ADOLESCENT AND EMERGING ADULT HELP SEEKING USING ANONYMOUS TELEPHONE AND LIVE CHAT TECHNOLOGY

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Abstract

Kids Help Phone is an on-demand, single-session, bilingual, free, and confidential service for young people in Canada who seek help for mental health issues and problems of daily living. 232 telephone clients and 230 "Live Chat" clients responded to the Counselling Client Questionnaire 2 (CCQ-2) to provide a demographic description of the youth who access this anonymous service, and assess and compare the effectiveness of telephone and text-based counselling. Transcripts of counselling sessions were analyzed using the Evidence of Mental Health Symptoms Scale for Adolescents (EMHSS-A) to describe the nature and level of risk associated with the situations clients brought to counselling, particularly as they related to mental health problems. 465 adolescents waiting in queue to access chat counselling responded to the Youth Self Report (YSR) to provide a description of the mental health symptoms of chat clients. Chat transcripts were further analyzed using the Collaborative Interactions Scale (CIS) to assess "what works" in terms of supporting the therapeutic relationship in time-synchronous text-to-text counselling. More clients had sexual and cultural minority identities than expected given their proportion in the population. 29% and 26% of clients were dealing with high- and medium-risk situations. According to the YSR, 64% of clients scored in the clinical range for affective problems, 56% for obsessive compulsive problems, and 51% for post-traumatic stress problems. Phone and chat clients reported decreased distress and perceived difficulty of their problems, and increased problem clarity, self-efficacy, and hope. Suggestions for how chat counsellors can manage ruptures and repairs in the therapeutic relationship are provided.

Keywords: telephone counselling, e-counselling, computer-mediated communication, help-seeking, adolescence

Dedication

To the young people in Canada who demonstrated enormous courage by reaching out for help in dark and confusing times and who trusted me with their deeply personal and private information. I am humbled by your strength, honoured by your decisions to share your stories with me, and overcome with hope and optimism by your desire and willingness to seek support to make things better. As always, I am rooting for you.

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ADOLESCENT AND EMERGING ADULT HELP SEEKING USING ANONYMOUS TELEPHONE AND LIVE CHAT TECHNOLOGY

Background

In a given year, one in five Canadians experiences a mental health problem (Smetanin, Stiff, Briante, Ahmad, & Khan, 2011). Seventy percent of mental health problems have their onset in childhood or adolescence (Government of Canada, 2006), and although 1.2 million Canadian young people are affected by mental illness, less than 20% of them will receive appropriate treatment (Mental Health Commission of Canada, 2013). Of those who do seek mental healthcare, less than 25% receive appropriate treatment (Waddell, McEwan, Shepherd, Offord, & Hua, 2005). One avenue through which youth in Canada may seek mental healthcare is Kids Help Phone (KHP). The present research focused on the mental health problems and problems of daily living faced by adolescents who seek counselling from KHP as well as the ways in which they seek help using KHP's anonymous social media technologies.

Adolescence is a time of physical and psychological change and most young people experience *common stressors* typical of this age group. Because it is developmentally typical for adolescents to value the input of peers and expert advice more than that of their parents during this stage of development (Wintre, Yaffe, & Crowley, 1995), they will seek help for common problems using their preferred channels. Developmental problems typical for this age group include relationship difficulties (including friendships, family relationships, and romantic or sexual relationships), sexual identity (LGBTQQ2SA issues), becoming independent, and physical health (including puberty and sexual health). Some youth also seek help for contextual problems that may not be a typical aspect of adolescent development such as violence and abuse, substance use, bullying, and serious physical and mental health problems. When youth do seek help for mental health problems, they commonly report symptoms consistent with anxiety,

depression, social problems, and to a lesser extent, somatic complaints (internalizing problems that cause the individual distress), although some report symptoms consistent with problems of thought and attention or oppositional and conduct problems (externalizing problems that are more likely to cause distress in others) (Haner, 2010).

