Virtual Walk-In Single Session Therapy: A Multiple-Case Study of Parents' Self-Efficacy

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Abstract

Various community-based mental health and family agencies offer walk-in counselling services, where clients are provided with immediate access to a single session of brief therapy without appointments or referrals. Several studies have demonstrated the effectiveness of single-session therapy (SST) delivered within walk-in counselling clinics. This type of service delivery model has been found to be helpful for parents, who experience decreased hopelessness and psychological distress by increasing their confidence about their parenting. The purpose of this multiple case study was to investigate how parents perceived their parenting self-efficacy over time following a virtual single-session therapy at a children's mental health centre. Additionally, this study explored how parents perceived their overall experience utilizing this type of service delivery model. Eight mothers participated in a retrospective individual interview. Findings indicate that virtual SST provided parents with greater parental knowledge and concrete collaborative problem-solving strategies that improved parent-child interactions. Further, the emotional support received at the SST reduced parents' distress while increasing hopefulness in the parenting role. In addition, parents valued the accessibility and convenience of the virtual option. Overall, the findings of this study provide evidence that virtual SST can be beneficial for parents and can foster parental self-efficacy.

Keywords: walk-in clinic, virtual therapy, single-session therapy, counselling, parental self-efficacy, community mental health centre

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Introduction

Over the recent decade, a growing number of community-based mental health and family agencies have implemented a walk-in counselling model of service delivery, where clients are provided with immediate access to a single session of brief therapy without appointments or referrals (Hymmen et al., 2013; Slive, 2008). The option of single-session walk-in counselling services is in response to the growing need for greater accessibility of mental health services (Hoyt et al., 2018). Through these sessions, counsellors help clients develop knowledge and skills in order to better manage and cope with their presenting problem (Bhanot-Malhotra et al., 2010). Fundamentally, this type of service delivery model is based on "providing help at the point of need rather than help at the point of availability" (Dryden, 2019, p. 15). Many walk-in counselling clinics offer support for a variety of issues, which include, but are not limited to mental health, psychosocial issues, relationship difficulties, and parenting (Cameron, 2007).

Particularly, parents turn to walk-in single-session consultations to obtain child-rearing information and emotional support from mental health professionals (Sommers-Flanagan, 2007). Several studies have investigated parents' outcomes following single-session therapy, where parents have reported experiencing a greater sense of hope and confidence in their parenting skills (e.g., Perkins, 2006; Sommer-Flanagan, 2007). Accordingly, parents who have greater confidence in their ability to parent, otherwise referred to as parental self-efficacy, often utilize more positive parenting practices as well as have better parent-child relationships (Coleman & Karraker, 1998; Jones & Prinz, 2005).

Although various studies have investigated parent's confidence in their parenting abilities following single-session therapy, no study to date has investigated parental self-efficacy in the

context of virtual walk-in single-session therapy. The purpose of this study is to explore parents' perceptions of their parental self-efficacy and how it evolved following a virtual single-session walk-in counselling appointment at a children's mental health clinic. Further, we are seeking to investigate parents' overall experience utilizing this type of service delivery model.

Literature Review

What is Single-Session Therapy?

The field of single session therapy has rapidly grown since the 1990 publication of Moshe Talmon's ground-breaking book, *Single-Session Therapy: Maximizing the Effect of the First (and Often Only) Therapeutic Encounter.* Talmon (1990) defined single-session therapy (SST) as one face-to-face meeting between a therapist and a client, with no previous or subsequent sessions within a one-year period. Over a period of thirty years, Talmon (1990) observed a high frequency of clients attending only one therapy session. He further indicated that these non-returning clients were perceived by their therapists as "drop-outs," who were resistant or lacked the motivation to change. However, when he conducted follow-up interviews with clients who had dropped out of therapy, he discovered that many reported that they had received substantial help from their single session and did not require further services.

Foregrounding his initial observation, Rosenbaum, Hoyt and Talmon (1990) examined one-off consultations and found that 58 percent of their 60 participants required only a single session and on follow-up (within 3-12 months) reported "much improvement" or "improvement" since the session. Following initial investigations that revealed that clients showed improvement after attending only one session, Talmon (1990) concluded that viewing non-continuing clients as therapeutic failures undervalues the power of a single session.

The Core Principles of Single-Session Therapy

The principles of SST challenge the numerous assumptions of traditional therapy, where change is thought of as taking place in the longer-term and through the therapist's clinical expertise. In contrast, SST is pragmatic, as it emphasizes the client's presenting concerns, and the therapist works collaboratively with the client to explore solutions to those concerns in a single session (Campbell, 1999; Slive & Bobele, 2011). Campbell (1999) argued that the practice of SST assumes that clients know what they need and have the inherent capacity to resolve their own challenges to get their lives "back on track." Another shared position of therapists practicing SST is that clients already have within them the capacity for change (Miller & Slive, 2004). Campbell (1999) further described SST as a "focused approach," given that it requires therapists to play an active role in identifying the presenting concern, exploring attempted solutions, considering barriers to these solutions, identifying available resources, and encouraging clients to develop constructive strategies. The therapist's role is to reframe the client's problem, enhance coping skills, and encourage the client to use what they found helpful in the session to effectuate change (Bloom, 2001; Campbell, 1999).

According to Hoyt, Young and Rycroft (2021), there are four themes that underlie single session philosophy and practice:

1) *Attitude* – treating the session "as if" it might the only one and therefore making the most of every encounter
2) *Accessibility* – responding in a timely manner, free of any unnecessary barriers to clients receiving help when they are most ready
3) *Acting Now* – accepting that the best opportunity to address change is *right now*, regardless of diagnosis, severity, or complexity of presenting problem, and

4) *Alliance* – asking what clients want to achieve by the end of the session, so that the therapist and client can work collaboratively, in the here-and-now, to reach that goal.

In essence, the role of the therapist is to help clients define the problem and construct small steps toward reaching their goals. As a result, clients view the problem as less overwhelming and more manageable (Talmon, 1993). From this perspective, therapists help clients identify existing strengths, gain a sense of autonomy and confidence, and immediately begin implementing the solutions examined during the session (Miller & Slive, 2004; Slive & Bobele, 2012).

Talmon (1990) argued that SST is meta-theoretical inasmuch as therapists who practice SST may utilize various therapeutic techniques from diverse theoretical perspectives. The successful implementation of SST is not dependent on a particular theory; rather, therapists tailor their techniques according to their client's goal or nature of the presenting problem (Bloom, 2001; Goodman & Happell, 2006). According to Young and colleagues (2012), SST is more of an approach to service delivery than a therapeutic model, where therapists can work using their preferred "base" therapeutic approach. With that being said, the authors further described the "good practice basics" of SST, which include identifying what the client wants from therapy, checking in with the client throughout the session, and providing direct feedback while addressing the client's needs.

Walk-in Single-Session Therapy

Over the last decade, walk-in counselling clinics have been established in community-based mental health and family agencies as an attempt to improve accessibility and reduce wait times (e.g., Miller & Slive, 2004; Stalker et al., 2015; Young, 2011). Clients are provided with immediate access to a single session of brief therapy during clinic hours (Bhanot-Malhotra et al.,

2010). Unlike scheduled SST, clients can immediately access single session therapy by "walking in." Slive and Bobele (2012) described the core principles of walk-in SST, where each session focuses on clients' single most pressing concern and what they want out of the session, rather than exploring clients' history or root causes of presenting problems. Walk-in SST is predicated on the notion that clients are most motivated for change when they first present themselves for therapy. For this reason, the walk-in model aims to provide a "whole therapy" in one session as clients may not return for subsequent sessions (Harper-Jacques & Foucault, 2014). According to Miller (2008), the fundamental objectives of therapists working within a walk-in framework are to provide clients with a clear, solvable framing of their presenting concerns. Clients and therapists work collaboratively to develop specific goals, and clients are encouraged to do something different or think differently about the issue (Harper-Jacques et al., 2008). That is, clients cultivate a solution-oriented thinking approach, thereby enabling them to view their current situation as more manageable and allowing them to "carry on" on their own (Slive et al., 1995).

Virtual Single-Session Therapy

The literature on virtual (or online) therapy has been rapidly growing over the past two decades (Wind et al., 2020). Particularly, following the outbreak of the Coronavirus disease-2019 (COVID-19), many mental healthcare providers have shifted from face-to-face to video-conferencing counselling sessions (Wind et al., 2020). Leading researchers on SST, Hoyt, Young and Rycroft (2020) recently published an article considering future practice developments of online SST. Given that virtual SST services are likely to expand following the pandemic, they assert that more research is still needed to explore the question: "What will online SST sessions look like and how will they compare with face-to-face sessions in terms of client satisfaction and

outcome?" (Hoyt et al., 2020, p. 226). Based on previous literature, the use of online psychotherapeutic interventions has been shown to offer several potential benefits, including easier access to empirically supported treatments (Berger, 2017). Further, recent research has also shown that a therapeutic alliance can be established over a virtual modality (Berger, 2017).

Effectiveness of Single-Session Therapy

Talmon (1993) outlined the common objectives of SST, which include helping clients reduce or overcome stress, improve interpersonal relationships, increase their self-esteem, and develop a greater sense of control over oneself and their surroundings. Numerous studies have investigated the effectiveness of SST since its implementation in the 1990s. The studies described below will look at client satisfaction and clinical outcomes following SST across community-based mental health agencies, with an emphasis on family-oriented services.

Community-Based Mental Health Services

At the South Calgary Health Centre-Mental Health Walk-in, Harper-Jacques and Foucault (2014) examined client satisfaction and clinical outcomes of 98 clients aged 18-80 years. Findings suggest that clients experienced a decrease in distress level and an increase in hopefulness post-session, with hopefulness continuing to improve one-month following the single session. Further, clients reported an improvement in their presenting concern and coping at one-month follow-up. In Ontario, Stalker et al. (2012) conducted a pilot study (N=24) investigating the clinical effectiveness of SST delivered in a walk-in clinic. The study measured psychological distress, stage of change, previous use of health and social services, work functioning, and ability to undertake normal activities. Participants reported a significant improvement in distress levels and general functioning at one- and four-month follow-up and a decline in health services use. Most recently, Schleider et al. (2021) found that clients who

attended a solution-focused single-session consultation compared to their wait-listed counterparts reported improvements in hopelessness, agency, and psychological distress.

Family-Oriented Services

Numerous child and family mental health clinics across Australia have implemented and investigated the effectiveness of SST programs in response to an over-demand and lack of adequate resources for clients seeking family therapy. At Dalmar Child and Family Care in New South Wales, the clinic adopted an "Open Day" concept where one day per week, families can receive therapy on an immediate and single-session basis. One month following their Open Day appointment, 32 families were surveyed, and 72% reported their problems as much better or a little better, and 94% described the service as very helpful or somewhat helpful (Price, 1994). At the Bouverie Family Therapy Centre in Victoria, Boyhan (1996) found that 78% of the 36 clients surveyed reported that their presenting problems were much improved or a little better following a one-off consultation. At Oakrise Child and Adolescent Mental Health Service in Tasmania, Campbell (1999) used a pre-post methodology to investigate whether the nature of family functioning will influence any changes in the presenting problem. He noted that families that felt hope prior to their single-session intervention reported greater reductions in their presenting problems and an increased sense of coping. Furthermore, Fry (2012) observed that 56% of 144 families utilizing services at the Alfred Child and Youth Mental Health Service in Victoria, reported a single session was helpful and effective in assisting them with their presenting problem.

Perkins (2006) implemented a single-session, two-hour semi-structured assessment and treatment intervention for the referred child, their caregivers, and household siblings. The clinician approached the session as if it were to be the only one and utilized a solution-focused

family therapy approach, where they addressed the family's difficulties and explored previously attempted solutions. Subsequently, they focused on developing strategies that would increase the client and family members' self-efficacy while providing them with a sense of hope and confidence in their ability to handle these problems. At the end of the session, the clinician and the family decided collaboratively whether further sessions were necessary or if a different type of intervention was required. The author found that families who received the single-session intervention showed statistically and clinically significant improvement, compared to the control group who was wait-listed for six weeks. Specifically, 74.3% of the clients reported improvement in the severity of the problem, and 71.4% reported improvement in the frequency of the problem (Perkins, 2006).

Perkins and Scarlett (2008) conducted an 18-month follow up with participants from the Perkins (2006) study. The authors wanted to investigate whether the short-term benefits of SST are maintained over the longer-term. They found that 60% of the participants from the original study showed significant improvement with a single session of therapy. Meanwhile, the remaining 40% of clients required one or more further sessions over the 18 months following their initial consultation. The authors concluded that SST could provide short and longer-term improvements for children and adolescents' mental health needs (Perkins & Scarlett, 2008).

