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ORIGINAL PAPER

Single Session Psychology Clinic for Parents of Children with Autism Spectrum Disorder: A Feasibility Study

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Abstract Children are being diagnosed with autism spectrum disorder at much higher rates than in the past, with the increasing rates arising primarily from the broadened diagnostic criteria and increased public and professional awareness of the disorder. In turn, this has resulted in increased demands for psychological services, which many service providers struggle to meet. Single session clinics are an innovative form of intervention which can facilitate quick access to psychological services, without the burden of lengthy waiting times. This feasibility study examined the nature of presenting problems, attendance rates and parental satisfaction with a single session clinic for parents of children with autism spectrum disorder. The service offers short one-to-one consultation with a psychologist and sessions can be booked up to one month in advance. The single session clinic was developed to provide individual intervention to families within the constraints of an overwhelmed service. Good attendance rates and relatively high satisfaction suggest the single-session consultation for parents of children with autism spectrum disorder is an acceptable form of service. Limitations include the a need for more detailed evaluation of the impact of the sessions on both parental anxiety and child outcomes, and to identify more clearly who may benefit most from this model.

Keywords Autism spectrum disorder · Single-session · Attendance · Parent satisfaction · Supply and demand

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Introduction

Autism Spectrum Disorder (ASD) has increased in prevalence significantly in the last three decades (Blumberg et al. 2013). Early epidemiological studies suggested a low prevalence rate of around 5 per 10,000 for autism in children (Wing and Gould 1979), whereas a study by Fombonne (2003) recorded a much higher rate of between 40 and 60 cases per 10,000 children. This higher figure received further support in a global review of ASD prevalence which found a rate of 62 per 10,000 (Elsabbagh et al. 2012). Taylor (2006) suggests three clear reasons for this ten-fold increase in the prevalence of ASD: the application of broader diagnostic criteria which may have led to some diagnostic transfer from other conditions, an increased awareness of the condition among professionals and parents which has led to the availability of better service provision, and an increased acceptance of ASD as a diagnostic category.

Demand for psychological services continues to outstrip supply (Branley and Byrne 2012). However, this burgeoning demand also raises specific challenges for disability teams established to provide services to a much smaller group of children. This study takes place in a public health disability service, at one time providing multidisciplinary support for 173 children with ASD but, with the substantial rise in the number of children being diagnosed, now provides services to 659 children: almost a four-fold increase in the number of children and families being offered a service, with the same level of staffing.

Requests for psychological interventions for children with ASD and their families vary greatly (Hartley and Schultz 2015; Weiss et al. 2012) and the treatments themselves vary both in intensity and in who delivers them. At one end of the spectrum are the resource and time-intensive

approaches such as ABA, developed in the context of institutional hospital settings, which Lovaas claimed required 40 h of one-to-one instruction per week (Lovaas and Buch 1997). However, Lovaas was working in a context in which a narrower definition of autism applied, and current services cater to a much broader spectrum of presentations.

Children with ASD frequently present with clinically significant behavioural and emotional problems including anxiety, over-activity and deficits in everyday living skills (Hartley and Schultz 2015), and with common childhood difficulties such as toileting, sleep problems and enuresis. Additional priorities identified by parents of children with ASD include support for setting up a specialized education plan, to be well-educated about the diagnosis of ASD, to be able to consult professionals for advice and information (Hartley and Schultz 2015). Not all of the presenting difficulties require a therapeutic model of intervention (such as weekly hour-long sessions with a psychologist which typically average 14 sessions; Dowd et al. 2011).

Single session therapy and drop-in clinics can enable people to access support without lengthy waiting times. A recent study by Anderson and Latimer (2015) highlighted the usefulness of a walk-in clinic in a primary care psychology service. Walk-in and drop in clinics provide many important benefits to clients, such as the relief of being able to access a service quickly, a greater sense of control over their treatment, an increased feeling of security and decreased levels of anxiety regarding the referral and treatment process (Clinton et al. 2014). Similar benefits have been found with single-session services, though the models do have some differences. As Slive and Bobele (2012) point out, both walk-in and single-session models of brief therapy challenge the idea that enduring change can only be brought about through lengthy psychotherapeutic intervention. Some psychotherapy research has argued that change most often occurs during the first few sessions of therapy (Howard et al. 1986; Seligman 1995) with the most ambitious claims for the single session model being proposed by writers such as Bernard Bloom, who argued that by identifying a focal problem and offering a starting point for a problem-solving sequence one could initiate change in a single session that is then elaborated and developed by the client after the session is over, with the client following a plan of action which might include keeping a diary or a log of behaviours, setting up a schedule, reading self-help materials about the difficulty or making a plan to behave differently in a certain setting (Bloom 2001).

