A clinical research project evaluating a newly structured, 4-session treatment intervention for anxiety through a multisite clinical trial

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Overview

1. Introduction and Brief Services
2. Brief Task Acquisition Scale
3. Best Practices in Brief Services
4. Innovative Moments (Portugal)
5. Results of 2 pilot studies: Transitional-aged youth
6. The Treatment Protocol: A multi-site clinical trial
Brief Services

- single session, walk-in, and 1 to 3 sessions
- assessing outcome measurement: change
- historical methods of measuring change, BS
- a newly suggested paradigm shift
The Myth

- counselling (BAS) vs psychotherapy
- just supportive counselling built on strengths
- offering of tips and ideas
- psycho-education focused
- little change is possible due to time factor
- results not comparable to long-term
Brief Task Acquisition Scale

- has a defined structure and process
- more than tips, ideas, and psychoeducation
- great change is possible due to time factor
- relatively new psychotherapy modality
Current context

• practitioners with experience delivering evidence-based (e.g. CBT, behavioural, solution focused) and popular (e.g. narrative therapy, emotion-focused) interventions were invited to discuss ‘common factors’ of the intervention components in only 4 sessions

• candidate components were identified as ‘tasks’ or goals common to these approaches, and potentially helpful in short-term intervention
• How much did the symptom reduce?
  - symptom reduction measurement
  - pre and post session evaluation

VS

How did the symptom reduce?
  - process of change client experienced
  - within session evaluation (and across)
Structure and Process Differences

long-term

{1 2 3} 5
6 10
11 15

short-term

1
2
3

single session

1
Redefining Outcome Measurement: A Model for Brief Psychotherapy

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Context: The zeitgeist for short-term psychotherapy efficacy has fundamentally shifted away from evidence-based practices to include evidence-informed practices, resulting in an equally important paradigm shift in outcome measurement designed to reflect change in this short-term modality.

Objective: The present article delineates a short-term psychotherapy structure which defines four fundamental stages that all brief therapies may have in common, and are represented through Cognitive Behavioral Therapy, Solution-Focused Brief Therapy, Narrative Therapy, and Emotion-Focused Therapy.

Method: These four theoretical approaches were analyzed via a selected literature review through comparing and contrasting specific and common tasks as they relate to the process of psychotherapy and change. Once commonalities were identified within session, they were categorized or grouped into themes or general stages of change within the parameters of a four to six session model of short-term therapy. Commonalties in therapeutic stages of change may more accurately and uniformly measure outcome in short-term work, unlike the symptom-specific psychometric instruments of longer-term psychotherapy.

Results: A systematic framework for evaluating the client and clinician adherence to 20 specific tasks for these four short-term therapies is presented through the newly proposed, Brief Task Acquisition Scale (BTAS). It is further proposed that the client–clinicians’ adherence to these tasks will track and ultimately increase treatment integrity.

Conclusion: Thus, when the client–clinician relationship tracks and evaluates the three pillars of (1) stage/process change, (2) task acquisition, and (3) treatment integrity, the culmination of these efforts presents a new way of more sensitively measuring outcome in short-term psychotherapy. Data collection is suggested as a first step to empirically evaluate the testable hypotheses suggested within this current model. Copyright © 2015 John Wiley & Sons, Ltd.

Key Practitioner Message:
- The clinician practitioner will note that the proposed Brief Services model removes the subjectivity of client satisfaction as a reliable outcome measure, and relies upon client and therapist adherence to specific tasks and stages of change within and across short-term psychotherapy.
- The clinical significance of the BTAS for the practitioner is three fold. The psychometric instrument (1) tracks stage or process change, (2) guides task acquisition, and (3) incorporates greater treatment integrity unlike other outcome measures.
- The BTAS present a new way of conceptualizing change in short-term psychotherapy regardless of modality or presenting issue, making it a more flexible and usable instrument for the clinician.
Cognitive Behavioral Therapy

In terms of defining and assessing the problem, CBT theorists and clinicians stress the importance of developing and maintaining a strong therapeutic relationship with the client from the first point of contact, and developing realistic goals for short-term work. While clients are instructed about the cognitive model, and educated about their problems, it is essential to work on reducing their distress. Clinicians also set in motion a process of socializing clients into therapy by instructing them about homework and its importance, by setting an agenda, by eliciting their reactions to the therapeutic process and by making sure that they understand what the clinician is thinking and proposing.