Coverley et al. (1995) investigated the long-term effects of a single session intervention in primary care for mothers of children with psychiatric disorders. During the sessions, child psychiatrists explored the presenting clinical issues while conveying empathetic encouragement and behavioural strategies to help mothers become more confident and less stressed in managing their children's behavioural and emotional difficulties. Of the 14 mothers who responded to the three-month follow-up questionnaires, 64% reported that the single session intervention had been

markedly or extremely useful. Specifically, mothers reported that they perceived improvement in their child's behaviour and emotional difficulties as well as their confidence in their parenting. Similarly, following single-session parenting consultations, parents reported feeling less stressed and overwhelmed by their children's needs or behaviours, and an increased sense of competency (Sommers-Flanagan, 2007).

In their meta-analysis of 50 randomized controlled trials (N=10,508), Schleider and Weisz (2017) investigated the effectiveness of single-session interventions for youth psychiatric problems. The authors found that single-session interventions revealed beneficial effects, regardless of youth problem severity and diagnosis. Further, single-session interventions were also found to be most effective in decreasing anxiety and conduct problems (Schleider & Weisz, 2017). Miller and Slive (2004) evaluated the effectiveness of walk-in SST at Calgary's Eastside Family Center, the first resource in Canada to implement a walk-in therapy model of service delivery. The authors contacted participants by telephone three to six months following the session and found that 67.5% showed improvement in the presenting concern.

Walk-In Counselling Clinics in Ontario

Bhanot-Malhotra et al. (2010) provided an overview of several walk-in counselling clinics in Ontario. The walk-in clinic at Catholic Family Services Peel-Dufferin in Mississauga conducted an evaluation of clients' experience of hopefulness and found that hopefulness significantly improved after clients completed their walk-in session. At KW Counselling Services in Kitchener, 67% of 1685 clients surveyed felt it was an excellent experience and that their issues were being heard, understood, and respected (Bhanot-Malhotra et al., 2010). In addition, Reach Out Centre for Kids (ROCK) in Burlington, evaluated the effectiveness of their walk-in counselling clinic. The results showed that following a walk-in session, clients were

significantly more competent about their skills as a parent, less worried about the problem, more knowledgeable about available resources, had more ideas about how to manage their problem, and were more confident in their ability to manage the problem (Young et al., 2008). When asked what they had learned during the session, clients reported gaining more general knowledge about the nature of the problem, knowledge of specific techniques to manage their issue, and better communication skills (Young et al., 2008). Clients who were contacted at two months follow-up reported less worry, increased confidence in their parenting skills and ability to manage their problem (Young et al., 2008). Taken together, these studies endorse the walk-in single session service delivery model, in that it has the potential to help families improve on or overcome their presenting concerns as well as promote parents' confidence in their parenting.

Potential Change Mechanisms

Through qualitative assessments, various studies have discussed the qualities that have contributed to the success of SST. In familial clinical settings, parents have indicated that the immediacy of single sessions was a distinct advantage, given that they can talk to a mental health professional at the time of their concern or crisis (Boyhan, 1996; Price, 1994). Similarly, Stalker et al. (2015) explored participants' experiences with walk-in and traditional counselling involving a wait list and found that participants valued the accessibility of the walk-in model. Notably, participants reported that being able to have an easily accessible walk-in session was not only helpful in terms of relieving distress, but also a good fit for those not interested in ongoing counselling.

Parents also reported that receiving concrete ideas, strategies, and advice was helpful, specifically being taught to use encouragement, mirroring, and positive feedback with their child (Sommers-Flanagan, 2007). Finally, yet importantly, several therapeutic characteristics were

identified as vital in parent's positive perceptions of the session, including displaying an empathetic and sensitive stance, a non-judgmental atmosphere, as well as providing supportive reassurance and personal validation (Coverley et al., 1995; Sommers-Flanagan, 2007). Likewise, clients who attended KW Counselling Services walk-in clinic reported that the counsellors were helpful, provided new strategies and alternatives to try, and were respectful and compassionate (Bhanot-Malhotra et al., 2010).

Young and colleagues (2008) provided examples of therapeutic conversations that occurred at ROCK's walk-in counselling clinic. Parents viewed the sessions as informative, supportive, fostered new viewpoints and ways of thinking and provided them with a good direction. More specifically, for one mother, the session created a space for the discovery of existing skills and values, which promoted her sense of agency and hope for the future. By therapists utilizing a "solution building" approach while collaboratively exploring the clients' own successes, strengths, and resources, allowed clients to develop a sense of control and empowerment (Young et al., 2008).

Limitations of Single-Session Therapy

Bloom (2001) reviewed the literature on the efficacy of planned short-term psychotherapy in treating intrapsychic difficulties and interpersonal conflicts in children, adolescents, and adults. He noted that single and multiple sessions of therapy were similar in terms of outcomes (Bloom, 1992; 2001). Previous research exploring the outcomes of traditional therapy suggested that clients typically show significant improvement in the early stage of therapy, and that the rate of subsequent improvement decreases with further sessions (Bloom, 2001; Seligman, 1995). Although Bloom (2001) provided considerable evidence of the effectiveness of SST, he also reported that the studies lacked sufficient methodological rigor.

Similarly, Hurn's (2005) review of SST concluded that the existing outcome studies have methodological limitations, given that they did not utilize standard measures and few included control groups. He further stated that there is "no conclusive evidence that SST is better than long-term therapy or that it is preferable to other more mainstream paradigms" (Hurn, 2005, p. 33). However, he did propose that SST may function best as a triage stage within the mental health system. More recently, Hymmen et al. (2013) conducted a meta-review of the effectiveness of walk-in and scheduled (i.e., by appointment) single-session therapy. Although the studies in the review included a diverse range of client samples and presenting problems, the authors noted that there were inconsistencies regarding the methods and instruments utilized to measure outcomes. Specifically, the methodological limitations identified included, absence of random assignment or comparison groups, use of unstandardized measures, clinicians participated in data collection, and samples were small and homogeneous (Hymmen et al., 2013).

Hurn (2005) advised clinicians not to view SST as a cure-all for every type of client, especially for complex cases. Bloom (2001) reported that a majority of clients could be helped relatively quickly regardless of diagnosis or problem severity; however, various studies had identified factors that may affect an individual's response to SST. Poor responses to single-session interventions were found to be associated with children who present with severe psychiatric disorders (Coverley et al., 1995), immediate suicidal risk (Campbell, 1999), and families with child abuse or neglect issues (Perkins, 2006). Boyhan (1996) claimed that single-session consultations might not be appropriate for clients who are court-mandated or referred by a protective agency. She further noted that clients whose problems pertain to sexual abuse, acquired brain injury and severe mental health illness should be referred to specialist teams. Fry

(2012) identified various SST exclusion criteria at the Alfred Child and Youth Mental Health Service that included psychosis, autism, and clients experiencing an acute crisis.

Theoretical Frameworks

This study draws on two major theoretical models to describe how a single-session counselling experience could impact parental self-efficacy. Bandura's (1977) self-efficacy theory will be introduced first and further described within the parenting context. Subsequently, Belsky's (1984) parenting process model will be described, where parenting is influenced by the parent's personality, the child's characteristics, and contextual sources of stress and support.

Self-Efficacy Theory

According to Bandura (1977), self-efficacy is defined as an individual's belief in his or her ability to successfully execute a given behaviour to accomplish a certain task. Bandura's social cognitive theory described high self-efficacy as a driving force behind motivation (Crain, 2010), where individuals with higher self-efficacy are more likely to persevere on a task (Plourde, 2002). On the other hand, when individuals have low self-efficacy, they may be more likely to become depressed and have self-doubts (Crain, 2010). In sum, efficacy expectations determine whether individuals will avoid or confront a given situation, how much effort they will expend, and how long they will persist in handling stressful situations (Bandura, 1977).

Parental Self-Efficacy

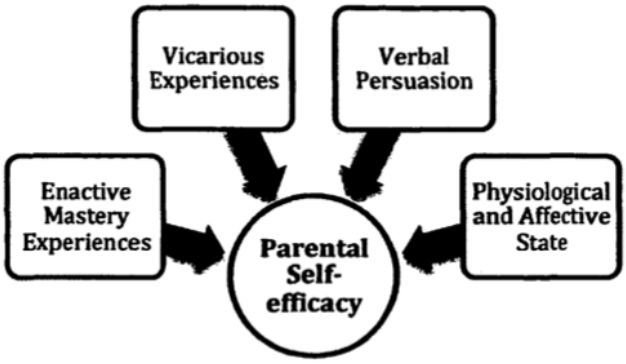
Parental self-efficacy, a derivative of self-efficacy, is defined as parents' belief in their ability to execute parenting tasks successfully and meet their child's psychosocial needs (Johnston & Mash, 1989; Wittkowski et al., 2017). Specifically, parental self-efficacy pertains to behaviours and actions relevant to parenting (e.g., caring for children, providing affection and compassion, and taking responsibility). According to Coleman and Karraker (1998), parents'

self-efficacy beliefs are derived from their knowledge about their children's behaviour as well as their confidence in their capacity to successfully execute the parenting role. More specifically, parental self-efficacy is determined by various factors, such as knowledge of suitable child care responses, knowledge of their child's development and self-confidence about their abilities (Coleman & Karraker, 1998).

Parental self-efficacy differentiates itself from other terms such as parental confidence and parental competence, as self-efficacy derives from one's own judgment based on personal capability as well as the strength of that belief (Bandura, 1997; de Montigny & Lacharité, 2005). Bandura (1997) identified four contributors to perceived self-efficacy: (1) enactive mastery experiences, (2) vicarious experiences, (3) verbal persuasion, and (4) physiological and affective states (See Figure 1 below).

Figure 1

Contributions to Parental Self-Efficacy



Enactive mastery experiences are an individual's most influential source of efficacy information with regard to their capabilities and limits (de Montigny & Lacharité, 2005). For instance, success at a task or overcoming a challenge strengthens a parent's beliefs about their capabilities as a parent, whereas failure undermines it (Bandura, 1997). *Vicarious*

experiences can influence self-efficacy beliefs by demonstrating and transferring competencies through observations and modelling and providing a reference point to judge their capacities to master a given situation (i.e., social comparison; de Montigny & Lacharité, 2005). Self-efficacy beliefs can also be reinforced through *verbal persuasion* through positive or negative reinforcement from other people or society (de Montigny & Lacharité, 2005). Finally, a parents' *physiological and affective state* will also influence the level of parental self-efficacy (de Montigny & Lacharité, 2005), where mothers who more stressed report feeling less efficacious (Reece & Harkless, 1998).

The Impacts of Parental Self-Efficacy

Extensive literature has demonstrated that there is a relationship between parents' self-efficacy and their parenting behaviour (e.g., Coleman & Karakker, 1998; Jones & Prinz, 2005). For instance, parents' perceptions of competence regarding their parenting practices have been positively linked to parental monitoring, involvement, and parental warmth (Shumow & Lomx, 2002). High parental self-efficacy has been associated with positive parenting practices and strategies. Researchers have argued that parents with high self-efficacy are confident about their capacity to manage their children's behaviour and use more authoritative and non-punitive parenting approaches, while parents with low self-efficacy employ more punitive methods (Coleman & Karraker, 1998; Johnston & Mash, 1989).

Furthermore, high parental self-efficacy has been linked to positive parent-child relationships (Jones & Prinz, 2005). Ardelt and Eccles (2001) found that mothers with higher parental self-efficacy engage in more promotive parenting practices (e.g., encourage the talents of their child, provide opportunities for attending programs in the community or school that promote their child's talent) which, in turn, fosters positive child adjustment. Similarly, Dumka

et al. (1996) found that parental self-efficacy was positively associated with parental warmth. Other studies have demonstrated that parental self-efficacy is linked to more responsive parenting (Aranda, 2014), greater effective child management strategies (Elder et al., 1995), and parental sensitivity (Wilson et al., 2014). In another study, Elder et al. (1995) concluded that parental self-efficacy predicted how much parents employed promotive and preventative parenting strategies. For instance, promotive strategies (e.g., assisting with the child's schoolwork and encouraging the development of interests) fostered positive child experiences, while preventive strategies (e.g., enforcing curfew practices and monitoring the child's whereabouts) decreased adverse child outcomes.

Parental self-efficacy has been linked to various aspects of children's behaviour, with higher parental self-efficacy largely predicting better behavioural outcomes for children (e.g., Albanese et al., 2019). In the context of children's social behaviour, higher parental self-efficacy has been linked to children's social competence (Juntilla et al., 2007). Evidence suggests that a social learning process is operative here, as parents with high parental self-efficacy have been found to engage in socially competent behaviour (e.g., behaving empathetically, taking care of others, and listening to others) in the home, and children learn these behaviours through modeling, reinforcement, and coaching (Putallaz & Heflin, 1990).