Single session therapy has been shown to reduce the length of waiting lists, the frequency of non-attendance for scheduled appointments and the level of clients' distress (Horton et al. 2011). Single session therapy may be useful both in reducing risk to individuals awaiting treatment and as a cost-effective provision for over-stretched services. An evaluation of a walk-in single session counseling service reported high levels of client satisfaction, with 44% of the service users believing once-off session was sufficient in dealing with their presenting problem (Harper-Jaques and Foucault 2014). Clients also reported decreased levels of distress and increased levels of hopefulness post-session. These changes were maintained at the one-month follow-up with additional improvements seen in coping and a decrease in problem severity. A study by Hoyt et al. (1992) was conducted to assess the efficacy of single-session counseling. Of those involved in the study, 58% were deemed not to require additional sessions and, within that group, 88% of individuals felt they were either improved or greatly improved at follow-up. Similarly, Askevold (1983) found no significant difference in the levels of improvement among women with Anorexia Nervosa who received single session therapy, a brief series of sessions, or regular sessions of psychotherapy. However, concerns have been voiced that single session therapy may only produce short-term change (Perkins and Scarlett 2008).

Despite many examples of the usefulness of single-session interventions and clinics, these innovations have not been reported in the literature on working with the parents of children with ASD. Single session clinics might be particularly useful in the area of ASD, given the high levels of common childhood difficulties that potentially can be addressed through psycho-educational approaches with parents (e.g. Kroeger and Sorensen 2010; Malow et al. 2014; Sharp et al. 2014). We could not find any published studies on the use of single session clinics in ASD services or any empirical evaluation of parent satisfaction with single session clinics. However, research has demonstrated raising children with ASD can be extremely stressful (Baker-Ericze´n et al. 2005) and we took the view that quick access to a single session clinic may have the potential to address some of the needs of parents. For the purpose of this study the term "single session clinic" is defined as a single session with a psychologist booked at relatively short notice (within a month) and is offered without the expectation that further sessions will be available immediately. Given the need for innovations when demand for psychology services outstrips supply, this paper describes a feasibility study on the introduction of a single session clinic for parents of children with ASD. It summarizes the nature of the presenting problems, collates attendance rates and carries out a preliminary analysis of parent satisfaction with the clinic.

The Single Session Clinic

We developed a single session clinic for parents of children with ASD in our service two years ago. This was a response

to the regular ASD psychology service waiting list growing to over a year, due to the rapid increase in the number of children diagnosed with ASD. The clinic offers half hour long specialist consultation to parents of children with ASD on a variety of issues. It differs from a traditional drop-in or walk-in clinic in that the appointments are booked by the client in advance. Appointments can only be made during the month prior to the clinic, to ensure lengthy waiting lists do not accrue. The single session clinic is only for parents whose children have already received a multi-disciplinary diagnosis of ASD. The session is conceived of as a single-session intervention. The clinic is an adjunct to other services offered; however, the single session clinic was only used by parents who were not regularly seeing a psychologist in the service, but could ask to be wait-listed for regular sessions after the single session clinic if this was needed. This happened infrequently, but did occur for some referrals when the presenting difficulty required significantly more intervention than could be provided in the single session. The psychology service is part of a broader multi-disciplinary service to children with ASD that provides diagnostic and intervention services, including clinical and educational psychology support, speech and language therapy, occupational therapy, physiotherapy and social work.

Referrals were not formally screened for the single-session clinic: parents could telephone and make an appointment through the administrator without speaking to one of the psychologists. On occasion, it became clear in the session, that the difficulty being presented could not be addressed in a single session and parents were given the option of further sessions (using a more traditional format) with the same psychologist for urgent and critical matters. With less urgent referrals, a discussion took place about being assigned to the waiting list for a regular slot with a psychologist.