Solution Focused Brief Therapy

The first stage of Solution Focused Brief Therapy work involves three main objectives: (1) inquiring about pre-session change, (2) discovering the strengths and resources of the client; and (3) defining the 'problem' and what the client wants different as a result of coming to therapy (solution and attainable goal). Main interventions include looking for previous solutions, looking for exceptions, questions instead of directives or interpretations, present and future-focused questions, assigning tasks, and compliments. Specific interventions consist of the 'Miracle Question', 'Solution-Focused Goals', and 'Scaling'.

Narrative Therapy

The client-clinician relationship may explore strengths and resources embedded within rich stories past, present, and even future. Deconstructing the problem begins by naming it, exploring its impact upon the areas of the client's life. Problems are identified, objectified, personified, and externalized, first through the use of language, and often later, in clinician-generated metaphors. A resulting person-and-problem relationship is described and viewed as separate entities, impacting upon the client's view of self, others, and life. The relationship begins to explore exceptions or unique outcomes that subvert the existing problem saturated story, and then taking position against the problem.

Emotion Focused Therapy

While an assumption of Emotion Focused Therapy is that emotions are fundamentally adaptive in human survival and well-being, emotional processes can become problematic for people as a result of past traumas or even ongoing misattunement between the person's emotional needs and what is available in their environment, leading to a pattern of emotion avoidance. This avoidance results in increasing pain and distress, as well as interfering with the individual's ability to identify their needs and goals.
Stage 1: Defining and assessing the problem

1. Name the problem and develop a common understanding

2. Identify influences of problem within areas of life

3. Explore the severity, or size, of the problem

4. Evaluate preferences, commitments, and motivations for change

5. Assess strengths and resources as they relate to problem
Stage 2: Shift the problem

6. Brief review and assess readiness/motivation to begin change

7. Explore experiences of emotion, beliefs, and actions as they relate to the problem

8. Further develop the change that is already happening

9. Develop positive action oriented plan and signs that it occurs in other aspects of life

10. Encourage smaller, manageable steps to maximize the likelihood of success based upon abilities
Stage 3: Change the problem

11. Review understanding of problem and progress since last session

12. Pay attention to and reflect what is working and do more of that

13. Assign tasks that clarify and build on plan, goals, and exceptions

14. Make small adjustments based on what the client is already doing, thinking, and feeling

15. Identify expected change between session, new change areas, and build independent support after ending
Stage 4: Generalize and maintain the change

16. Develop plan to maintain the change, while including the support from others to sustain this change

17. Expand the change to include other areas

18. Anticipate and plan for obstacles to continued success, and when getting off track

19. Evaluate to what extent the tasks, stages, and change resulted in the goal for therapy

20. Discuss ending and possible need for other services *
# Process Evaluation

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Internalizing VS Externalizing
BTAS Summary

• one size doesn’t fit all (short vs long-term)

• unifying structure and process of change

• 20 tasks representing 5 therapy schools

• greater treatment integrity: common structure

• time-sensitive information for client-clinician

• save resources due to duplication of services
• clients contribute directly to outcome
• psychotherapy is more transparent than ever
• offers clinician and agency PD information
• introduces a new language of change
• provides ‘profiles’ on specific problems
• serves as treatment monitoring tool
• relies upon continuous evaluation/feedback
• affirming change = increasing motivation
Evidence-based treatments

BEST PRACTICES IN BRIEF SERVICES
In subjects presenting with **CBT for generalized anxiety disorder**, 11 studies contributed an effect size of **0.92** for clinically-representative studies (95% CI = 0.77-1.07), and depression scores also decreased **0.89** (0.70-1.07). Patients were allowed concurrent treatment such as medication. (Stewart & Chambless, 2009).