Previous research has also linked parental self-efficacy to academic and school-related outcomes in children. For instance, higher parental self-efficacy is related to fostering a more optimal home learning environment (Bojczyk et al., 2017) and school-related social competence (e.g., cooperative skills, empathy, impulsivity, and disruptiveness; Junttila & Vauras, 2014). Similarly, higher parental self-efficacy has been linked to better academic performance in both childhood and adolescence (Phillipson & McFarland, 2016). In sum, parents who feel confident

in their parenting role are more likely to provide a home environment that fosters children's social, emotional, and academic development (Jones & Prinz 2005).

Finally, various studies have also demonstrated that parental self-efficacy is associated with children's mental health outcomes. In a longitudinal study, Ahun et al. (2017) found that low parental self-efficacy is predictive of children's internalizing problems. Steca et al. (2011) investigated the relationship between parents' self-efficacy and their children's psychosocial adaptation. The authors found that the children of parents with high parental self-efficacy displayed better psychosocial adaption. That is, they showed fewer depressive symptoms and behavioural problems and communicated more openly with their parents. Conversely, children of parents with low parental self-efficacy were reported to have lower levels of well-being and greater behavioural problems (e.g., more involvement in violent behaviours).

Interventions to Increase Parental Self-Efficacy

There is increasing acknowledgement that strategies aimed at enhancing positive parenting practices are effective methods to improve the health, well-being, and development of children (Stewart-Brown, 2008). Various studies have increased parental self-efficacy through interventions. Evans et al. (2003) examined the effectiveness of intensive home-based interventions as an alternative to hospitalization for children experiencing a psychiatric crisis and their families. The authors found that the majority of families experienced gains in parental self-efficacy and adaptability following an in-home psychiatric intervention program. Similarly, Miller-Heyl et al. (1998) implemented an intervention program with high-risk families to foster young children's resiliency to later adverse behaviours. The authors found that parents' self-efficacy improved while using more positive parenting practices. In a different intervention study, mothers who participated in a 10-week parent training program were found to have

significant increases in maternal self-efficacy, decreases in maternal stress, and improvements in the quality of mother-toddler interactions (Gross et al., 1995).

In a recent study, Bloomfield and Kendall (2012) wanted to investigate whether changes in parental self-efficacy following a parenting program are associated with changes in child behaviour and parenting stress. The authors found a relationship between parental self-efficacy and parenting stress. That is, parents who felt less efficacious experienced greater levels of stress, whereas higher self-efficacy was associated with less stress (Bloomfield & Kendall, 2012). Notably, several studies have also established interventions that have increased parental self-efficacy while decreasing child behaviour problems. Sofronoff and Farbotko (2002) implemented a parent management training intervention aimed to improve parental self-efficacy. The findings indicated that parents in the intervention condition reported greater parental self-efficacy and decreased child behaviour problems. In another study, Sanders et al. (2000) wanted to investigate the influence of a 12-episode television series on disruptive child behaviour and family adjustment. The parents who viewed the television series reported increased parental self-efficacy and lower levels of disruptive child behaviour. Mouton et al. (2018) examined a parenting program aimed to improve child behaviour by enhancing parental self-efficacy. The results indicated that improving parental self-efficacy is effective in reducing externalizing behaviour in children.

Parenting Process Model

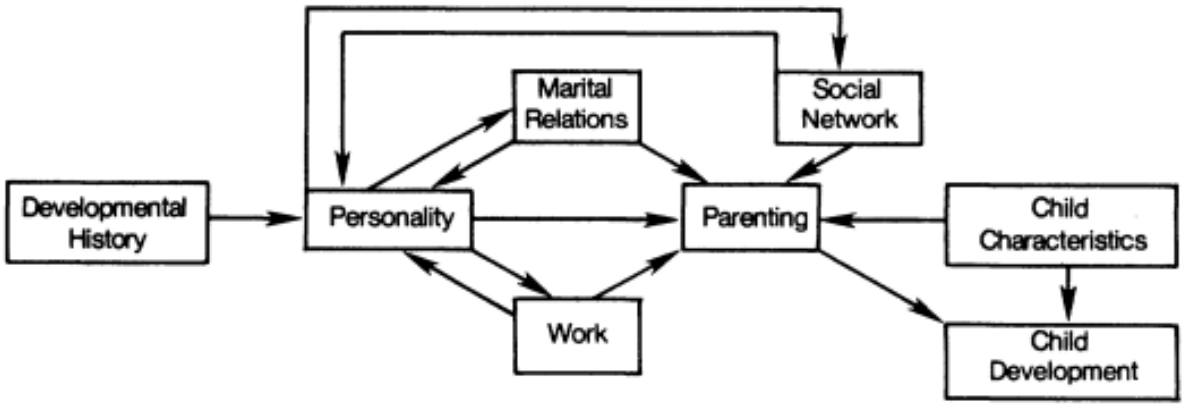
This study will also utilize Belsky's (1984) parenting process model as a guiding theoretical framework. The model considers individual parent and child characteristics as well as aspects of the social context. As shown in Figure 2, the parenting process model links key external factors to parents' psychological well-being, which, in turn, influence parenting and

child development. Given that parent-child interactions are bi-directional, the model also explains the bi-directional impacts of child characteristics on parenting and child development.

Belsky's (1984) parenting process model assumes that parenting is directly and indirectly influenced by the broader social context (specifically, marital relations, social networks, and occupational experiences), the parents' personalities (i.e., parental functioning and well-being), and the child's characteristics (e.g., temperament). The model illustrates how the broader social context can influence the psychological well-being of parents and thereby, parenting and, in turn, affect child development (Belsky, 1984). The model is described under three domains, child characteristics, psychological resources of parents (i.e., parental functioning), and contextual sources of stress and support (e.g., social network). Though I will briefly discuss all three domains, the purpose of my research is to look closely at the aspects of parental functioning and social network.

Figure 2

Belsky's (1984) Parenting Process Model



Parental Functioning

Belsky (1984) asserted that healthy developmental experiences of parents fostered healthy psychological well-being, which, in turn, positively affected parenting practices, thereby

promoting optimal child functioning. For instance, parents who reported greater levels of parenting stress were found to employ more authoritarian discipline strategies and have more negative interactions with their children (Belsky et al., 1996; Deater-Deckard & Scarr, 1996). Likewise, parenting stress has been found to be associated with children's behaviour problems (Crnic & Low, 2002).

Parental self-efficacy, an important facet of parental functioning, has been identified to both predict and mediate child outcomes (Coleman & Karraker, 2003; Jones & Prinz, 2005). Higher perceptions of competence in general have been found to be positively associated with parenting, including parental monitoring, involvement, and parental warmth (Shumow & Lomx, 2002; Teti & Gelfand, 1991). Across various studies, depressed mothers compared to non-depressed mothers have been found to have low self-efficacy of their abilities to parent and demonstrated poor parenting behaviours (Belsky, 1984; Gelfand & Teti, 1990; Goodman & Tully, 2008). Other factors, such as social support and child temperament, have been found to impact parental self-efficacy (Leahy-Warren et al., 2012).

Child Characteristics

Previous literature has demonstrated that child characteristics can influence parenting practices. In a review by Deault (2010), oppositional and conduct problems were associated with negative parenting practices and increased family conflict. In a study by Kashdan et al. (2004), mothers and fathers were asked to complete self-report measures rating their children's symptom severity, the quality of the parent-child relationship, parental social adjustment, and parental anxiety and depression. Oppositional defiant disorder (ODD) symptoms predicted less positive parenting, including a lack of warmth and positive parental involvement, as well as more negative discipline strategies and parental intrusiveness.

Social Network

According to Belsky (1984), social support promotes parents' sense of competence and functions in three ways: by (1) providing emotional support (i.e., interpersonal acceptance by others), (2) providing instrumental assistance (e.g., offering information and advice), and (3) providing social expectations (i.e., serves as guides regarding acceptable and unacceptable behaviours). Having a strong social support network besides the spouse (e.g., family and friends) presents a beneficial impact on positive parenting practices and the parent-child relationship. Perceived positive support enhances parents' self-efficacy and self-esteem (Farmer & Lee, 2011), which leads to increased patience, responsiveness and sensitivity exercised in the parenting role. As a result, parents effectively provide the social support their children need for social functioning. Working within the parenting process model, this study will consider single-session walk-in counselling as a potentially influential element of the social support network that can foster parents' self-efficacy.

The Current Study

To address the mental health needs of the community, a growing number of community mental health agencies have implemented single-session therapy in walk-in counselling clinics (Hymmen et al., 2013; Slive, 2008). Single-session therapy is based on "providing help at the point of need rather than help at the point of availability" (Dryden, 2019, p. 15). Parents typically attend single-session consultations to obtain child-rearing information and support regarding their children's mental health difficulties (Sommer-Flanagan, 2007). Numerous studies have indicated that parents have acquired a greater sense of hope and confidence in their parenting skills following a single session (e.g., Perkins, 2006; Sommer-Flanagan, 2007; Young, 2011). Accordingly, enhancing parents' self-efficacy can lead them to better cope with their

child's difficult behaviour (Bloomfield & Kendall, 2012). Given the importance of parental self-efficacy on parenting and child development, it is imperative to understand how walk-in single session therapy can impact parental self-efficacy. The purpose of this study is to explore how parents describe their parenting self-efficacy and how it evolved following a single-session walk-in counselling experience at a children's mental health clinic in Ottawa, Ontario. In addition, we are seeking to investigate parents' overall experience utilizing virtual walk-in counselling services. This aspect arose in the context of COVID-19 restrictions that led the agency to move services into a telehealth platform.

Although numerous studies have looked at parental self-efficacy within the walk-in SST paradigm, to date, however, no study has investigated these variables within the parenting process model. Using the parenting process model as a guiding theoretical framework, this study will consider walk-in SST as a social support network component. Moreover, this study will be one of the first investigating parents' experiences utilizing virtual single-session therapy. Finally, previous studies investigating parenting self-efficacy and SST have mostly been conducted using quantitative methods, therefore this study utilized a mixed methods approach with primarily qualitative approach to data collection and analyses and with supplementary quantitative data. The qualitative approach will provide new insights foregrounding parents' voices, permitting an in-depth exploration of parents' experiences in the SST and their perception of its effects on their lives in the wake of their SST experience.

Research Questions

The current study explored the following questions:

1) What are parents' perceptions of their parenting self-efficacy, both historically and currently?

   a. What links do parents make between their walk-in session experience and any observed changes in their parenting self-efficacy?

2) How do parents perceive their experience of virtual walk-in counselling services at a children's mental health clinic?

Method

Research Design

This study will utilize a mixed method multiple-case study (Yin, 2018) approach to explore parents' lived experiences following virtual walk-in SST. Case studies are typically utilized when the purpose of the study is seeking to *explain* in-depth a given contemporary circumstance, where the researcher has little or no control (Yin, 2018). In this multiple-case study, each family will be viewed as an individual case and findings will be synthesized to describe the common emerging themes across cases. The purpose of mixed method research is that the use of both qualitative and quantitative approaches provides a better understanding of the research question than either approach can realize alone (Creswell, 2009). As Greene (2007) argues, mixed method research is "generative and open, seeking richer, deeper, better understanding of important facets of our infinitely complex social world" (p. 20). The qualitative approach in this study involved retrospective interviews with parents following their use of virtual single-session counselling services. The quantitative approach was implemented by parents completing a parental self-efficacy questionnaire at two time points (before the SST session and at the follow-up interview).

Research Site

An established partnership with Crossroads Children's Mental Health Centre (CCMHC) in Ottawa, Ontario was used to recruit participants and conduct the current research. CCMHC is

a non-profit organization which provides a variety of services for children under the age of 12 and their families. More specifically, CCMHC's walk-in clinic provides free of charge, readily accessible counselling services for families seeking immediate assistance for their child's emotional, behavioural, and social difficulties. Typically, families seeking counselling services at the walk-in clinic do not require a referral or appointment. However, due to the COVID-19 pandemic, walk-in clinic services have been adjusted to pre-booked virtual appointments. Families can book for a same or next day phone or video counselling session through *Counselling Connect*, a one-stop website which connects individuals to publicly funded mental health agencies.

Overview of CCMHC's Walk-In Counselling Clinic

Families who utilize walk-in services are often seeking help for their infant, toddler, or child's severe social, emotional, and behavioural challenges. The clinicians at CCMHC utilize the Collaborative Problem Solving (CPS) approach (Greene & Ablon, 2006), which promotes the belief that "*kids do well if they can*." The CPS approach focuses on identifying specific skills deficits (e.g., frustration tolerance, cognitive flexibility, problem solving) and assisting the child in developing the skills that are lagging. The clinician and the family work collaboratively to identify the triggers to the child's challenging behaviour and develop realistic solutions that work for everyone. The aim is for the family to recognize their resources and strengths and formulate a feasible plan to overcome the presenting concern. If the clinician and family determine that their issues require further professional assistance, the clinician will provide a referral.