Single Session Techniques

Some of the principles articulated by Paul and van Ommeren (2013) were adapted for use in the development of the single session clinic. These included practical measures such as beginning each session clarifying the amount of time available and that the session is a single session; explaining if parents need more than one session when they return they may see a different psychologist and assessing risk factors that might indicate that the single session is unlikely to be sufficient (e.g. referrals primarily concerning physical aggression or self-injury). Secondly, we utilized a range of questions to guide the session including asking the parent to focus on identifying the single most important concern for them at this moment, checking what has been tried in the past and attempting to identify the smallest change needed to help the family feel that they are making progress. Identifying an area of focus is a primary goal of the single session model, allowing parents to decide and helping them clarify in the first few minutes of the session what they wanted to discuss in the session.

Psychologists

An educational and a clinical psychologist ran the single-session clinic, both of whom had in excess of 3 years ASD experience (one with 4 years, the other with 13 years of experience). Both psychologists worked full time with the ASD service in diagnostic work and with traditional intervention caseloads.

Referral analysis

The single session clinic was set up for parents to attend without their child. To clarify the nature of the problem for which the parent was seeking help, we collected data on the referring problem, age and sex of the child over 16 monthly sessions. Table 1 shows the frequency of various presenting problems. Sleep, toileting, tantrums and behaviour management issues made up 44% of presenting problems.

The sample consisted of parents of forty boys and three girls. Parents of children between the ages of 3 and 7 made up a considerable proportion (47%) of those who attended the single session clinic.

Attendance Rates

Attendance rates are displayed in Table 2. Parents rang the service to book a session with the single session clinic at a time convenient for them; however, the number of sessions available was limited.

Table 1 Presenting problems to single-session clinic

Presenting problem	Frequency
Tantrums and behaviour management	7
Sleep difficulties	6
Toileting	6
Academic progress	4
Anxiety	4
Discussing diagnosis	3
Emotion regulation	3
Social interaction difficulties	3
School placement discussion	2
Sibling conflict	2
Accessing pornography on internet	1
Oppositionality	1
Parenting	1

Table 2 Attendance rates

	n	(%)
Attended	51	(88%)
Did not attend	2	(4%)
Cancelled by parent	5	(10%)

These rates of attendance compare well with international data which suggests DNA (did not attend) rates of around 30% are not unusual for psychology clinics (Conduit et al. 2004). A small number of families attended the single session clinic on more than one occasion. It is difficult to draw any firm conclusions on the reasons for multiple single session appointments, but the referring reason tended to be for behaviour problems and tantrums or anxiety difficulties. Waiting for regularly scheduled psychology appointments may have been difficult to tolerate and the single session clinic might have been used as a stopgap.

Interventions

The psychologists employed a variety of intervention methods including psycho-educational approaches, such as informing parents about specific needs relating to ASD and typical child development and the use of some cognitive-behavioral therapy techniques. As an illustration of the work of the single session clinic, we will highlight how sleep problems were typically addressed in a single session.

The common occurrence of sleep problems in children with ASD are well documented, including problems with sleep onset, early morning waking, night waking and difficulties associated with co-sleeping (Moon et al. 2010). Children with ASD may have additional difficulties regulating their activity and arousal levels during the day, and this can lead to problems when trying to settle for bedtime (Richdale and Baglin 2015). The general difficulties with transitioning common in ASD may also occur in the transitions involved in going to bed and from active to inactive behaviour, necessary for sleep onset. Though sleep disturbance in children with ASD can be associated with a range of physiological differences including in melatonin production and the use of daytime stimulant medication, behavioural causes of sleep difficulties (e.g., poor sleep hygiene) are common. The difficulties in social communication, typical of many children with ASD, may mean the child does not understand the expectations of bedtime, and may need the support of visuals and more structured routines to learn these expectations.

In the single session clinic, the psychologist asks questions about the kind of the sleep difficulty the child is experiencing. In doing so, they can highlight the importance of a range of features to the child's bedtime routine, including activities before bed, relaxation, how to manage the transition to a sleepy state, the sleeping environment and sleeping arrangements. The intervention would often include some focused discussion with the parents to promote positive sleep habits for their children, which can include the importance of developing a consistent bedtime routine for their child, utilising a late bedtime when sleep onset is highly likely, increasing the amount of physical exercise during the day for children with sedentary interests (Wachob and Lorenzi 2015), cutting down caffeine use (Ogeil and Phillips 2015), developing soothing evening routines and rituals in a warm, relaxing environment (Kräuchi et al. 1999), managing light levels in the bedroom and eliminating the use of blue-light devices (Chellappa et al. 2013) and television (Falbe et al. 2015) from the bedroom. In the context of a single session, any one or two of these changes could be a potential focus for action for the parents. This does not discount the possibility of following more of these changes after the session and this is incorporated into the written material sent to the parents after the session is over. In studies that used just information leaflets, parents reported they thought it would be more useful to have specific ideas of how to take the information and put it into practice (Adkins et al. 2012).The single session clinic allows for an elaboration and exploration of how to apply the ideas that appear in the leaflet to a real world difficulty in the parents' own unique context. In our clinic, we regularly gave copies of psycho-educational leaflets to parents to support and supplement the work done in the single session; these include information leaflets on how to tackle sleep problems in young children with ASD.