Kids Help Phone

KHP is Canada's on-demand, free, bilingual, anonymous, and confidential counselling service available to any young person in Canada with access to a telephone or the Internet. KHP is unique among any service that young people in Canada may choose to contact for help or information in that it guarantees anonymity and confidentiality through its technology. Working in partnership with one of its core funders, Bell Canada, KHP has removed its ability to trace phone calls or Internet Protocol (IP) addresses. This phenomenon ensures that clients remain anonymous even when a duty-to-report may have otherwise been triggered. Counsellors are trained to inform clients of their duty-to-report at the beginning of contacts so that clients remain in control of what happens next in terms of their problems or situations. This communication is done in such a way as to take into account the developmental appropriateness of this responsibility with each unique client. However, KHP counsellor training emphasizes the practice of informing clients of the duty-to-report and cautions them against providing identifying information unless they want a counsellor to facilitate making a report should the situation warrant this action. By virtue of this practice, KHP is considered a safe place to discuss any problem or situation without concern that an adult will take action that will result in unwanted trouble for clients. KHP is widely advertised throughout Canadian school systems using posters, wallet cards, and a student ambassador program. It is also widely advertised online (e.g., using Google adwords the website is found quickly using terms that young people

may use when seeking information on mental health issues such as "I hate myself" or "I want to die"). KHP is also advertised through several celebrity brand-ambassadors, such as popular Canadian performers (e.g., Nikki Yanofski, Billy Talent, Simple Plan). In recent years, much of this advertising has focused on reaching young people dealing with mental health concerns (e.g., putting KHP contact info at the end of a music video that deals with suicide), poster campaigns emphasize that clients can call for any reason. The unofficial motto of KHP is "No problem's too big. No problem's too small."

Theory

Understanding adolescent help-seeking using social media technologies requires taking a relational perspective that arises from developmental-systemic theory (Bronfenbrenner, 1986; Ford & Lerner, 1992). This holistic theory enables one to view help seeking through two essential lenses. First, a developmental lens allows one to see individual adolescents who are living with self-defined problems. This lens allows one to see behaviours, motivations, and challenges that change with development and highlights individual risk and protective factors within adolescents' particular stages of physical, emotional, social, and intellectual development. The systemic lens highlights the various reciprocal relationships adolescents have with the contexts in which they live, as well as with other individuals and groups. This second lens highlights reciprocal influences within family, peer, school, and larger cultural systems.

Developmental-systemic theory also underlies current thinking in KHP counselling processes as it takes into account the multiple determinants of adolescent problems including demographic factors, developmental strengths and weakness, and contextual or systemic influences. With this theoretical orientation in mind, KHP counsellors utilize a process of scaffolding (Bruner, 1971; Vygotsky, 1986) to support service-users to regulate emotions,

process their situations, and problem solve. Scaffolding is a relationship process and refers to the process of supporting learning and development through dynamic supports so that young people can perform above the levels at which they can perform on their own. As young people learn and practice new skills, adults can reduce or change the scaffolding to support the next task in development. The scaffolding metaphor enables supportive adults to consider the appropriate supports necessary for youth to obtain the skills, capacities, and cognitions to move away from unhealthy developmental trajectories and toward healthy ones (Pepler, 2006). Within KHP, scaffolding is a relationship process that reflects the functioning of the therapeutic relationship wherein therapists or counsellors maintain holding and supportive spaces in which clients develop skills, capacities, and cognitions that allow them to regulate emotions, process difficult situations, and solve problems.

Marginalized youth may experience barriers to seeking help for common problems of adolescent development, as well as more serious mental health problems, not encountered by those who benefit from privileged social status across the country. Age alone is a risk factor for mental health problems as young people aged 15 to 24 years are more likely to experience mental illness than any other age group (Statistics Canada, 2013a). Gender and sexual orientation are also factors with girls and transgender youth experiencing greater effects of marginalization than boys (Jiwani, 1998; Caragata, 2003; D'augelli, Grossman, & Starks, 2008). Ethno-cultural identification and socio-economic status (SES), factors which are often related to each other and to a young person's level of risk for mental health problems and threats to well-being, are concerns for marginalization (Simich, Matier, Moorlag, & Ochocka, 2009; Steele, Glazier, & Lin, 2009). *Individual factors* are associated with marginalization and the problems experienced by young people in Canada. Of particular concern in Canada are First Nations,