Participants

This study was approved by the University of Ottawa Research Ethics Board. Participants consisted of families utilizing the walk-in clinic at Crossroads Children's Mental Health Centre

(CCMHC). A total of nine parents participated in the current study. The exclusion criteria for this study included participants who have previously utilized walk-in services at CCMHC and/or are concurrently receiving or received other counselling services in the past year and/or who did not speak fluent English. Following the interviews, one parent was excluded from the total sample given they were attending a course on Collaborative Problem Solving (CPS) at the time of the interview, which confounded their responses. The participant was excluded because the CPS course was deemed a concurrent treatment intervention since it is the same therapeutic model that CCMHC uses. Therefore, the final sample consisted of eight mothers between the ages of 34 and 50 (*M*= 41 years) who utilized CCMHC's walk-in counselling services between March and July 2021. On average, parents were interviewed six weeks following their SST session (range: 3-7 weeks). More specifically, four participants were interviewed 7 weeks post-SST, two participants 6 weeks post-SST, one participants 4 weeks post-SST, and one participant 3 weeks post-SST. The majority of mothers in the present study were Caucasian (75.0%), have lived in Canada their whole life (75.0%), work-from-home (62.5%), and have more than one child residing in the home (87.5%). Although only mothers attended the interview, they all reported that they were married and that both they and their spouses were involved in parenting their child. Of the eight parents, six reported that their child had received a formal diagnosis, where three (37.5%) children had an ADHD diagnosis, one had an autism spectrum disorder (ASD) diagnosis, one had a septo-optic dysplasia diagnosis, and one had an adjustment disorder diagnosis. The children were between Grade 1 and Grade 6 and were composed of six males (75.5%) and two females (25.0%).

Measures

Parenting Self-Agency Measure

Parent participants completed the Parenting Self-Agency Measure (PSAM; Dumka et al., 1996) at two time-points (before and following the virtual SST). The PSAM measures the level of confidence parents have in their ability to parent, for example, resolving parent-child conflict and managing their child's behaviour (Dumka et al., 1996). For this study, the revised 4-item questionnaire was used, containing statements such as "I feel sure of myself as a parent" and "I know I am doing a good job as a parent" (see Appendix A). Parents rated the extent to which they agree or disagree with the statement using a 1 (almost never or never) to 5 (almost always or always) point Likert scale with lower scores indicating lower parental self-efficacy. The revised version of the PSAM has been found to be a valid and reliable measure (Dumka et al., 1996; Whittaker & Cowley, 2006; Wittkowski et al., 2017). In case study research, questionnaires can be used in conjunction with other case study techniques, such as interviewing (Mills et al., 2010). Consistent with mixed methodologies, the quantitative data obtained from the PSAM questionnaire were used to describe parents' perceptions of their self-efficacy before and after the SST experience and to complement the data collected through the interviews.

Procedure

Parents who attended CCMHC's walk-in clinic completed a pre-session questionnaire, which included the PSAM pre-questionnaire and a consent form requesting permission to be contacted for future research studies. Twenty-five participants who had previously consented to be contacted for research purposes were asked to participate in this study through an email recruitment message (see Appendix B for recruitment statement). Parents were asked if they would be interested in partaking in an interview following their walk-in counselling session at CCMHC. Nine parents of the 25 initially contacted expressed interested in participating in the study and met the inclusion criteria. Participant recruitment stopped when data saturation was

deemed to have been reached. At this point, the latter interviews yielded similar responses to those that emerged from the earlier interviews in the data collection phase (Saunders et al., 2018). Following the interviews, one parent was excluded from the total sample as they were concurrently taking a course on CPS, which confounded their responses concerning their parenting post-SST.

Interview Protocol

The nine participants were emailed the consent form to review and sign (see Appendix C). The principal investigator coordinated with the participant to choose a convenient time to schedule a one-on-one interview. Previous research has suggested that a follow-up interview between six to eight weeks is optimal given that participants may forget significant aspects of the session over time (Boyhan, 1996; Sommers-Flanagan, 2007; Perkins, 2006). Further, in some instances, clients may have commenced longer-term counselling, which may confound the single session's outcomes (Boyhan, 1996; Sommers-Flanagan, 2007). One-on-one virtual interviews over Zoom or by phone were conducted by the principal investigator. Before starting the interview, informed consent was obtained verbally, and participants were reminded that they could withdraw or refuse to answer any question without any consequences. Interview participants were offered a $20 Amazon gift card as compensation for their time.

At the beginning of the interview, participants were asked a set of demographic questions (see Appendix D). Questions included parental age and gender, ethnicity, years lived in Canada, work circumstances (e.g., work-from-home), grade and gender of their child, and number of children living in the home. Participants were also asked if their child has been formally diagnosed with any medical, developmental, or mental health conditions, and if they had, they

were asked to list the official diagnosis. Parents were also asked to verbally complete the PSAM post-questionnaire following the demographic questions.

A semi-structured interview format with predefined questions was used to help guide the interviewer's exploration. This format allowed participants to elaborate and express their thoughts, feelings, and beliefs on their terms, thereby permitting both interviewers and interviewees to have the freedom to clarify responses and questions, respectively (Creswell, 2009). The interview consisted of seven key questions, and the semi-structured format allowed for probes and follow-up questions where appropriate (see Appendix E). To ensure participant anonymity, the parents were each provided with a participant ID. The interviews were audio-taped on a recorder and were transcribed by the principal investigator for analysis purposes. Interviews ran for an average of 22 minutes (range: 15:17-32:26). All audio files are stored in a secure, password protected cloud service (e.g., SharePoint) and only be accessible to the University of Ottawa research team.

Data Analysis

Braun and Clarke's (2006) procedures for thematic analysis were followed to identify themes within and across cases. Initially, all interviews were transcribed verbatim by the student researcher. In the first level of analysis, single-case analysis was conducted where I read through each case transcript multiple times and completed an initial coding using "mind maps" to identify case-level patterns in the data (Braun & Clarke, 2006). A mind map is a radial diagram that represents words or concepts linked to and arranged around a central concept and branch out to sub-topics that allows to better analyze, comprehend, synthesize, recall, and generate new ideas (Eppler, 2006). Mind maps are an effective method of identifying recurring themes and a visual way to display and communicate qualitative data (Burgess-Allen & Owen-Smith, 2010;

Kotob et al., 2016). The research team, which included the student researcher and the thesis supervisor, reviewed the case-level findings. The thesis supervisor provided feedback, which led to minor revisions in the case level-codes. For example, modifications were made to some of the wording of the codes and organization of the mind maps. The quantitative data gathered from the Parental Self-Efficacy Measure (PSAM) was used to complement the qualitative data in order to widen the perspective when analysing case-level findings (Mills et al., 2010).

In the second level of analysis, cross-case analysis was conducted to identify common themes that arose across all eight parents' interviews (Creswell, 2007). I formulated an initial set of overarching themes and identified quotes in the case transcripts that were congruent with the overarching themes. The research team discussed the initial generated overarching themes and the thesis supervisor provided feedback and input, and revisions to the themes were made subsequently. This process of collaborative discussion, whereby the thesis supervisor provided feedback on the student researcher's themes, was conducted once more. In the second round, revisions were minor, and the research team arrived at a consensus that the final themes best captured the study data to the fullest extent. The final themes reflect a balance of the researchers' differing perspectives (Bradley et al., 2007). Clarke and Braun (2013) argue that thematic content analysis is an important dimension of qualitative analysis as it captures the complexities of meaning within a textual data reference.

Results

Case Descriptions

The eight cases comprising the data set are described below. In all cases, the child referred to in the case description is the child who attended the counselling session with the parent. All names presented in this study are pseudonyms.

Case 1: Nora

Nora is a 45-year-old Caucasian married woman. She has been living in Canada her whole life and is currently working within a hybrid work model (i.e., working both from home and at her workplace). She has a son in Grade 5 who is formally diagnosed with ADHD and anxiety. Nora initially booked a walk-in session because her son was demonstrating disruptive behaviour at school; specifically, he would get angry and "shut down," which was interfering with his learning. She felt pressure from the school to do something regarding her child's difficulty regulating his emotions; therefore, she decided to seek counselling services. At the same time, Nora was hoping to gain some tools on how to help manage her child's behaviour.

Before attending the single-session counselling appointment, Nora felt overwhelmed and frustrated because she did not know how to help her child. The session provided her with a newfound understanding of how to identify behavioural triggers and, in turn, help her child recognize when he is getting worked up. Further, having someone validate and normalize that other parents also experience similar struggles was empowering. She also enjoyed meeting the counsellor virtually, saying it was much more comfortable doing the session in her own home than at the agency office. Nora indicated that, overall, the session met her expectations. Nora's pre-session average score on the parental self-efficacy questionnaire indicated she was feeling efficacious as a parent *a lot of the time*. At the time of the interview, following the intervention, her average score indicated that Nora felt efficacious *a lot of the time*, thus indicating that she felt similarly self-efficacious in relation to her parenting following the intervention session.

Case 2: Ava

Ava is a 37-year-old Filipino married woman. She has been living in Canada for the past 35 years and currently works from home. She has a son in Grade 2 who is formally diagnosed

with septo-optic dysplasia (SOD), a disorder of early brain development, which results in impaired vision in one or both eyes. In the case of Ava's child, he is completely blind. Ava initially booked a walk-in counselling session because she was worried her son was experiencing anxiety. Specifically, her son was exhibiting outbursts, fits of crying, and was having difficulty completing school-related tasks, specifically journaling, which was the focus of the curriculum in his Grade 2 class. She was seeking clarity on whether the constant back-and-forth between remote learning and in-person learning led to her child experiencing anxiety or if there was anxiety around completing his schoolwork (i.e., journaling). She was hoping to receive a professional opinion about whether or not her child was exhibiting signs of anxiety and a treatment plan with new coping strategies that she had not yet tried.

In the past, Ava had taken various foundational parenting courses and programs (e.g., behaviour management) in order to educate herself on how to raise a child with special needs, and her comments in the interview indicated that she already felt confident about her capacities as a parent. She was seeking additional services and support to augment the strategies that she had previously deployed in parenting her son. Ultimately, she did not find the session helpful as the children's mental health clinic was unable to meet her particular needs (i.e., providing a formal anxiety diagnosis), and it was recommended in the walk-in session that her child complete a psychoeducational assessment. She did find the experience of meeting with the counsellor virtually comfortable, given the nature of her work requires her to spend a lot of time online. Ava's pre-session questionnaire score indicated she was feeling efficacious as a parent *almost always or always*. Her post-session score indicated she was feeling efficacious *almost always or always*, thus indicating that her parental self-efficacy remained high and unchanged following the walk-in session.

Case 3: Eleanor

Eleanor is a 50-year-old Caucasian married woman. She has been living in Canada her whole life and currently works from home. She has a daughter in Grade 6 with no formal diagnosis. Eleanor initially booked a session with CCMHC because her daughter had expressed concerns about how she handled certain situations emotionally. Although Eleanor tried to provide the best advice she could as a parent, she wanted a mental health professional to speak with her daughter. She was hoping a counsellor could provide guidance and formulate a concrete plan for her daughter on how she can deal with similar situations going forward.

The overall session met Eleanor's expectations. Eleanor reported that during the session, the counsellor listened to their concerns and them with tools and strategies. Since the session, Eleanor has been implementing the strategies provided to her and shifted her parenting approach, where she takes the time to discuss and reflect with her daughter following a difficult situation. She felt at ease meeting the counsellor virtually as she has been working remotely since the beginning of the pandemic. Eleanor's pre-session average score indicated she was feeling efficacious in the parenting role *sometimes*. Her post-session average score indicated she was feeling efficacious *a lot of the time*, thus indicating that her parental self-efficacy improved following the intervention.

Case 4: Grace

Grace is a 38-year-old Caucasian married woman. She has been living in Canada her whole life and currently works from home. She has a stepson in Grade 5 who is formally diagnosed with adjustment disorder and a slight learning delay. She initially booked a walk-in counselling session because her stepchild was exhibiting bathroom regression and attitude problems, which included "lying and sneaking around". Grace attended the session with the

child's biological mother. Prior to the pandemic, Grace and the child were utilizing counselling services at a different family mental health center for his bathroom-related issues.

Grace and the biological mother were seeking guidance from a professional on what further steps should be taken. She did not find the session inherently helpful, as the counsellor mainly focused on providing practical parenting strategies. She was hoping that the counsellor would be speaking to the child himself to get to the root of the problem. Given that Grace had previously received similar information and resources on parental strategies from the aforementioned family mental health agency, she did not express making any changes to her parenting approach. Grace's pre-session average score indicated she was feeling efficacious in the parenting role *sometimes*. Her post-session average score indicated she was feeling efficacious *sometimes*, thus indicating her parental self-efficacy remained moderate and unchanged following the intervention.