Parents are often very tired themselves from the difficulties of putting a reluctant child to bed and the subsequent disturbance to their own sleep caused by night waking (Meltzer and Mindell 2007). Sometimes both parents are involved in the night-time routine on the same night. In families with two parents, there is an opportunity to problem solve by choosing one parent who might prioritise the bedtime routine one night and get a good night's sleep the following night, with a role reversal for the other parent, so they work turn-and-turnabout. This can be a useful first step to strengthen the parent alliance and potential for positive co-parenting (Feinberg 2003; Teti et al. 2015) and to implement extinction procedures which have good support in the sleep literature (Mindell 1999; Vriend et al. 2011).

Parent Satisfaction

As part of the evaluation of our service, a brief parent satisfaction survey was conducted with families who attended the single session clinic since it was established two years ago. Parents of forty-three children were

identified and contacted either via email or post and invited to participate. The questionnaire was developed specifically for the single session clinic and was informed by previous research in the areas of single session therapy (Hoyt et al. 1992) and walk in clinics (Salisbury and Munro 2003).

The questionnaire was comprised of a 10 point scale assessing global satisfaction (satisfaction scores ranged from 1-10 with higher scores reflecting greater satisfaction). Ten point scales are widely used to assess overall judgments with a wide range of psychological phenomena including patient satisfaction (Thompson et al. 2015), job satisfaction (Jongbloed et al. 2014), and satisfaction with attainment (Brands et al. 2015).

Satisfaction questionnaires were returned by parents of 21 children, representing a response rate of 49% of parents who had attended the single session clinic. The majority of respondents were satisfied with the service they received ($M = 7.1$, $SD = 2.3$), with 76% reporting a satisfaction score of six or higher. Just over half (52%) of participants felt one session was sufficient in dealing with the issue they brought to the clinic and a further 33% reported that while the one session was useful, more sessions were required. A total of 10% reported that the single session clinic was unhelpful and what they needed was ongoing sessions. Positive feedback was generally related to being seen by a psychologist within a short space of time. Several participants commented on the sense of urgency they felt regarding their issue. Other parents mentioned the reduction in their stress at being able to see a psychologist quickly.

Discussion

Single session clinics are a novel intervention. In this article we described a feasibility study of a single session model applied to a psychology service for parents of children with ASD. The excellent attendance rates achieved for the single session clinic point to high levels of acceptability for parents. This view is supported by the reasonable levels of parent satisfaction achieved in the small sample who took part in the parent satisfaction survey.

Children with ASD spend the majority of their time with their family; therefore, it is crucial to support parents in their interactions with their children and in learning how to manage common behavioural and developmental problems (Sears et al. 2013). We found that the most common presenting problems were sleep difficulties, toileting training difficulties and accidents, tantrums and managing difficult behaviours early in childhood. These difficulties are sometimes described as 'ASD-associated conditions': clinical or behavioral issues that frequently accompany ASD presentations (Carbone et al. 2013). The presenting problems in Table 1 are very similar to the ASD-associated conditions highlighted in the study by Carbone et al. (2013). This accorded with our view that many of the difficulties for parents of children with ASD may be amenable to a brief psycho-educational intervention. Missed appointments are a significant waste of resources and have been the focus of a number of studies attempting to address resource shortages in psychological and mental health care (Loumidis and Shropshire 1997). Attendance rates at the single session clinic were high, with only 4% of parents not attending, and only a small number of cancelled appointments. This compares well to international data on attendance rates at psychological and mental health services, in which treatment non-attendance rates are frequently around 30% (Watt et al. 2012; Watt et al. 2007). It would seem likely the short waiting time for an appointment at the single session clinic played a significant role in maintaining high attendance rates as non-attendance has been shown to be significantly related to prolonged waiting times (Loumidis et al. 1997).