Inuit, and Métis (also referred to as "Aboriginal") adolescents (Smith, Varcoe, & Edwards, 2005), as well as immigrant and first-generation adolescents (Hansson, Tuck, Lurie & McKenzie, 2013), all of whom experience stressors not experienced by their peers who identify with the dominant culture. A non-heteronormative sexual orientation is also a risk factor for increased distress for youth as they experience harassment and marginalization within our society (Lehmiller, 2012). Finally, because these demographic risk factors may co-occur (Khallad, 2013; Safaei, 2012), there are some adolescents experiencing multiple identities that which leave them marginalized in Canadian society. In the present study, I examined the prevalence of young people with marginalized identities and how marginalized identities may contribute to the success of counselling at KHP.

In spite of these developmental and contextual challenges, young people are often reluctant to seek help. Adolescents cite lack of privacy and confidentiality as major barriers to help seeking (Coker et al., 2010), and a loss of confidentiality carries a risk of unwanted trouble (Gilchrist & Sulivan, 2006). Adolescents also face many barriers to mental health services (Owens et al., 2002). Depending on their contexts, they may not have access to transportation, parental consent to services, health insurance, or money to pay for privately funded services. In addition, they may be overwhelmed with unfamiliar issues in navigating health systems. Adolescents are also susceptible to negative family attitudes towards counselling and mental illness.

Young people report that confidentiality and trust are important factors when deciding to seek help for personal problems through youth helplines on the telephone or over the Internet (King et al., 2006; Kids Help Phone, 2013a). Kids Help Phone (KHP) is Canada's on-demand, confidential, anonymous, professional, and bilingual telephone and Internet helpline for children,

adolescents, and emerging adults in Canada. The reputation of KHP as a confidential and trustworthy source of help is due largely to its confidentiality policy. KHP does not trace calls or IP addresses, nor does it have call display. In 2012, there were over 260,000 contacts with KHP counsellors for help with everyday problems of living and more serious problems of mental health using the telephone and Internet (R. Howie, personal communication, January 18, 2013). Forty-three percent of callers to the helpline in 2012 indicated that they had not spoken to anyone else about their problem before speaking with a KHP counsellor (KHP, 2013). Given the role that KHP plays in filling a developmentally appropriate need for anonymous and confidential adolescent help seeking, it is vital that counselling processes in telephone and Internet helpline services be understood and validated.

Empirical Foundation

The Developmental-Systemic Perspective demands consideration of both individual factors and relationships processes as potential influences on counselling success at KHP.

Individual factors

Individual factors contribute to the problems experienced by young people in Canada. Age alone is a risk factor for mental health problems; specifically, those in the 15 to 24 year age group are the most likely to experience mental illness (Statistics Canada, 2013a). Twelve percent of children aged nine to 19 years old live with a mood or anxiety disorder at any given time (Government of Canada, 2006). Suicide is the second leading cause of death (after car accidents) for Canadian youth aged ten to 19 years; it accounts for 11% of deaths among ten to 14 year olds and this number increases to 24% for 15 to 19 year olds.

Gender is a factor in adolescent mental health. Girls report more internalizing or "emotional" problems than boys, who report more externalizing or "behavioural" problems than

girls (Freeman, King, Pickett, & Craig, 2011). Although mental health problems arise for both genders as they move through the adolescent years, this deterioration appears worse for girls with positive indicators decreasing and negative indicators increasing for female adolescents at greater rates than they do for male adolescents (Freeman et al.). In terms of gender, transgender youth are most at-risk, experiencing higher rates of both anxiety and depression symptoms than the general population (Budge, Adelson, & Howard, 2013). Adolescence is a particularly difficult time for transgender youth, with 47% of Ontario's transgender youth reporting that they have considered suicide in the past year and 19% having attempted (Public Health Agency of Canada, 2011). Gender is also a factor in help seeking and the experience of stigma. Female youth and adults are more likely to seek help in general than male persons, who tend to experience more stigma regarding personal mental health issues (Chandra & Minkovitz, 2006).