Case 5: Ellie

Ellie is a 46-year-old Caucasian married woman. She has been living in Canada her whole life and is currently working within a hybrid work model. She has a daughter in Grade 5 who is formally diagnosed with ADD and has an IEP at school. Ellie initially booked a walk-in counselling session because her daughter needed support as she was undergoing significant stress and anxiety related to growing up and adjusting to the pandemic. Ellie was hoping her daughter could receive additional support and age-appropriate strategies to help her better manage her emotions.

Ellie was finding it hard seeing her child struggling and felt like she was not doing enough to help her. During the session, the counsellor listened to and was attentive to her concerns. She appreciated that the time allotted for the session was one hour, which made her

feel like she did not have to rush. Following the session, Ellie felt relief to have received some extra support and strategies as well as gained a newfound hope in working through her daughter's troubles. She also appreciated that the services were free and easily accessible and found that meeting the counsellor virtually was a positive experience. Ellie's pre-session average score indicated she was feeling efficacious as a parent *a lot of the time*. Her post-session average score indicated she was feeling efficacious *almost always or always*, thus indicating her parental self-efficacy increased to a very high level following the intervention.

Case 6: Lily

Lily is a 37-year-old Caucasian married woman. She has been living in Canada her whole life and is a stay-at-home mom. She has a son in Grade 2 who is formally diagnosed with autism spectrum disorder (ASD). She initially booked a walk-in counselling session as her son was having difficulty regulating his emotions, particularly anger and frustration. She sought services from a children's mental health agency following the recommendation of his general physician. Her son was diagnosed at the age of four; therefore, she was seeking age-appropriate coping strategies now that he is seven.

The overall session met Lily's expectations. Before the session, she felt frustrated, stressed, and worried that she was failing her child. She found the session helpful, as she was provided with several ideas for her to attempt with her son. She found the counsellor to be knowledgeable, friendly, and patient, which put her at ease. She felt heard and reassured regarding her parenting and left the session feeling calmer. Since the session, she has been significantly less stressed and more confident and has shifted her parenting approach to be more flexible and focus on her child's needs. Lily also appreciated the virtual aspect of the session as it met the needs of her family. It was easier for her to hop on a video call rather than planning for

hours to leave the house, as her child often has a “meltdown or fuss”. Lily’s pre-session average score indicated she was feeling efficacious *sometimes*. Her post-session score indicated that she was feeling efficacious *a lot of the time*, thus indicating her parental self-efficacy improved rising from a moderate level prior to the intervention to a very high level following the intervention.

Case 7: Natalie

Natalie is a 40-year-old Latina married woman. She immigrated from Brazil and has been living in Canada for the past seven and a half years. She is currently on maternity leave; however, she will be returning to working from home once her maternity leave concludes. She has a son in Grade 3 with no formal diagnosis. Natalie initially booked a walk-in counselling session because her son was experiencing sleep disturbances shortly after the pandemic began. More specifically, after putting him to bed at nine, he would wake up at midnight, unable to go back to sleep.

The session met Natalie’s needs; she received support for her son and herself. The counsellor took the time to explore Natalie’s concerns and provided her with strategies to implement with her son. Specifically, the counsellor recommended she cut off screen time one hour before her son’s bedtime as well as use the Collaborative Problem Solving (CPS) approach to brainstorm with her son what he can do to fall back asleep by himself. She felt heard and encouraged and left the session feeling supported. Since the session, she has been more empathetic towards her son’s worries, and, through brainstorming, they identified that reading a book when he wakes up has been a successful strategy. Although she finds the CPS approach beneficial and has gained valuable knowledge, she does find it challenging to implement. She also enjoyed meeting the counsellor virtually; she is comfortable with technology since she has

been working remotely during the pandemic. Natalie's pre-session average score indicated that she was feeling efficacious in her parenting role *a lot of the time*. Her post-session average score indicated she was feeling efficacious *sometimes*, thus indicating her parental self-efficacy decreased following the intervention, which was not in alignment with her descriptions in the interview.

Case 8: Isabel

Isabel is a 34-year-old Caucasian married woman. She has lived in Canada her whole life and is currently working from home. She has a son in Grade 2 who is formally diagnosed with ADHD. Isabel initially booked a walk-in counselling session because her son had been having severe temper tantrums at home, and she was seeking strategies to handle his angry episodes. After speaking with his general physician, he recommended she seek services at a children's mental health agency.

The overall session met Isabel's expectations. During the session, the counsellor listened to and validated her concerns and provided her with information on ADHD, including the typical signs and symptoms associated with the disorder. The counsellor also provided Isabel with techniques based on the Collaborative Problem Solving (CPS) approach and walked her through different scenarios and how she could handle similar ones moving forward. Since the session, she has been implementing the techniques provided to her, where she collaboratively problem-solves with her son when he is having an outburst and tries to help him express his emotions more productively. Isabel also enjoyed the virtual aspect of the session as it was adaptive to her family's needs. Isabel's pre-session average score indicated she was feeling efficacious in her parenting role *sometimes*. Similarly, her post-session average score indicated she was feeling

efficacious *sometimes*, thus indicating her parental self-efficacy remained at the moderate level and stable following the intervention.

Cross-Case Analysis

Quantitative Findings

Overall, parents reported moderate to high levels of PSE prior to partaking in the SST. Only a few parents reported modest gains in PSE following the SST. Most parents, whose pre-test score of PSE was already at moderate or high, reported no change in PSE following the SST (See Table 1 below).

Table 1

Results of Parenting Self-Efficacy Measure by Participant Before and After SST

Participant	Experiences self-efficacy in relation to their parenting:				
	Almost never or never	Once in a while	Sometimes	A lot of the time	Almost always or always
Nora				Before After	
Ava					Before After
Eleanor			Before	After	
Grace			Before After		
Ellie				Before	After
Lily			Before	After	
Natalie			After	Before	
Isabel			Before After		

Qualitative Findings

The interviews with parents about their experience in the SST and its impact on PSE revealed a more nuanced portrait than the scale results summarized above, and this section provides a narrative of the themes generated from the analyses that emerged across the cases in relation to the research questions. The themes were grouped into two categories that align with the research questions: *Therapy Experience* and *Experience of the Service Modality.* Throughout both sections, when highlighting participant quotes, there may be grammatical and sentence structure errors. This was done to keep true to the participants' authentic style and not take away meaning from the participants' stories.

Therapy Experience

The themes under Therapy Experience answered the research question centred on parents' perceptions of their parenting self-efficacy following their virtual single-session therapy experience, which had taken place between 3-7 weeks earlier at the CCMHC. In particular, the themes that represent parents' overall therapeutic experience are as follows: (a) increased parental knowledge supports self-efficacy, (b) parenting with collaboration improved parent-child interactions, (c) the therapeutic relationship helped empower parents, and (d) parents moved from a state of distress towards hopefulness.

Increased Parental Knowledge Supports Self-Efficacy

Following the SST session, several parents alluded to their parental knowledge increasing. Parental knowledge of child development is defined as "parent's understanding of developmental norms and milestones, processes of child development, and familiarity with caregiving skills" (Benasich & Brooks-Gunn, 1996, p.1187). Particularly, parents mentioned that they gained new insight into their child's mental health condition as well as tools and resources

to better support their child. For example, Natalie mentioned that the counsellor introduced her to the CPS approach, which allowed her to be more knowledgeable about appropriate ways to communicate and navigate issues with her son in an empathetic and collaborative way. By incorporating these new techniques, she felt that she has become a "better" parent. Nora shared that the session provided her with a greater understanding of what behavioural cues to look out for that she had not considered before. By gaining valuable knowledge of how to proactively help her child with ADHD, she felt more sure of herself as a parent and knew what to do going forward. She stated,

> We were completely oblivious [before]. We just didn't know to look for this, to help him with this. We learned that we needed to help him recognize when his emotions started to build. So, it's still challenging, but it has given us an awareness that we didn't have before. […] Because for us it's like, 0 to 60 in like a second. So, it's very hard for us, as parents, we only see the angry. We don't recognize the build, especially with a child who is very quiet, and doesn't express himself.

Isabel also mentioned that the counsellor took the time to explain the background of ADHD and the common symptoms associated with the disorder. "The [Agency name] session was more of an understanding I guess for me," she remarked. Isabel also gained specific tools on how to better manage her child's temper tantrums which led her to feel more self-assured when parenting her child. She stated,

> So, within the session she kind of walked me through different scenarios and said, "Oh this is how we should handle it." The next time this happens, here's an example of what you should do and try that. Uhm, the next temper tantrums we try to apply whatever examples [the counsellor] gave us. And it helped guide some stuff and trying- we were trying to change our mechanism of dealing with these outbursts. It's more just understanding of what's going on through my son's head, whenever he has these episodes and how we can try to help deal with these and try to regulate his emotions.

Lily described that when her child would get angry and make extreme statements, such as "I never get this," she would try to challenge and question his thinking by asking, "Is that true

through? Do you never get anything?" During the session, the counsellor suggested a more appropriate approach for Lily to support her child when he is at the height of emotion. She explained,

> After talking with [the counsellor], she suggested that what might be better is just validation, in the height of emotion […] So, instead of saying, "Is that true though?" say, "I'm sorry you feel that way." When he's at the height of the emotion, just cater to the emotion, "How can I help?" and leave it that way. So, that is a concrete example of what we used to do and now we're changing our approach.

Lily described that the SST session helped her gain a deeper understanding of the developmental milestones of a child with ASD. Implementing the new developmentally-appropriate parenting approaches has led her to focus more on her child's unique needs. "I'm a lot more confident [and] I'm a lot more calm," she expressed.

Parenting With Collaboration Improved Parent-Child Interactions

Given that CCMHC adheres to the Collaborative Problem Solving (CPS) philosophy, one of its goals is to shift parents to a more compassionate mindset and embrace the notion that "*kids do well if they can*" (Ablon & Pollastri, 2018). Some parents provided examples of how they integrated more efforts to collaborate with their children following their SST session with the counsellor. For example, Eleanor described that she now takes the time to reflect with her daughter on a given difficult situation while incorporating the tools provided to her and asking follow-up questions. She stated,

> When certain situations, for example, interactions between my younger daughter and my older daughter that don't go so well– I'm able to say [to] my eldest daughter, "Okay, do you remember the think technique?" And that was just kind of a guidance for you know helping her objectively look at that situation. It's hard in the moment, but afterwards when the situation happens it blows over– you know, I'll sit down with her and say, "Okay, let's take that same technique, let's walk through that situation, what did you learn from that? If this happened again, how could you possibly change the outcome?"

Eleanor further mentioned that prior to the session, she would try to talk things through with her daughter and inquire how her daughter was feeling; however, the session provided her with specific tools to navigate conversations with her daughter. She elaborated on a technique she now uses with her daughter,

> Look at A, this certain part of the interaction that didn't go so well, B let's take a look at how you, like what was the trigger, you know, what was the reaction that you have emotionally, what was your verbal reaction to it, and then see how could you prevent those triggers in the first place, how could you moderate your response in terms of just walking away or you know falling down and crying and having a tantrum. Uhm, how could you deal with that in a more mature way?

For Ellie, the CPS strategies provided by the counsellor fostered healthier, more open communication between her and her daughter following the SST session. Prior to the session, Ellie described being overly involved by constantly asking her daughter how she was feeling. She explained,

> I realised that maybe I was asking her too regularly how she was doing and that might have been putting a little bit pressure on her to maybe try and feel better because she knew I was worried about her.

However, since the session, she mentioned changing her approach with her daughter. She elaborated,

> It has made me more willing to listen before jumping to conclusions […] I'm kind of letting her be more the lead, I'm not checking in with her as often. I was encouraged to see things through my daughter's eyes. It's definitely been an eye-opener and something that I definitely am going to practice with her.

Like Ellie, Natalie implemented a more collaborative parenting approach with her son. She attended Crossroads because her son was having sleep disturbances and his solution was to immediately go to his parent's bed to sleep. She explained that she was not empathetic towards her child, often minimizing and invalidating his fears. However, since meeting with the counsellor, she had tried being more empathetic toward her son; she realized that that was

something she needed to work on. With the counsellor's advice, she has been using a collaborative approach to finding more appropriate solutions when he wakes up. She explained,

> She suggest us to talk to him, what to do when he wakes up to help him to go back to sleep. And it was really helpful because I didn't think about that and so we started involving him to brainstorm, oh you wake up, but the solution is not go to our bed, because you go there and no one sleeps, you don't sleep and we don't sleep. So, we talk about fears– like if he's having fears, how to talk about the fears and how to accept his fears and help him to overcome them.

Similarly, Isabel has been implementing the CPS approach with her own son. Rather than taking a more authoritarian approach and telling him he cannot do something, she has started including her son in finding a suitable solution. She provided an example,

> So, if he does not want to do something, we have to give him the opportunity to talk and express his feelings before we kind of work together to come up with a resolution. "Well, I have to go make supper, you want to play video games, how- how can we come together to form a solution?" I'm more inclined to ask him questions to get out his feelings as opposed to just telling him, "No, we can't do this."