Westbrook & Kirk (2005) examined effectiveness of 906 patients presenting at a free adult mental health clinic for various concerns. Mean number of sessions was 13.2 (SD = 5.7), in which therapists used a **wide variety of counseling or treatment**. When applying symptom measures regardless of presenting concern, **BDI 0.67** and **BAI 0.54**. When examining only those records above clinical cut-offs, BDI 1.15 BAI 0.94. 0.54 was therefore used in this study to best match the current sampling techniques.

Finally, Minami and colleagues (2007) report an unstandardized mean difference in BDI scores of **1.86** in a review of 29 psychotherapy outcome studies involving 1 387 participants with **depression**.
• Searched PsycINFO and the Cochrane Collaboration for outcome studies, review papers, and meta-analyses from January 1990 to January 2012.

• Keywords “intervention" OR "therapy" OR "outcomes" AND "child*" OR "adolesc*" OR "family" AND "outcome*" OR "trial*". The search was limited to English-language, peer-reviewed journal articles.

• Search strategies also included a thorough investigation of reference lists in relevant review articles and personal communications with authors of relevant studies.

• The inclusion criteria for the present meta-analysis were the following:
  – nature of treatment was limited to psychotherapy;
  – treatment was delivered within 6 sessions, weeks, and hours;
  – youth were 19 years of age and younger;
  – youth were the clinical focus of treatment;
  – there was sufficient information to calculate an effect size;
  – outcome was measured in terms of change in psychological symptoms.
Meta-analysis of brief treatment
Carlson & Armstrong, unpublished

Youth
k = 6

Parent
k = 8

Clinician
k = 7
Brief Services

d=1.0
Building success: Defiance / Opposition

Treatments

- EMDR
- Family Relations
- Problem Solving
- Triple P

OLS weighted regression predicting parent ratings

k = 6
Building success: Anxiety / Mood

Treatments

k = 6

OLS weighted regression predicting clinician ratings
#Treatments That Work for Brief Children’s Services

- **Three** controlled trials indicating EMDR / imaginal exposure for traumatic stress
- **Three** controlled trials indicating exposure for specific phobias (OST)
- **Two** controlled trials indicting parent management training (PCIT/PPP) for child defiant behavior
- **Two** controlled trials note a number of interventions possibly efficacious for youth anger (anger mgmt, CBT, EMDR)
- **Three** clinical trials note promising practices of stress management / solution focused / cognitive-behavioural approaches for interlananizing problems
Innovative Moments

• Unique Outcome or Exceptions to the Problem
• 7 types of Innovative Moments
• Between session worksheet (BTW S1+S2)
• Examples of IMs for anxiety

• 800 transcripts coded
• Active priming of IMs in psychotherapy
Diagram of Work Between Sessions

An heuristic model of good outcome cases

- Former problematic narrative
  - Action IMs
  - Reflection IMs
  - Protest IMs

- Therapy evolution

- Reconceptualization IMs
  - New Action IMs
  - New Reflection IMs
  - New Protest IMs

- Performing change IMs

- New Emergent Self Narrative
Transitional-Aged Youth: Pilot Study (4 Ontario Universities)

• To evaluate the size and nature of effects of a proposed short-term treatment for anxiety and stress difficulties

• This information will be used for the design of subsequent clinical trials
Participants

• Eligibility
  – Included students presenting concerns of stress and anxiety at post-secondary counseling centers.

• Exclusion criteria
  – Diagnosis of OCD, PTSD, PD, or other severe mental illness
  – Moderate to severe risk of self-harm or harm to others
Baseline Assessment
- Demographics
- STAI
- DASS

Session #1

Session #2

Session #3

Endpoint Assessment
- STAI
- DASS

Evaluation Wrap-up
Figure 1. Participant allocation flow diagram.