Canada is a culturally diverse country and ethno-cultural identity factors into the mental health concerns experienced by adolescents in this country. The well-being of Aboriginal youth is of particular concern in Canada as they are the only cultural group that has endured the severe social, economic, and psychological effects of colonization, residential schools, and reserve living (Embree & De Wit, 1997). Many Aboriginal communities are not only underserviced in terms of mental health support, but are also geographically isolated (Minore, Boone, Katt, Kinch & Birch, 2004). Aboriginal youth report higher levels of anxiety and depression than non-Aboriginal youth in Canada (Statistics Canada, 2004). Although suicide rates differ by tribal council and by language group, the rates of adolescent suicide are higher among Aboriginal adolescents than non-Aboriginal adolescents in Canada. The suicide rate for First Nations male youth aged 15 to 24 is 126 per 100,000 compared to 24 per 100,000 for non-First Nations male youth. For First Nations female youth of the same age range, the rate is 35 per 100,000

compared to 5 per 100,000 for non-First Nations female youth (Statistics Canada, 2004).

Immigrant youth also face unique challenges not experienced by their Canadian-born counterparts. They are less likely to be acclimatized to the dominant culture and children of immigrants often deal with additional stresses of balancing old world cultural beliefs of their parents with their own desires to fit in with peers in a Canadian context (Beery, 1999). In particular, immigrant youth face problems with first-contact health services in the healthcare system (Sanmartin & Ross, 2006). Furthermore, children of recent immigrants report feeling less autonomy, less self-esteem, and more stress than their Canadian peers with Canadian-born parents (Wintre, Sugar, Yaffe, & Costin, 2000).

Young people from the extremes of both financially advantaged and disadvantaged families may find themselves at risk for problems with mental health and well-being that lead them to seek help from KHP. Financial distress greatly influences an adult's ability to parent, which has profound effects on a child's development (McLloyd, 1990; 1999). Parents who are affected by economic stress are often less responsive to their children and display more harsh punishments than those parents who are not financially struggling. Family risks that stem from chaotic family environments associated with poverty, such as poor parenting practices, function to interrupt developmental processes like self-regulation and the ability to plan (Pepler, Craig, Jiang, & Connolly, 2010). Offord (2001) found that poverty is associated with increased rates of psychiatric disorders among children. Economically advantaged children may also have reasons for using KHP. Luthar (2003) contends that the characteristics that promote affluence of parents in western society (independence, competitiveness, and aggression) conflict with youths' need to form social bonds in which they can seek developmentally appropriate help. Affluent parents may be unlikely to seek professional help for a child who is struggling with mental health issues

in part to protect a veneer of success they feel compelled to maintain and in part due to fear that doing so would limit the child's potential for future academic and professional success (Luthar & Latendrese, 2005). School professionals who are concerned about children of affluent parents are also hesitant to offer links to professional services for fear of a negative or litigious reaction from affluent parents (Luthar, 2003).

The above developmental and systemic characteristics are risk indicators for problems of daily living and mental health problems for adolescents in Canada. Therefore, in this study I assessed the associations of age, gender, ethno-cultural identity, and generational status with the frequency and nature of problems presented by KHP service-users. The nature of the problems for which adolescents seek help is also an important factor in determining their risk for severe difficulties in life and serious mental health problems (Aarons et al., 2008; Herrenkohl, Lee, Kosterman, & Hawkins, 2012; Klika, Herrenkohl, & Lee, 2013). Therefore in this study, I describe the nature of the problems for which adolescents seek help at KHP and provided a basic assessment of the mental health symptoms they discuss in their counselling sessions. The mental health symptoms of potential chatters are more thoroughly described using of a validated clinical assessment tool.