The Therapeutic Relationship Helped Empower Parents

Various parents spoke to the support and validation received from the counsellor, which in turn, empowered them in their parenting role. The therapeutic relationship helped clients move towards fulfilling their capacity to thrive by providing support, unconditional acceptance, and empathic understanding.

Ellie indicated that speaking with the counsellor allowed her to gain a more optimistic perspective. The new learning that emerged from the SST experience resulted in her viewing the challenges as an opportunity to grow, which led to little changes that served to lift her parenting self-efficacy. She stated,

> I think maybe just knowing, knowing that uhm, like sometimes you can't fix everything, you know. It's just changed a little bit how I view the issues, that maybe it's not the end of the world, maybe it's just an opportunity – and I realized, you know, you do see things a little bit dark at times, think it's going to be bad forever, but then you start to see these

> little changes that start to happen with coping. And that lifts a bit, and kind of helps, uhm, how you feel about yourself as a parent.

Lily made reference to certain qualities the counsellor possessed that made her feel heard and comfortable during the session and that the therapeutic encounter left her feeling more capable than she was seeing herself prior to the SST. That is, the counsellor validated what she already had inside herself but had become out of reach to her. She remarked,

> When we first connected with the [counsellor], she was very friendly, very bright, she listened, she was chockful full of ideas and she – I think what I noticed the most was her – her friendliness and persona, it really put us at ease, I guess it was right to have a third-party say, "It's not as bad as you think it is" because it's not uhm, so having her being able to do that and really listen. It's definitely – it's helped *a lot, a lot, a lot*. Having that validation, yeah.

Moreover, prior to her conversation with the counsellor, Lily felt overwhelmed and defeated with external messages from social media and other parent friends regarding her approach to parenting her child. After speaking with the counsellor, she regained a sense of confidence and validation that parenting a neurodivergent child may look different and that it is acceptable and necessary to meet her family's needs, that may diverge from those in other families. She explained,

> I'm not doing typical parenting and that's OK and that's necessary to meet [my child's] needs so, uhm, while there's a billion things flying around social media about parenting and things like that, uhm, they are not geared towards me and my family, my needs and it's easy to forget that it's easy to forget that I'm not in the 80% bucket of parents and children. We're in the 20% bucket that need a bit more tweaking and a different approach. It's I suppose difficult to remember that we are doing the right thing and that we can't always listen to the advice of neurotypical families if we share feelings of frustration.

Nora also described the experience of having someone validate and normalize her situation was powerful and empowering for her in her parenting role. When asked what had stood out to her during the session she remarked,

> Uhm, I think, just being acknowledged. Uhm, having support, like feeling like there's somebody there who can help. Uhm, so it was definitely felt empowering, uhm, [the counsellor] was knowledgeable, she understood, uhm, the issue, like I was confident that we weren't alone in these kinds of situations. The school makes you feel like you're the only one. And so, having that very- like it was warm, it was safe, it was responsive, it was supportive.

Natalie echoed similar observations about the session and the counsellor. She shared,

> I felt encouraged as a parent, and I felt that I had someone to talk about these things that are hard and someone that is expert that could give me some advice. She made me comfortable. And when I left the session, I felt supported.

Moving from a State of Distress Towards Hopefulness

While reflecting during the research interview on their therapy experience, most parents recalled feeling distressed in the time leading up to the SST. Furthermore, they reported that a feeling of emotional relief and hopefulness in relation to the presenting concerns subsequently emerged in the days and weeks following the SST. For instance, Nora shared how she was feeling prior to receiving services: "As a parent, the feeling before we had the meeting was like frustrated, desperate, alone, powerless, like not knowing what to do." Lily echoed similar concerns, she remarked,

> Well yeah, prior to that I was a lot more stressed, a lot more frustrated, a lot more scared that I was doing the wrong thing. I was afraid that we were failing our children, especially [child's name] because yeah, I wasn't – I felt like I wasn't making any headway, we weren't seeing any progress, we weren't seeing any better skills showing up.

Following the session, the mothers described experiencing a sense of relief and renewed sense of hopefulness. Lily shared how talking with the counsellor has significantly reduced her stress. She stated,

> After talking with [the counsellor], taking her advice into consideration, has allowed me to be less stressed about certain things in terms of remembering what the needs are for [my child] and our family and how to make sense of it. So, I think since talking to [the counsellor], I've been a lot less stressed, having that reminder and it's been a lot, not

> easier, but calmer for me, for me. And I guess it will spill onto the kids too if I'm not, you know, yelling.

Lily mentioned that prior to the SST she would often find herself doubting her parenting approaches, thereby contributing to her distress: "It undoubtedly gets you down" she expressed. However, since the session, she has turned her negative self-talk into a more positive inner dialogue. She stated,

> What has really changed is me, [husband's name], that's my husband, our inner approach– not my inner approach, my inner monologue in a way, I guess. I think that would be more accurate because I've been less stressed.

In the same way, Ellie mentioned that it has been difficult for her to see her daughter struggling with her mental health and know that she cannot "fix it." After attending the session, it alleviated some of her concerns. "Well, I'll say from a personal standpoint, I feel a little bit of relief to know that there's been this other person involved," she remarked. She further elaborated,

> Because I feel like it gives me an option to, uhm, I don't want it to sound the wrong way but kind of share that responsibility, like sense of – as a parent you don't always know if you're being helpful or saying too much or like, you know, it's good to have that objective person, I think that's helped me.

Although the parents attending Crossroads were seeking support for their children, they also made reference to the session being helpful in reducing their worries with regarding to their parenting. For example, Natalie stated, "I got support not just for my son, but for some stuff I was doing as a parent. It was really helpful." Likewise, Eleanor claimed, "I actually got a lot more out of it because I didn't realize that it was mainly for the parents, I actually initially thought that my daughter would just talk to [the counsellor] about her issues."

Experience of the Service Modality

The themes under Experience of the Service Modality answered the research question centred on how parents perceived their experience of utilizing a virtual single-session

counselling service at a children's mental health centre. The main theme that emerged was advantages to virtual counselling, with subthemes including accessibility of service, familiarity and safety of home environment, no commuting with children to the agency, and familiarity with virtual platform makes service easy to navigate.

Advantages of Virtual Counselling

Accessibility of Service. One aspect of the service modality that all parents valued was readily receiving access to counselling services. Ellie praised the accessibility of the service, stating, "I really hope this service continues long past when the pandemic is over – it's free, you can probably get in today or tomorrow to talk to somebody." Grace was also pleased with the speed in which she was able to talk with a counsellor. Similarly, Lily was impressed and satisfied by how quickly she was able to get an appointment. She shared,

> What really stood out in my mind and excited me was […] that they had openings the next day. Anything with ASD, or anything with that, you're on the waitlist six to eight months, and that's usually what you hear. But being able to talk to [Agency name] the next day was unbelievable. I got to talk to [the counsellor] the next freaking day. That never happens so that was awesome.

Ellie also discussed some of the benefits of the service, she remarked, "I knew through my workplace that Counselling Connect was a great way to get in quickly to talk to a professional. you know like there was no cost. So, to me it was just – you know a win-win."

Familiarity and Safety of Home Environment. While reflecting on the virtual aspect of the service, parents expressed feeling comfortable, and some even preferred to meet the counsellor virtually. Particularly, for certain parents, receiving virtual services met the particular needs of their family. Nora explained,

> I really like it. It's really nice for us because we don't have to drive, we don't have to go somewhere. Also, I have to say for my child who, uhm, gets anxious in new settings, for him to be at home, he's so much more comfortable. So, I think everyone was so much

> more comfortable, everyone in our house was more comfortable being able to do it virtually.

No Commuting with Children to the Agency. Lily echoed similar advantages to meeting the counsellor virtually. She stated,

> I like it because getting somewhere on time is very difficult for my family. Uhm, if there is a meltdown or a fuss, which often happens like I have to plan a couple of hours ahead and that sucks. So, virtual is great because I didn't have to rush, no stress, just put on the computer at the right time and be dressed half-decent top up.

Familiarity with Virtual Platforms Makes Service Easy to Navigate. Various parents spoke to the fact that working-from-home has fostered a familiarity with using technology. "I'm fairly comfortable, uhm, in these sessions because I – the nature of my work requires me to spend a lot of time online" Ava remarked. Eleanor made a similar comment,

> For me, I have no problem because I've been working from home since the beginning of the pandemic. So, meeting with people, uhm, virtually, you know, is a daily experience so, for me I don't have a problem with it.

Natalie also mentioned being comfortable with technology, and really sees a value in virtual counselling sessions. She articulated,

> I'm used to it. I work with technology so work from home or work with remote people, It's normal for me so I'm comfortable with that. And I think that they can reach more people online and it's such a rich service that they can reach more people, I think that it's good, maybe even better online.

Discussion

The purpose of this multiple case study was to investigate how parents perceive their parenting self-efficacy and how it evolved following single-session therapy (SST) at a children's mental health centre. Additionally, given that the services were delivered by necessity in a virtual format due to the COVID-19 pandemic, we wanted to explore how parents perceive their overall experience utilizing virtual "walk-in" counselling services. This section will provide a discussion of the results, and answers to the two research questions gleaned from the results are explored.

Furthermore, contributions to literature, theory, and clinical practice are provided. Finally, limitations and directions for future research are discussed.

Parents' Perceptions of their Parenting Self-Efficacy

The first research question asked how parents perceive their parenting self-efficacy before and after their SST session at a children's mental health centre walk-in clinic. The themes that emerged from the data aligned with the first research question include, (a) increased parental knowledge supports self-efficacy, (b) parenting with collaboration improved parent-child interactions, (c) the therapeutic relationship helped empower parents, and (d) parents moved from a state of distress towards hopefulness.

Increased Parental Knowledge Supports Self-Efficacy

The majority of parents in the present study expressed during the post-SST interview that they gained a deeper understanding of their child's mental health condition. They further described that the counsellor provided them with developmentally appropriate strategies and tools to better support their child. For example, parents were introduced to the Collaborative Problem-Solving (CPS) approach, which allowed them to be more knowledgeable about appropriate ways to communicate and problem-solve with their children. According to Coleman and Karraker (1998), parental self-efficacy is determined by various factors, including knowledge of suitable child care responses, knowledge of their child's development, and self-confidence about their abilities. Bandura (1977) claimed that mastery requires a combination of both correct knowledge and confidence to influence behaviour (Bandura, 1977), and therefore, "parents may need to have accurate knowledge about the parenting task and what 'success' in that domain would look like in order to achieve competency" (Grimes, 2012, p. 10). Parents in the current study gained a more accurate understanding of what constitutes developmentally

appropriate parenting practices, and by implementing such practices, became more confident in their parenting role.

Parenting knowledge has been also shown to be associated with more positive parent-child interactions and more competent parenting practices (Conrad et al., 1992; Hess et al., 2004). For example, Conrad and colleagues (1992) found a significant effect between maternal knowledge and maternal self-efficacy in predicting the quality of parent-child interactions. Specifically, mothers who reported the greatest knowledge of parenting and parental self-efficacy demonstrated a greater quality of parent-child interactions than their less knowledgeable and less confident counterparts. Research has shown that parental self-efficacy can be improved through intervention programs that provide parents with instruction on parenting skills, education about child development and age-appropriate abilities, and strategies to improve positive interactions with their children (e.g., Bloomfield & Kendall, 2012; Evans et al., 2003). This study suggests that parental knowledge can be increased in a single session of therapy, where parents gained more insight into their child's mental health condition and received specific information and strategies on how to navigate their child's needs. The new parenting skills also appeared to support the emergence of stronger self-efficacy in relation to the participants' parenting role.

Parenting with Collaboration Improved Parent-Child Interactions

Data from this study indicate that, following the SST session, parents reported implementing the collaboration strategies provided to them. Parents indicated in the interviews that interactions with their children were more effective when they integrated collaboration into problem-solving strategies with their children post-SST session. The Collaborative Problem-Solving (CPS) approach, which is used at CCMHC, has been found to improve the quality of

parent-child relationships as it emphasizes a more practical and compassionate approach to resolving problems (Ablon, 2019). Externalizing behavioural issues, such as noncompliant, defiant, aggressive behaviour, are among the most common reasons for referral to child mental health services (Loeber et al., 2000), and such behavioural difficulties are the primary concern of parents during early childhood (Fixsen et al., 2005). Children who exhibit such behaviours are typically diagnosed with disorders such as attention-deficit/hyperactivity disorder (ADHD), anxiety disorders, autism spectrum disorder (ASD), nonverbal learning disorder (Ablon, 2019), which encompass the majority of the children whose parents participated in the present study. As Ablon (2019) affirms, "parents struggle with how to manage these difficult and seemingly intractable behaviors" (p.1). By having concrete CPS strategies and tools at their disposal, parents indicated that they felt more confident about their skills as parents. Parents in this study expressed that since the session they have altered their parenting approaches, not only by implementing more collaborative and flexible strategies, but have also become more empathetic towards their children. In line with the present study, Heath et al. (2020) found that parents who used the CPS approach at home reduced their parenting stress and improved their empathy towards their children.