Multi-site EMT Evaluation

Enrollment

Cluster #1 (Nipissing / Laurentian)
- Excluded (n= n/a)
  - Not meeting inclusion criteria
  - Declined to participate

Allocated to EMT (n= 18)

Follow-up
- Lost to follow-up (n= 0)
- Discontinued intervention (n= 0)

Analysis
- Analyzed (n= 18)
  - Excluded from analysis (n = 0)

Cluster #2 (Ottawa / Carelton)
- Excluded (n= n/a)
  - Not meeting inclusion criteria
  - Declined to participate
Randomized

Allocated to EMT (n=32)
- Anomaly in randomization resulted in overassignment to this condition

Allocated to TAU
- Anomaly in randomization resulted in underassignment to this condition

Follow-up

Lost to follow-up (n=n/a)
Discontinued intervention (n=0)

Analysis

Analyzed (n=32)
- Excluded from analysis (n=0)

Lost to follow-up (n=n/a)
Discontinued intervention (n=0)

Analyzed (n=15)
- Excluded from analysis (n=0)
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<td>General and social anxiety¹</td>
<td>14 (28%)</td>
<td>18 (36%)</td>
<td>18 (36%)</td>
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<tr>
<td>Depression and Dysthymia²</td>
<td>11 (23.4%)</td>
<td>8 (17%)</td>
<td>28 (59.6%)</td>
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<td>Personality disorders</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>48 (98%)</td>
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<tr>
<td>Alcohol or substance use disorders</td>
<td>0 (0%)</td>
<td>2 (4.1%)</td>
<td>47 (95.9%)</td>
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</table>

1. Includes Social Anxiety Disorder, Generalized Anxiety Disorder and Anxiety Disorder Not Otherwise Specified
2. Includes Major Depressive Disorder and Dysthymic Disorder
3. Includes Specific Phobia, Panic Disorder, Obsessive Compulsive Disorder, and Post-traumatic Stress Disorder
Difference between baseline & endpoint

- Depression (n=48): $p < 0.005$
- Anxiety (n=48): $p < 0.005$
- Stress (n=48): $p < 0.005$
- Trait Anxiety (n=46): $p < 0.005$
EMT
d=0.95
Equivalence to Treatment as Usual

- EMT proved as effective as typical intervention in an exploratory analysis of control-group data
- Independent samples t-tests revealed no significant differences in raw change scores (i.e., pre – post) for
  - DASS-21 Depression \[t(42) = .057, p = .96]\,
  - DASS-21 Anxiety \[t(42) = -1.069, p = .29]\,
  - DASS-21 Stress \[t(41) = -.56, p = .58]\, or
  - STAI Trait Anxiety \[t(40) = -.231, p = .818]\.
The EMT Treatment Protocol

An overview of the structured, 4-session treatment intervention
Development of EMT

• a short-term treatment intervention for internalizing behaviors: Externalizing Metaphors Therapy

• based upon an externalizing process, transforming of metaphoric imagery, and shifting underlying maladaptive emotional schemas

• two specific change processes: (1) externalizing of problems, (2) purposeful client-generated metaphor manipulation impacting upon underlying schemas

• treatment protocol based upon Narrative Therapy (externalizing and deconstruction) and Metaphor Therapy (metaphor transformation)
• relevance for brief services and in its versatility for the clinical populations: (1) children and adolescents, (2) high functioning autism (3) adults with dual-diagnosis, and (4) adults in general.*

• EMT treatment protocol may be taught through a one-day training event lasting only 6 hours

• a 3-session model for anxiety and depression, offered individually (possibly group format, pilot)

• offers a model for clinically evaluating a new Brief Services model within transitional aged youth and CMH settings
Externalizing Metaphors: Anxiety and High-Functioning Autism

Everett McGuity, MA, David Armstrong, PhD, John Nelson, MA, and Stephanie Sheeler, BA

Everett McGuity, MA, is Child and Family Therapist, Hands TheFamilyHelpNetwork.ca; David Armstrong, PhD, is Psychologist (Supervised Practice), Hands TheFamilyHelpNetwork.ca, and Director, Behavioral Health Sciences Lab Nipissing University. John Nelson, MA, is Psychological Associate, Hands TheFamilyHelpNetwork.ca; Stephanie Sheeler, BA, is a Research Assistant, Behavioral Health Sciences Lab, Nipissing University, North Bay, Ontario, Canada.