Process of counselling

Seeking counselling support is generally seen as an effective coping strategy which increases a person's self-efficacy (Bandura, 1977; Bandura, Adams, & Beyer, 1977), coping ability (Tedeschi, Zhu, Anderson, Cummins, & Ribner, 2005), and hope (Scheel, Davis, & Henderson, 2013; Larsen, Edey, & Lemay, 2007). Participation in counselling is also considered an effective way to reduce distress (Cristea, Montgomery, Szamoskozi, & David, 2013) and the perceived difficulty of the clients' problems by increasing their agency (Langaard & Toverud,

2009). At KHP, counsellors provide scaffolding through the use of brief solution-focused therapy (BSFT) and narrative therapy (NT). Regardless of the particular modality used by individual counsellors, scaffolding processes are used to guide clients through a hierarchical process. First, counsellors work with clients to help regulate emotions and tolerate distress. Necessarily, some element of distress brings clients to contact KHP and the first task of counselling is to help clients regulate their emotions sufficiently so that more active and problem-focused work can be done. Once clients are sufficiently regulated to carry on counselling conversations, counsellors proceed to the second task of helping clients process the difficult emotions that cloud their abilities to think clearly about their problems and to work towards next steps. By doing so, the clients begin to experience a sense of hope regarding their situations. Last, the counsellor supports the client in problem-solving or problem-reducing strategies. This final step in the counselling process is strengths-focused and equated with a sense of self-efficacy – a sense that the client has some skills or personal attributes which will assist him or her in coping with or changing his or her situation for the better. Because these scaffolding processes of counselling are tied to indicators of counselling success, in this study I measured changes from immediately before counselling to immediately after counselling in the constructs of distress, isolation, perceived difficulty of the problem, problem clarity, hope, and self-efficacy.

Relationship quality as an indicator of counselling success

The process of counselling is a relationship process. The therapeutic alliance is a relationship in which the client may practice relationship skills. It is also a relationship in which the counsellor provides scaffolding for the client to attain and practice skills that help him or her face the problem for which he or she is seeking help. Therapy success is predicted by the quality

of the therapeutic relationship (Karver, Handelsmann, Fields, & Bickman, 2006; Luborksy, 1994) and the therapeutic relationship has been shown to account for more variance in therapy success than treatment modality (Lambert & Barley, 2001). Because the quality of the relationship is consistently tied to counselling and psychotherapy outcomes, I investigate and discuss the collaborative processes, ruptures, and repairs in the therapeutic alliance for clients with the best and worst counselling outcomes.

Research Objectives

Child Helpline International (CHI) is a community of 183 child helplines in 142 countries (CHI, 2015). This research provides an important foundation for knowledge mobilization to the international child helpline community for responding to requests for help from young people presenting with mental health problems and crises. This research also illuminates the role that anonymous help lines can play in supporting youth who choose not to access or face barriers to accessing ongoing mental health services. Due to the anonymous nature of KHP services, there is not a clear description of the characteristics of adolescents who seek help for mental health problems and problems of daily living using social media at KHP. There are also limited data on the level of risk associated with the types of problems and severity of symptoms for which these young people seek help. As emerging technologies become more widely adopted in society and used in mental health contexts, it is vital that their efficacy for delivery of services is validated and understood. My research therefore focused on four objectives:

1. to provide a demographic description of the youth who access KHP services
2. to describe the nature and level of risk involved in these clients' presenting problems, particularly as they relate to mental health symptoms

3. to assess and compare the perceived effectiveness of KHP counselling using the two service media on improving clients' distress, isolation, perceived difficulty of the problem, problem clarity, hope, and self-efficacy
4. to assess "what works" in terms of supporting the therapeutic relationship using type-to-type technologies, which, by definition, lack the contextual and emotional cues available in face-to-face and ear-to-ear counselling

Methods

This study was based on information provided by adolescent and emerging adult clients of KHP telephone and chat counselling services. I gathered descriptive data on the characteristics of the clients, the severity and nature of their problems, and an assessment of indicators of counselling success (decreased distress, perception of problem difficulty, feelings of isolation, and increased hope, clarity around the problem, and self-efficacy). I also conducted an assessment of the counselling processes negotiated through the therapeutic relationship using chat, the most current form of social media.