Increased quality of parent-child interactions has also been associated with high levels of parental self-efficacy (Albanese et al., 2019). Specifically, higher parental self-efficacy has been linked to more effective parenting styles and behaviour, such as: more responsive parenting (Aranda, 2014), an authoritative parenting style (Celada, 2010), and more effective child management strategies (Elder et al., 1995). Notably, previous research has also found a strong relationship between parental self-efficacy and adaptive parenting, which refers to parents' capacities to change their parenting strategies. Research suggests that parents with low parental

self-efficacy may be less motivated and less likely to implement new parenting techniques (Ardelt & Eccles, 2001; Elder et al., 1995). During the post-SST interview, parents described implementing the new strategies and tools provided to them, with one parent, Natalie, even mentioning signing up for a future course on CPS. Parents' willingness to implement the new parenting approaches following the SST session suggest that they have high parental self-efficacy.

The Therapeutic Relationship Helped Empower Parents

The validation, emotional support, and reassurance received from the counsellor were influential in promoting feelings of empowerment in parents that supported them in their parenting role. These therapeutic characteristics have been found to play an important role in promoting positive client outcomes. For example, in a study by Gibbons and Plath (2012) gathering in-depth feedback from clients about their experience of SST, clients identified various helpful qualities of the mental health professional, such as being empathetic, easy to talk to, non-judgmental, and knowledgeable.

Based on the SST philosophy and practice, the primary focus is on empowering clients to connect with their own strengths, resources, and solutions to their problems (O'Neill, 2017). As with the current study's findings, parents were encouraged to approach parenting to meet their particular family/child needs. Through the support provided by the counsellor, parents found more capacity and resources within themselves to address the parenting challenges they faced. Parents who receive verbal feedback and encouragement (i.e., *verbal persuasion*, Bandura, 1977) from supports like healthcare providers may feel more confident that they have the skills needed to care for their child (Aranda, 2013). Furthermore, parents, Ellie and Eleanor, reported that they attended SST services as they wanted an objective perspective from a mental health professional.

Similarly, Sommers-Flanagan (2007) found that parents who attended a child-rearing single-session consultation expressed appreciation for obtaining an objective and supportive outside perspective from an authority. In sum, these findings are useful in understanding what occurs in an SST session that helps empower parents.

Parents Moved from a State of Distress Towards Hopefulness

A final prevailing message in participant interviews, with the exception of two parents, Ava and Grace, was that the SST session led them to feel more hopeful and less stressed in the parenting role. Of the six parents who benefited from the SST session, they recounted at the post-SST interview that they had felt distressed, frustrated, and unsure of their parenting behaviour prior to receiving services at CCMHC. At the follow-up interview, parents described feeling less stressed and more confident, hopeful, and relieved. These results are in accordance with previous research suggesting that SST reduced distress, increased hopefulness and provided emotional relief to parents post-session (Harper-Jacques & Foucault, 2014; Slive et al., 2008; Young et al., 2008).

Furthermore, according to Bandura (1977), parents' *physiological and affective state* will also influence the level of parental self-efficacy. Parents with low parental self-efficacy are more likely to experience significant distress. For example, studies have found that parents with low parental self-efficacy are at a risk of frustration, stress, and depression, which translated into less effective parenting (Fox & Gelfand, 1994; Sanders & Woolley, 2005). Parental self-efficacy also has been linked to feelings of helplessness, negative affect, and low levels of parent satisfaction (Kwok & Wong, 2000; Teti & Gelfand, 1991). On the contrary, high parental self-efficacy is associated with higher satisfaction with the parenting role, better coping, and lower levels of

stress (Jones & Prinz, 2005). In the current study, the SST session left parents feeling less stressed, more capable to face their challenges and more confident in their parenting role.

Based on the case-level data, all parents described visiting CCMHC to obtain help with navigating their child's behavioural and emotional issues. However, parents' differing expectations of the service led to different experiences. In particular, two parents, Ava and Grace, had negative experiences with the SST intervention as it did not meet their particular needs and expectations. For instance, Grace had previous experience with a community family counselling agency for her child's issues with bathroom regression. Previous research on the issue of prior counselling experience indicates that the former seems to influence expectations of the SST walk-in experience that clients have (Cait et al., 2017). In the same vein, research has suggested that single-session therapy may not be useful for complex cases (Hurns, 2005).

Furthermore, in the current study, Grace reported that she was hoping that the counsellor speak with her child rather than focus on parenting strategies she could implement. In this case, it appears a single session may not have been sufficient to delve deeply into the presenting concern, and ongoing, specialized counselling might have been more helpful (Cait et al., 2017). In Ava's case, she was expecting to receive a concrete diagnosis of whether her child was experiencing anxiety; however, she was advised to seek a formal diagnosis or a psychoeducational assessment from another service provider. These findings suggest that the nature of the service and the potentially restricted range of counselling goals that can be addressed in an SST model did not align with the needs of clients. Also, these findings highlight the potential limitations of SST. A concern that emerges is whether SST is contra-indicated for more complex, severe, or chronic issues (D'Souza, 2019). During an SST session, the focus remains on the problem as it occurs in the present and not on exploring the past or underlying

causes. For some clients, a single session may be sufficient; however, previous research indicates that approximately 30% of clients require more extensive assessments or something other than brief interventions (Hoyt, 1998). According to Paul and van Ommeren (2013), SST can be used to provide supplementary support to clients living with severe mental disorder and/or at elevated risk of suicide; however, such clients will need more extensive treatment. In sum, SST sessions should be viewed as one component of a larger mental health service delivery system, where "a successful single session leaves open the possibility of further ongoing work if needed" (D'Souza, 2019, p.15).

Additionally, Ava and Grace both indicated to the researcher that they had previously attended parenting workshops and therefore, came to the SST session with a pre-existing foundational knowledge of parenting practices and techniques. Previous research has shown that clients who did not find walk-in SST services useful were already utilizing similar coping strategies suggested by the counsellor (Cait et al., 2017), which suggests why Ava and Grace did not find the session inherently valuable. Alternately, in the current study, the parents who benefited most from the SST session had little or no previous experience with receiving counselling services. These findings may suggest that walk-in SST is perhaps more helpful for parents seeking resources for the first time and/or requiring new approaches to their parenting. In fact, parents are more likely to turn to professional experts when they want parenting advice (Sommers-Flanagan & Sommers-Flanagan, 2003). Several studies have explored brief consultation services for parents who seek parenting skills and information but who might not want longer-term educational or therapy services (e.g., Bitter, 2004; Ritchie & Partin, 1994).

Parents' Experience of Virtual "Walk-in" Counselling Services

The second research question answered how parents perceived their experience utilizing virtual "walk-in" services at a children's mental health centre. The main theme that emerged was advantages to virtual counselling, with subthemes including accessibility of service, familiarity and safety of home environment, no commuting with children to the agency, and familiarity with virtual platform makes service easy to navigate.

Advantages of Virtual Counselling

The prevailing message in participant interviews was that parents' overall experience of utilizing virtual services was positive. Specifically, parents valued the accessibility and convenience of the virtual "walk-in" clinic and felt safe and comfortable conducting the session within their own home. Results are in line with various research suggesting that accessibility is one of the main benefits of walk-in counselling (Cait et al., 2017), by providing help at the point of need rather than help at the point of availability" (Dryden, 2019, p. 15). Further, virtual counselling provides the ability to meet the mental health needs for a variety of populations, including those without reliable transportation, those in rural, under-served areas (Baker & Ray, 2011).

Parents also expressed that familiarity with technology made it easier to navigate the virtual counselling service. In a recent study investigating components of successful engagement with videoconferencing psychotherapy, Hensel et al. (2020) identified that participants were more willing to use videoconferencing if they were familiar with how it worked. Specifically, participants mentioned having experience with videoconferencing in their personal life (e.g., FaceTime, Skype) as a means to communicate with colleagues, family and friends, which made them feel more inclined to use it for their therapy appointments. Likewise, the parents in the

current study cited experience with virtual platforms as it was their primary means of communication as most were working-from-home due to the pandemic.

Furthermore, parents voiced appreciating virtual services because it eliminated the trouble of commuting to the agency with their children. Various barriers to care, including transportation, childcare, weather, have been identified as motivators to using videoconferencing for therapy, where the more significant the barriers, the more motivated participants were to use videoconferencing (Hensel et al., 2020). In the current study, a handful of participants expressed that the virtual aspect met the needs of their families as getting to an in-person appointment is often challenging and requires substantial planning. For example, one parent, Lily, mentioned that getting somewhere on time is quite difficult for her family as her child often has a meltdown, and therefore she needs to plan a couple of hours ahead of time. By completing the SST session virtually, Lily expressed not having to "rush and stress" and has eliminated the challenges of getting to an in-person appointment. Altogether, the praise and positive feedback of virtual services illuminate the importance of continuing to offer this service delivery option, even after the pandemic.

Contributions to the Literature

The current study was initially developed prior to the COVID-19 pandemic; however, in response to rising cases and government safety guidelines, many mental health agencies, including CCMHC, shifted to providing virtual counselling services. As a result, the current study adjusted the second research question in the interest of investigating parents' experience of utilizing *virtual* "walk-in" single-session counselling services at a children's mental health centre. To date, few studies have explored virtual single-session interventions, however, none within the counselling context. For example, Schleider et al. (2022), investigated the effects of

two self-guided, online single-session interventions (SSIs), one teaching behavioural activation and another teaching growth mindset of personality in adolescents with depression. Results indicated that both self-guided online SSIs reduced hopelessness, strengthened perceived agency, and mitigated symptoms of depression and anxiety. In another study, Ziadni et al. (2020) investigated the efficacy of a single-session, Zoom-delivered, skills-based intervention among those with chronic pain. Findings indicated that the single-session, web-delivered group intervention had high participant satisfaction and high engagement as well as efficiently improved pain intensity and symptom management. The authors also argued that web-delivered interventions could allow greater accessibility and address the inconveniences and barriers faced by individuals attempting to receive in-person care.

Although the aforementioned studies investigate the effectiveness of virtual single-session interventions, none examine virtual SST within the context of therapeutic services. Thus, results from the current study contribute to novel research on virtually delivered SST. Results of this study demonstrate that the use of virtual SST appears promising in terms of increasing accessibility to mental health services and in promoting client satisfaction and clinical outcomes.

Contributions to Theory

The current study used the parenting process model (Belsky, 1984) as a guiding theoretical framework. The parenting process model was beneficial in illustrating how SST services could be considered as a social support network for parents. Results from this study are in line with Belsky's description of the key components that make up a social network. Firstly, the counsellor provided emotional support through empathy, validation, and reassurance. Secondly, the counsellor provided parents with instrumental assistance, that is, equipped them with concrete tools and knowledge to better support their child's needs. Belsky (1984)

acknowledged that a strong social support network presents a beneficial impact on positive parenting practices and the parent-child relationship, which was evidenced through this study. Therefore, if a parent has a lower sense of parental self-efficacy, feeling unable to meet their child's needs, social support from a mental health agency helps them build new and more effective parenting skills, increasing their parenting self-efficacy over time.

Contributions to Clinical Practice

The proposed research study has the potential to inform virtual SST services at community mental health clinics that provide services and support to parents. Understanding the experiences of parents utilizing this type of service delivery model shed light on the most and least effective aspects of the intervention. Given the importance of supporting parents and empowering them in their parenting role, this study emphasized the importance of providing parents with emotional support, validation, and reassurance all while providing them with vital information and strategies to better support their child's needs. The findings suggest that SST may not be inherently helpful to parents who already possess considerable knowledge on parenting strategies or whose children present with complex issues.

Finally, given that parents appreciated the virtual aspect of the service, it may be worthwhile for community-based agencies to consider offering virtual services indefinitely. In fact, the importance of virtual mental health services has been further highlighted in the face of the COVID-19 pandemic (Moroz et al., 2020). Various Canadian provinces have begun implementing strategic plans to improve access to mental health professionals, including using virtual technologies to overcome geographic and demographic barriers (e.g., rural communities and Indigenous populations; Moroz et al., 2020). The sample in the current study was demographically narrow as it was composed of all women, predominantly Caucasian, and who

had access to technology, which was required to access the SST session, which does not capture the full range of potential clients who could benefit from this service (e.g., immigrants and refugees). Given that immigrants and refugees, compared with the Canadian-born population, are less likely to have consulted mental health professionals, it is important to consider how virtual services could have an impact on these vulnerable groups (Ng & Zhang, 2021).

