others and shifting sense of life with the metaphor. Sage describes taking on more of a leadership role in the rock climbing club due to his interviewing skills course and related assignment. Sage describes joining the executive committee in order to promote the club through a province-wide competition, where he will receive additional course credits. He also games with his high school friends on Wednesday nights. Sage expresses that his dream of becoming a nurse feels more attainable now. He has evidence of altering the course of the performance anxiety tornado and decreasing the winds of the social anxiety tornado. He indicates it feels more like an interactive relationship rather than a fearful, unpredictable relationship.

Sage and the clinician prepare for the ending of brief therapy together. They discuss the concern for reverting back to isolating himself socially and academically procrastinating. Sage acknowledges his responsibility for creating the conducive environment for the twin tornadoes to develop and flourish. Sage plans to monitor and grade them over the coming weeks, leading up to his winter vacation in Alberta. Through the college's student success office, he will prepare to enrol in even more challenging courses than anatomy in the spring academic term. Sage further commits to spending time with high school friends and further consolidating their gaming team in person during vacation. He plans to continue rock climbing with the executive committee and join another college club. Sage ends the final session with his evolving drawings of the twin tornadoes, knowing that they and the environment Sage creates will continue to shift.

(*60 min*)

6 | Discussion

Prevalence rates for anxiety and depression among youth were noted after the onset of the COVID-19 pandemic with efforts in therapeutically treating this clinical population. Walk-in clinics and brief therapy are common forms of treatment in Ontario, Canada, with minimal evidence from small-scale clinical trials and randomised controlled trials. The research team noted that these treatment models exist separately, and their clinical processes are not purposefully and structurally integrated. This disconnect in process continuity may result in inefficient service delivery and, most importantly, client outcomes.

The research team also drew attention to the existing 'one-size-fits-all' generalist approach to the single-session counselling

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model (offered through walk-in clinics). Mental health therapists are trained to address all presenting concerns with one therapeutic approach, rather than using specific approaches that are for specific presenting concerns, such as anxiety and/or depression. No specific walk-in model exists that therapeutically addresses internalising problems, such as anxiety and/or depression.

A new treatment intervention was highlighted (EMT) that integrates the processes of the single-session model with the brief therapy model. Additionally, the EMT model was developed to therapeutically address internalising problems. The current article outlined this novel therapy approach to treatment through a detailed description, an integrative treatment protocol and a case illustration.

Testable hypotheses may be explored through the clinical evaluation of the current integrative 1 + 3 session treatment model. Perhaps most importantly, it will be important to know if integrating the single-session process into a subsequent three-session process improves outcomes for youth presenting with anxiety and/or depression. A randomised controlled trial using a comparison group (treatment as usual) will help evaluate this hypothesis through pre-post psychometric outcome instruments.

Within and across session change will provide important information about which aspects of the single session (each of the six sections) impact each of the subsequent three brief therapy sessions. If clients do well in Sections 3/4, are their improvements related to Session 2? This would be expected because they are the most closely related in terms of the change process. Likewise, the other sections (1/2, 5/6) and sessions (Session 1, Session 3) should be empirically related, which is another testable hypothesis of such an integrative model.

This article has presented a new integrative approach to mental health treatment for youth presenting with anxiety and/or depression. Moderators of change may be explored to evaluate their efficacy and compare them with treatment as usual for this clinical population. Such exploratory clinical research into developing new models of change is important for existing treatment models and for the field of youth mental health.

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Conflicts of Interest

The authors declare no conflicts of interest.

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