Participants

Participants were 462 KHP clients aged 12 years and older who used telephone or chat services during the hours of chat availability (6pm – 1am Eastern Time, Wednesday to Saturday in English; Thursday to Sunday in French); 232 participants were phone clients and 230 were chat clients. Data were gathered on the phone sessions between May 8th and June 16th, June 29th and 30th, and July 4th and 7th, 2014. Data were gathered on the chat sessions between May 8th and September 1st 2014. During the data collection period for phone, 2166 callers met the inclusion criteria (age 12 or older, genuine counselling call), resulting in a 12.1% participation rate. During the data collection period for chat, 1117 chatters met the inclusion criteria, resulting in a 20.6% participation rate. However, for chat, only 129 of the 230 chatters who consented to participate completed both pre- and post-counselling portions of the questionnaire. If only the 129 completed questionnaires are considered, the chat participation rate is reduced to 11.6%. The voluntary nature of this study combined with the anonymity of the service did not allow for calculation of the true representativeness of the sample. For example, it is unlikely that clients

experiencing intense distress would self-select into a research study, particularly if the next step they had negotiated with a counsellor was to contact a referral or emergency services.

Measures

Counselling Client Questionnaire 2.

Participants were asked for informed consent and responded to the Counselling Client Questionnaire, version 2 (CCQ-2) (version 1 can be found in Kids Help Phone, 2012a; 2012b), which is found in Appendix A. The CCQ-2 includes demographic questions (age, geographical location, sexual identity, ethno-cultural identity, generational status, SES), satisfaction with KHP counselling services, and questions regarding the use of different KHP service media. This questionnaire contains the Perceptions of Preparedness Scale (POPS). This 16-item scale consists of six subscales measuring intended counselling outcome variables: distress, perception of problem difficulty, feelings of isolation, hope, clarity around the problem, and self-efficacy. Each subscale consists of two to three items with item scores ranging from 0 to 7. Items that are reverse coded are indicated by "[rc]" in the appendix. The POPS was administered before and after counselling to allow the calculation of change scores.

For the phone participants, the CCQ-2 was administered by a team of 17 research assistants who were trained in the administration of the questionnaire. Training was 20 hours over three sessions and included instruction in probing ambiguous responses, using metaphors to explain Likert-type items, and developmentally appropriate explanations of concepts such as gender and ethno-cultural identity. Training also included role-playing of difficult-to-handle clients, including clients who may be triggered and require reconnection with a counsellor, angry clients, and those who may become inappropriate or abusive. There was a minimum of one French-speaking research assistant available at all times during data collection. Research

assistants were undergraduate, Masters, and PhD students from psychology, social work, and biology programs at Toronto universities.

Objective appraisal of risk level.

A team of two undergraduate and one Master's level research assistants was trained to code call recordings and chat transcripts for objective risk level (Haner, 2010).

To be given a high-risk classification, the counselling conversation had to contain explicit evidence that the client was dealing with one of the following situations: developmental risk factors including formal mental health diagnosis, imminent suicide risk, active self-harm, serious medical health condition or disability, and being pregnant or having fathered a child, and contextual risk factors including living with violence or abuse, delinquency, poverty, and street involvement. A classification of medium risk was given if the counselling conversation contained implicit evidence of one of the above risk factors or explicit indication that a close friend or family member was living with one of the above risk factors (with the exception of a parent or adult family member being pregnant or having fathered a child). A low-risk classification was given if there was no evidence of one of the nine risk factors present in the counselling contact. Note that KHP counsellors are not trained to specifically probe for information regarding these risk factors and so any mention of them is considered to be naturally occurring within the counselling conversations.

Youth Self Report and Evidence of Mental Health Symptoms Scale for Adolescents.

The Youth Self Report (YSR) (Achenbach & Rescorla, 2001) is part of the Achenbach System of Empirically Based Assessment (ASEBA). It consists of 112 short "I" statements to which adolescents (ages 11 to 18) rate their agreement (0 = not true, 1 = somewhat or sometimes true, 2 = very true or often true). Agreement with these statements maps onto eight syndrome