The findings of this study suggest reasonable levels of satisfaction with the single session clinic with over 76% of participants reporting high rates of satisfaction. These findings corroborate the qualitative results and previous research. Within this study, 80% of participants said they preferred to be seen within a month over receiving multiple sessions, reinforcing the sense of urgency parents feel in receiving support for themselves and their children. Conversely, those who were more critical of the service felt a month was too long to wait and that a non-appointment based, walk-in style clinic would be more effective.

While the single session clinic was designed to be self-contained, in practice the psychologist must sometimes engage in a degree of follow-up after the sessions. In addition to providing multiple sessions to a small number of clients, the psychologist frequently is required to take on tasks such as sending out reading lists to parents or writing letters of recommendation to schools. As such, there is a risk the single session clinic will generate additional work after the session, and when this additional work exceeds capacity, parents are likely to be dissatisfied. From our experience, we estimate that the time required for follow up tasks, was in the order of 20% of the total planned clinic time.

The nature of this study does not allow us to draw strong conclusions on whether the single session clinic was successful in reducing demands on the service. However, of those who responded to the survey 76% did not book further sessions, and the majority expressed satisfaction with the service, which suggests that at least for some parents attending the single session clinic was sufficient. We did not track access to other psychological services outside of our own service. It is possible some parents sought other support from private psychologists but this was never reported to us. These results are similar to those of Talmon (2012)

who found single-session therapy to be effective for 44% of clients. However, it is important to note that 10% of participants felt the consultation was unhelpful, suggesting that the single session clinic was inappropriate for a small proportion of families. As a service development, it will be important to identify the factors which influence this 10%, so they may be re-directed to more suitable intervention services. Similarly, there was a group of parents who attended the single session clinic on more than one occasion. This group might benefit from a short term model which is longer than the single session. Parents who attend a single session clinic may be more likely to have less severe difficulties than those who request more long-term interventions, and as such single session consultation will not be appropriate for all families of children with ASD.

The results of this study suggest a single session clinic can be an acceptable form of support to offer to parents of children with ASD. This style of service may be particularly suited to the area of ASD, as concerns are often psychoeducational in nature which might respond well to brief models of psychological intervention that focus on enabling the parents to carry out the work themselves. For those working within other areas, certain adaptations may be needed to the structure of a single session clinic. For instance, within the model of single-session psychotherapy, it is recommended that sessions are of a longer length than would be typical for regular psychotherapy, with Hoyt et al. (1992) suggesting 60–90 min sessions as being more effective. Though single session clinics can be useful in providing support for some parents of children with ASD, there remains the issue of how we advocate for increased resources within psychology to meet the unmet needs caused by underfunded services.

The study has a number of limitations. Though we suspect an important factor in the work of the clinic was in reducing parental anxiety, we did not include a measure of this variable. Explorations of the interaction between parental anxiety and ASD such as those carried out by Falk et al. (2014) and Machado et al. (2016) could extend this research, particularly with the use of an anxiety measure such as the Hospital Anxiety and Depression Scale (Zigmond and Snaith 1983) as a pre and post measure for parents attending the single session clinic.

Secondly, even if parental anxiety is ameliorated by attending the single session clinic, the wider goal of addressing the underlying difficulty for the child still needs to be addressed. It was not possible to gather data on the outcome for the children involved, to assess whether the difficulty that had prompted the parent's appointment had been resolved. This would be an important goal of future outcome studies for this clinic.

The sample size was small, however, as the single session clinic is a new, innovative service; we wanted to have some measure of satisfaction rates before investing more resources into the model. An unstandardized parent satisfaction survey was used in this study as we wanted to understand how parents would balance the competing needs of short response times with a brief therapy model. Further evaluation of the parents' satisfaction would benefit from the use of standardized measures such as Treatment Acceptability Rating Form-Revised (TARF-R; Reimers and Wacker 1988). A number of confounds exist in the parent satisfaction survey: we did not control for age, gender, parent educational status, the length of time since diagnosis, or comorbidities.

This study offers some preliminary findings on the use of single session model within a psychology service for parents of children with ASD. Good attendance rates and early indications of parental satisfaction are positive indicators for the potential of such a service. However, a number of other important parameters to be considered in any follow up study have been identified which include a) anxiety levels of the parents, b) outcome measures for the children c) measurement systems which show the impact of single sessions on other referrals and treatment options.

Further work is needed to evaluate the outcomes of the service and identify more clearly who may benefit from this model.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no competing interests.

Ethical Approval The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this service evaluation was not required by their local REC.

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