Search terms: Asperger's, externalizing, high-functioning autism, metaphor, narrative therapy

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TOPIC: The intent of this article is to explore the efficacy of both the literal and concrete externalization aspects within narrative therapy, and the implementation of interactive metaphors as a combined psychotherapeutic approach for decreasing anxiety with people who present with high-functioning autism.

PURPOSE: The purpose of this exploratory article is to propose the use of externalizing metaphors as a treatment modality as a potentially useful way to engage clients. Specifically, a three-step process of change is described, which allows for concretizing affective states and experiences, and makes use of visual strengths of people presenting with an autism spectrum disorder.

SOURCE: A selective review was conducted of significant works regarding the process of change in narrative therapy, with particular emphasis on metaphors. Works were selected based on their relevance to the current paper and included both published works (searched via Psyc-INFO) and materials from narrative training sessions.

CONCLUSIONS: Further research is needed to address the testable hypotheses resulting from the current model. This line of research would not only establish best practices in a population for which there is no broadly accepted treatment paradigm, but would also contribute to the larger fields of abnormal psychology, emotion regulation, and cognitive psychology by further elucidating the complex ways these systems interact.

Pervasive developmental disorders (PDDs) represent a number of syndromes sharing impairments in reciprocal social interaction and communication skills, as well as the presence of restricted, repetitive, and stereotyped patterns of behavior (American Psychiatric Association, 2000). Estimates of prevalence rates of PDD range from 2.5 to as high as 10 in 1,000 individuals (Center for Disease Control and Prevention). HFA and Asperger’s disorder toward the treatment of comorbid anxiety.

Individuals with HFA may also have other conditions of clinical focus, such as anxiety. Prevalence studies utilizing structured clinical interviews in the assessment of anxiety reported co-occurring anxiety disorders in over 40% of individuals with ASD ages 2 to 18 (de Bruin, Ferdinand, Meester,
EMT: Autism

- explored the efficacy of both the literal and concrete externalization aspects within Narrative Therapy, and the implementation of interactive metaphors as a combined psychotherapeutic approach for decreasing anxiety with high-functioning autism

- a change process is described which allows for concretizing affective states and experiences, and makes use of visual strengths of clients (HFA)

- Cashin - externalizing (2005); Ory – metaphors (2004); Nash - storage of image vs narrative (2002)
A Clinical Treatment Intervention for Dysphoria: Externalizing Metaphors Therapy

Everett McGuinty,1 David Armstrong1,2 and Anne-Marie Carrière2,3

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2 Nipissing University, North Bay, Ontario, Canada
3 Lakeshore Medical Centre, North Bay, Ontario, Canada

The purpose of this article is to explore a novel, short-term treatment intervention for internalizing behaviours. This intervention is primarily based upon an externalizing process, transforming of metaphoric imagery, and shifting of underlying maladaptive emotional schemas. This article addresses the clinical population of children and youth, specifically through outlining the protocol, externalizing metaphors therapy. A selective review of significant works regarding the efficacy of short-term therapy was conducted, including the process of change within narrative therapy. It is proposed that two specific processes account for the mental health change experienced by clients who receive this new treatment intervention: (1) externalization of problems and (2) purposeful client-generated metaphor manipulation, impacting upon underlying schemas. From these theoretical constructs, the present article outlines a three-session treatment protocol that manualizes these key clinical processes. A case study is presented to illustrate this intervention for anxiety and depression. Further clinical research is underway to address the testable hypotheses resulting from the current theoretical model. Clinical trials in brief psychotherapy are suggested to empirically evaluate the efficacy of this new treatment intervention for dysphoria.