scales of disorders commonly arising in adolescents and found in the Diagnostic Statistical Manual of Mental Health Disorders, 4th addition revised (American Psychiatric Association, 2000). The eight syndrome scales are post-traumatic stress problems, obsessive compulsive problems, conduct problems, oppositional defiant problems, attention deficit/hyperactivity problems, somatic problems, anxiety problems, and affective problems. In clinical practice, the YSR is not used as a diagnostic tool on its own. Rather, similar questionnaires are given to multiple informants in a young person's family and school systems. These questionnaires, along with observational and interview data, are used to make diagnoses. Therefore, in the present study, the YSR is used as a proxy for potential mental health diagnoses only. The YSR has excellent internal-consistency reliability (all scales $\alpha > .80$ for adolescents) (Ebesutani, Bernstein, Martinez, & Chorpita, 2011). The YSR syndrome structure has been extensively studied in 23 distinct societies and found to be generalizable to youth 11 to 18 years old; therefore it is considered an appropriate framework for analyses of adolescents' presenting problems (Achenbach, 2007). Potential chatters were invited to complete the YSR online before chatting with a counsellor (there was an average 35 minutes wait time for the chat service and participants were able to discontinue the YSR if a counsellor became available). The YSR was made available in North American English and Québécois French.

The YSR also contains symptom scales, which have been used as the basis for a qualitative coding scheme, the Evidence of Mental Health symptoms Scale for Adolescents (EMHSS-A), which is used to assess mental health symptoms of clients using their call recordings and chat transcripts (Haner, 2010; found in Appendix B). The eight symptoms scales outlined in the YSR are anxious-depressed, withdrawn-depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour, and aggressive

behaviour. The EMHSS-A is based on the 112 "I" statements on the YSR. Utterances in transcripts can receive a code indicating the symptom of one of the eight syndrome scales if it approximates an "I" statement from the YSR. The EMHSS-A provides numeric scores representing the number of times codes from any of the eight syndrome scales are identified. The EMHSS-A was piloted with 108 KHP requests for counselling using the "Ask Us Online" (post-based) counselling medium and had 85% agreement between the two trained undergraduate raters (Haner, 2010). The EMHSS-A was also used at KHP by two undergraduate research assistants coding transcripts of chat counselling sessions for an internal KHP evaluation. It had high inter-rater reliability (all Ks $> .80$). In the present study, I intended to validate this coding scheme by correlating EMHSS-A subscale scores with YSR subscale scores for chat participants. If the scales were highly correlated, all phone and chat transcripts were to be coded using the EMHSS-A. In the present study, 40 participants completed the YSR, gave consent to review their chat transcripts, and completed chats that were saved in KHP's supervision database. Their T-scores on YSR syndrome scales were correlated with the number of phrases that triggered an EMHSS-A code in their chat. Syndrome scales for *anxious depression* ($r = .456$, $p < .01$), *social problems* ($r = .373$, $p < .05$), *and attention problems* ($r = .372$, $p < .05$) were statistically significant. The remaining subscales: *withdrawn depression* ($r = .117$), *somatic complaints* (with only one participant in the clinical range on the YSR), *thought problems* ($r = .012$), *rule-breaking behaviour* ($r = .081$), *and aggressive behaviour* ($r = .088$), produced non-significant correlations. However, these results were obtained with small sample sizes and relatively low identification of problems linked to these scales. Therefore, EMHSS-A results data are presented only for chat participants.

The Collaborative Interactions Scale.

The Collaborative Interactions Scale (CIS) (Colli & Liangiardi, 2009) (Appendix C) assesses the quality of the therapeutic relationship as it pertains to ruptures and repairs in the therapeutic alliance. It contains scales for direct and indirect rupture markers as well as collaborative processes that describe moment-to-moment interactions between client and therapist or counsellor. The CIS has generally good inter-rater reliability ($K = .66$ to $.81$). In the present study, three research assistants were trained extensively on the scale with input from its creators. The three coders each independently coded the same 10% of the transcripts and evenly split the rest of the coding work. They had excellent inter-rater reliability (mean $K = .88$).

Procedure

Phone.