Limitations of the Study

Although this study offers some important findings to the literature, some limitations were evident to the study as well. First and foremost, the sample was made up of only married mothers, with the majority identifying as Caucasian. For this reason, the results have limited applicability to other clinical contexts because the eight parents who participated may not be representative of all families seeking services at a community mental health agency. Further, the parents needed to have familiarity with and access to technology in order to participate in the study. The data does not account for the perspective of vulnerable, lower SES groups, who may experience barriers to accessing virtual services.

A second limitation of the study was that the quantitative findings revealed that the majority of parents reported similar pre-and-post parental self-efficacy ratings, with ratings being scored relatively high on both occasions. That is, if parents scored high in terms of their perceived parental self-efficacy prior to attending the SST session, there was little to no room to increase scores on the questionnaire post-session. Given that assessment of parental self-efficacy relies on self-report, some parents may have inflated their reported parental self-efficacy beyond their actual level of confidence to conform in a social desirable direction (Jones & Prinz, 2005). Alternatively, employing a different method, such as the retrospective post-then-pre design (e.g., Howard, 1980; Pratt et al., 2000), may have been more suitable to assess parents' self-reported

changes in their parental self-efficacy. In the retrospective post-then-pre design, both pre-and-post information is collected at the same time. In other words, at the follow-up interview, parents would have been asked to rate their parental self-efficacy *currently* as a result of the SST intervention, and then, asked to reflect back and rate their parental self-efficacy *before* attending the SST session. Utilizing this design avoids response shift bias that results from pre-test overestimation or underestimation (Howard et al., 1979; Howard, 1980). This bias can be defined as an intervention-produced change in the participants' understanding of the construct being measured (Pratt et al., 2000). In a study measuring program outcomes, Pratt et al. (2000) found that when response shift bias is present, a retrospective pre-test design generates a more legitimate assessment of program outcomes than does traditional pretest-post-test design. Perhaps, parents in the present study were not able to accurately assess their parental self-efficacy until after the session, which may have masked the effectiveness of the SST intervention.

Furthermore, it is worth noting that three levels of parenting self-efficacy (PSE) have been distinguished in the literature: general, narrow-domain, and task-specific (Fang et al., 2021). General PSE refers to parents' perceptions of their ability to engage in the behaviours expected in the parenting role without focusing on specific parenting tasks (Jones & Prinz, 2005). Narrow-domain PSE focuses on parents' perceived competence in one parenting domain, such as discipline, promotion of learning, or communication (Jones & Prinz, 2005). Finally, task-specific PSE refers to the confidence a parent has over a specific set of parenting tasks (e.g., tasks related to childrearing activities such as breastfeeding, toilet-training, or caring for a sick child; Jones & Prinz, 2005). The current study used the PSAM (Dumka et al., 1996) to measure PSE, which assesses general levels of PSE (Jones & Prinz, 2005; Wittkowski et al., 2017).

According to Bandura (1977), general PSE is considered a less sensitive measure to assess changes in PSE compared with narrow-domain and task-specific levels of PSE. The discrepancy in the qualitative and quantitative findings may be explained by the level of PSE being measured. That is, the questionnaire measured general PSE (e.g., I feel sure of myself as a parent), whereas the retrospective interviews targeted more narrow-domain PSE (i.e., their perceptions of their parenting following an SST session in dealing with their children's social, emotional and behavioural challenges). Therefore, parents may have perceived to feel confident in their "overall" parenting; however, when questioned more specifically on concerns/difficulties with their child, it revealed a lack of self-efficacy in dealing with specific behavioural and emotional challenges in their children.

Strengths of the Study

The current study also presented a few strengths. Firstly, the sample size was adequate for qualitative studies so as to make in-depth analysis of participants' experiences. According to Saunders et al. (2018), data saturation is based on the concept of informational redundancy; that is, decisions about whether further data collection is necessary are based on the researcher's sense of what they are hearing in the participant interviews. As a result, data saturation can be identified at an early stage in the process and, therefore, precedes formal data analysis (Saunders et al., 2018). In the current study, data saturation was deemed to have been reached as the latter participants were providing comments that largely replicated those made by earlier participants, and therefore, no new information was emerging in the latter interviews. Moreover, this study is situated in a real-world context, which provides rich insights into what actually happens in everyday clinical practice at a children's mental health centre.

Future Directions

Given that research about virtual SST is in its infancy, there are many exciting possibilities for future research, both qualitative and quantitative in scope. For instance, future studies should consider how virtual SST compares with in-person single-session therapy in terms of client outcomes, including both parent and child. Furthermore, future research should include fathers' perceptions of their parental self-efficacy and include a broader sample including partnered and single parents, different cultural and ethnic backgrounds, which would provide a more complex and varied data set. This may require the use of purposive sampling techniques and adequate compensatory supports (e.g., transportation to the research site; child care while parents participate in an interview) in order to reach parents who tend to be less apt to participate in research studies. Additionally, future research should include observational studies so as to observe real-life outcomes in the family and child. For example, naturalistic observations would allow the researcher to observe whether or how parents implement the strategies provided to them during an SST session.

Conclusion

Analysis of interviews conducted with eight parents resulted in five themes. The themes were: (1) increased parental knowledge supports self-efficacy, (2) parenting with collaboration improves parent-child interactions, (3) the therapeutic relationship helped empower parents, (4) parents moved from a state of distress towards hopefulness and, (5) advantages of virtual counselling. Themes were described and illustrated with participant quotes in the results section of this thesis. The discussion revisited the two major research questions and explored possible answers in light of the results of this study. Additionally, contributions to the literature, theory and clinical practice were discussed. Finally, limitations and recommendations for future

research were provided. In summary, findings indicated that virtual SST provided parents with greater parental knowledge and concrete collaborative problem-solving strategies that improved parent-child interactions. Further, the emotional support and validation received reduced parents' distress while increasing hopefulness and empowering them in the parenting role. In addition, parents valued the accessibility and convenience of the virtual option. Overall, the findings of this study provide evidence that virtual SST can be beneficial for parents and can foster parenting self-efficacy.

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Appendix A

Parental Self-Agency Measure (PSAM)

1. **I feel sure of myself as a parent.**
    a. Almost never or never
    b. Once in a while
    c. Sometimes
    d. A lot of the time
    e. Almost always or always

2. **I know I am doing a good job as a parent.**
    a. Almost never or never
    b. Once in a while
    c. Sometimes
    d. A lot of the time
    e. Almost always or always

3. **I know things about being a parent that would be helpful to other parents.**
    a. Almost never or never
    b. Once in a while
    c. Sometimes
    d. A lot of the time
    e. Almost always or always

4. **When things are going badly between by child and me, I keep trying until things begin to improve.**
    a. Almost never or never
    b. Once in a while
    c. Sometimes
    d. A lot of the time
    e. Almost always or always

Appendix B

Participant Recruitment Statement

I am contacting you on behalf of Crossroads Children's Mental Health Centre as you consented to us reaching out to you to participate in specific research studies.

My name is Julia Renauld, and I am a graduate student at the University of Ottawa in the M.A. Counselling Psychology program. I am currently recruiting participants for my master's thesis project under the supervision of Dr. David Smith in affiliation with Crossroads Children's Mental Health Centre (CCMHC). The purpose of my study is to explore parents' experiences of walk-in services at Crossroads. Participation in this study will consist of completing a 30-minute telephone or video interview with the Principal Investigator (Julia Renauld). As compensation for your participation, you will receive a $20 Amazon e-gift card.

During this interview, you will be invited to talk about your experience of using walk-in counselling services at Crossroads. I will be audio-recording the interview to accurately capture our discussion. Your participation will help us to better understand how walk-in services are helpful to families like yours and improve services to other families in the community. Your input is valued and appreciated, and our research would not be possible without the help of families like yours.

Please note that the interview will be conducted in English. To be eligible to participate, you and your child must not have received any other mental health services within the past year to address the problem that initially brought you to Crossroads walk-in services.

Your decision to participate in this research study (or not) will have no impact on the services received and/or relationship with Crossroads. This research study is being conducted independently from Crossroads, and the organization will not know who chooses to participate (or not).

Please let me know if you are interested in participating, and I will send you the consent form to review. If you have any questions about the study, do not hesitate to contact me by email.

Appendix C

uOttawa

Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

Interview Informed Consent Form

Title of the Study: Walk-In Single Session Therapy: A Study of Parents' Self Efficacy

Research Team:

Ms. Julia Renauld (Principal Investigator)
Master's Student
Faculty of Education, University of Ottawa

Dr. David Smith (Project Supervisor)
Faculty of Education, University of Ottawa
Phone: 613-562-5800 ext. 4344
Email: David.smith@uottawa.ca

Invitation to Participate: I have been invited to participate in the abovementioned research study being conducted as part of Ms. Julia Renauld's Master's Thesis, under the supervision of Professor Dr. David Smith.

Purpose of the Study: The purpose of the study is to capture the lived experiences of parents utilizing single-session walk-in counselling services at a children's mental health centre.

Participation: My participation will consist of participating in an interview about my experiences with walk-in single-session counselling services. The time needed for this is approximately 30 minutes. The interview will focus on my experiences of single-session counselling services and the effects of the session on my parenting. The interview will be audio-recorded. I will have the choice to be interviewed either over telephone or Zoom.

If I choose to conduct the interview via Zoom, I give my permission to the Principal Investigator to have the interview video recorded. (Please indicate your decision below)
☐ Yes
☐ No

Assessment of risks: My participation in this study entails no foreseeable risks. However, if I experience any emotional discomfort, I may decide to not answer questions and/or stop the interview at any time without consequences.

Benefits: My participation in this study will allow me to reflect on my experiences and to contribute to the development of practice guidelines

for practitioners delivering single-session counselling for youth and parents.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for research publications and the development of practice guidelines. I understand that all data will be pooled together so that when findings are presented, they will not be presented individually. I understand that my confidentiality will be protected by assigning me a pseudonym. All documents generated by this study, including publications, will only refer to me by my pseudonym. A spreadsheet linking my name and pseudonym will be kept by the Principal Investigator in a password-protected file saved separate from the rest of the data. With respect to other information (e.g., names of locations or other individuals) that might indirectly identify me, will be permanently removed from the transcripts. In sum, any information that I share that may be identifiable will be anonymized or removed. Anonymous data will be stored on a secure cloud platform (Sharepoint) that is maintained by the University of Ottawa and only the researchers, Ms. Renauld and Dr. Smith will have access. All files will be password protected.

Conservation of data: The data collected, which will consist of audio and video recordings and transcripts of interviews, will be kept in a secure manner. Upon the completion of the data collection, audio and video recordings and transcripts of interviews will be removed from cloud storage and transferred to a USB drive that will be stored in a locked cabinet at the Project Supervisor's office at the University of Ottawa. Data and research documents will be retained for a period of five years following the completion of the study. Following the five years, all the data will be destroyed in a secure manner.

Compensation: I will receive a $20 Amazon e-gift card to be sent following the interview. If I choose to withdraw from the study, I will still receive this compensation.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____[*Name of participant*], agree to participate in the above research study conducted by Ms. Julia Renauld of the Faculty of Education at the University of Ottawa.

If I have any questions about the study, I may contact Ms. Julia Renauld or Dr. David Smith.

If I have any ethical concerns regarding my participation in this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, 550 Cumberland Street, Room 154, (613) 562-5387 or ethics@uottawa.ca.

This copy of the consent form is mine to keep. I will sign and return a digital copy to the Principal Investigator conducting the interview with me.

Participant's name	Signature:	Date:

Researcher's name	Signature:	Date:

Appendix D

Demographic Questions

1. Could you please state your age?
2. What gender do you identify with?
3. Is there a racial, ethnic, and/or cultural group you and your family identify with?
4. How long have you lived in Canada?
    - **a.** Your whole life?
    - **b.** Part of your life? How long?
5. If you are currently employed outside the home, can you describe the circumstances of your work?
    a) Home
    b) At your workplace
    c) A combination of both
6. Who is involved in parenting your child?
7. Are there any other children in the home that reside with your child?
8. What is your child's gender identity?
9. What grade is your child in?
10. Does your child live with a disability, whether it is physical or mental disability?
    - **a.** Does this disability have a formal diagnosis?
    - **b.** Are there any other diagnoses?

Appendix E

Open-Ended Interview Questions

1) What lead you to initially book a walk-in session with Crossroads?
2) What were you hoping to get out of the session, and did it meet your expectations and/or needs?
3) Can you tell me what happened in the session [from what you remember]? For example, what stood out to you, what did you notice?
4) What have you noticed, if anything, in your parenting following the walk-in session?
5) How does that compare to your parenting prior to you attending the walk-in session?
6) How did you find the experience of meeting the clinician virtually, what was that like for you?
7) That is all the questions I had prepared. I'm wondering, is there anything else that I have not asked you that you feel is important for me to know?