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Key Practitioner Message:
- This article outlines a short-term treatment intervention for anxiety and depression (dysphoria) through a novel 3-session model, where the clinician-practitioner can obtain competency through a one-day workshop.
- Its relevance for the clinical researcher and the mental health community is in its versatility in addressing internalizing behavior for four clinical populations: (1) children and adolescents; (2) children and adolescents on the autism spectrum; (3) adults in general; and, (4) adults with a dual-diagnosis.
- The treatment protocol described within is based upon the externalizing and deconstructive properties of Narrative Therapy, and the transformation of metaphoric imagery of Metaphor Therapy; both of which have little empirical support with narrative practices gaining international attention and widespread usage - through brief therapy, long-term therapy, and walk-in clinics in North America.
- For the first time, the theoretical constructs of the 3-session model are described and a case example illustrates the interlinking concepts.

Keywords: Anxiety, Depression, Externalizing, Metaphors, Schemas, Dysphoria

Although estimates of psychotherapy dropout rates vary, the evidence strongly suggests that the majority of clients do not attend 12–25 sessions, which are typical of protocols in clinical research. In a 2002 article, Hansen, Lambert and Forman suggested that one-third of clients attend only one session, with 50% dropping out of treatment within three clinical realities clients present with do not often match the evidence-based resources available to them and their families. Government funding in managed health care, for many countries, has recently led to a brief services zeitgeist; hence, clinical research on short-term treatment interventions and outcome studies is becoming an important focus, especially...
EMT: CMH

- A Clinical Treatment Intervention for Dysphoria: Externalizing Metaphors Therapy, Clinical Psychology & Psychotherapy (2013)
- shortened version of treatment protocol (table)
- structure of each session is outlined
- training exercises for clinician in training
- case study with Tommy & Kathleen, 3 sessions
- literature review of Brief Services
Session #1: Externalizing the problem

1. Strengths/resources with hopes, dreams and wishes
2. Externalization introduced
3. Influence/impact of the problem on three domains (sense of self, sense of others/relationship and sense of life) and three aspects (thoughts, feelings and actions)
4. Evaluation—posturing
5. Exercises: (a) strength/resources list compared to (b) what the problem wants for client’s life list
Session #2: Metaphor development

1. Externalizing 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
5. Intervention choice: relaxation, cognitive restructuring and problem solving
Session #3: Metaphor shift

1. Externalizing 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 client examples of success to see if metaphor changed; (d) use the exercises taught to see if metaphor has changed
Session #3: Metaphor shift (continued)

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. Intervention choice: relaxation, cognitive restructuring and problem solving

5. Create a plan of action
Session #4: Maintenance and Generalization

1. Client and guardian review externalizing language clinician takes outsider witness position
2. Review the 7 IMs since treatment group began
3. Expand upon domains impacted by anxiety into other areas of life (Generalization)
4. Maintenance plan – client directed to use same metaphor in other domains of life, affirming an active plan to further shift metaphor after therapy ends
Treatment Group: Pilot Study

- **MASC2 pre-measurement**
  
  Session 1. Externalize the problem

  Session 2. Create metaphor

  Session 3. Shift metaphor

  Session 4. Maintain and generalize change

- **MASC2 post-measurement**

  * IMs between session exercises

  * International Journal of Group Psychotherapy
Multi-site CMH Pilot Study

• Pathstone Mental Health (2 CFTs = 20 clients)

• HN REACH (2CFTs = 20 clients)

• Hamilton Health Services (2CFTs = 20 clients)

• Recruitment of 2 other CMHO agencies (40)
Baseline Assessment
- Demographics
- Pre measurement
- MASC2
- Parent/Youth forms

Session #1

Session #2

Session #3

Session #4

Endpoint Assessment
- Post measurement
- MASC2
- Parent/Youth forms
Questions?