When callers access KHP by telephone, they are routinely greeted with an automated internal voice recording (IVR) briefly describing the service and describing the KHP phone menu (e.g., callers can dial 5 to access privacy information). During the data collection period, the IVR was altered to contain a message indicating that KHP was conducting a study and offering callers the opportunity to opt-in to the pre-counselling portion of the CCQ-2. If callers selected this option, they were transferred to a research assistant who took them through an informed consent procedure and administered the pre-counselling portion of the questionnaire. When this portion of the questionnaire was completed, callers were asked to choose a code word that would allow their pre- and post-counselling questionnaires to be matched. Then they were transferred to the counselling queue. Callers who indicated that they accidentally selected the research queue were immediately transferred back into the counselling queue.

The data collection procedure changed after approximately two weeks. Initially, this procedure was followed: After receiving service, counsellors inquired if the callers had

completed the pre-counselling portion of the questionnaire and inquired if they would like to participate in the post-counselling portion (callers could proceed to the post-counselling portion of the questionnaire even if they had not done the pre-counselling portion). If they agreed, callers were transferred to a research assistant who took them through an informed consent procedure (in addition to or separate from the pre-counselling portion) and administered the second part of the questionnaire. Unfortunately, it quickly became apparent that insufficient data would be collected if this method was strictly adhered to. Therefore, the method was altered after approximately two weeks of data collection. The initial pre-post questionnaire method was maintained; however, callers who did not speak to a research assistant before counselling were permitted to complete both the pre- and post-counselling portions of the CCQ-2 after counselling. This method was carried out such that phone participants fell into three groups:

1. Those with true pre-post data (n = 41; 17.7%).
2. Those who were asked the pre-counselling POPS retrospectively (after finishing their counselling calls). In this condition, counterbalanced group A, participants were asked for post-counselling POPS data before being asked to think back to how they felt before speaking to a counsellor and completed the pre-counselling portion of the POPS (n = 96; 41.4%).
3. Those who were asked for their pre-counselling POPS retrospectively (after they finished their counselling calls). In this condition, counterbalanced group B, participants were asked to think back to how they felt before counselling and answer the pre-counselling POPS based on their memory. Then they were asked to complete the post-counselling POPS thinking about how they felt now that they were done their counselling sessions (n = 95; 40.9%).

In counterbalanced group A, the following script was used to cue the post-counselling POPS:

"I'm going to ask you to rate some of your feelings and experiences using a scale from 0 to 7. All of these questions are about how you are doing NOW THAT YOU'VE SPOKEN TO A COUNSELLOR."

The following script was then used to cue participants before answering the pre-counselling POPS:

"Okay, so now I'd like to just stop you for a moment. You've been thinking about how you are doing now that you've finished speaking with your counsellor. Now I'd like you to just take a moment and think back to a little while ago – just BEFORE YOU WERE SPEAKING TO A COUNSELLOR. Think about how you were feeling just as you picked up the phone to call Kids Help Phone today. I'm going to ask you the same questions again, but this time, please rate how you were feeling about your problem or situation before calling the counsellor."

In counterbalanced group B, the same scripts were used but in reverse order.

Chat.

When clients access KHP by chat, they are routinely required to choose a username and to answer three questions from the CCQ-2, specifying age, gender, and province or territory. During the data collection period, once these questions had been answered, chatters were presented with an invitation to participate in the study and asked to read an informed consent procedure. If they consented to participate, they responded to the pre-counselling portion of the CCQ-2 and then joined the queue for counselling services. If they declined, they were immediately joined the queue for counselling services. Chatters who completed the pre-counselling portion of the CCQ-2 saw a pop-up window after being put into the queue for

counselling services. This pop-up window contained text that asked if they would consider filling out the YSR while waiting for a counsellor to become available. The YSR was presented using Survey Monkey (surveymonkey.com), and participation in the YSR portion did not delay the chatters from joining the counselling queue. After providing services, counsellors provided a link to participate in the post-counselling portion of the CCQ-2. Those clients who clicked on the link were presented with an informed consent procedure and, if they consented, could access the post-counselling portion of the CCQ-2. Unlike the phone participants, chatters could only access the post-counselling portion of the CCQ-2 after counselling and no corresponding counterbalanced POPS groups were created. This difference was due to limitations in the technology available in KHP chat service.

After completing the CCQ-2, participants were reminded, either by a research assistant (callers) or by written message (chatters), that they could speak to a counsellor anytime by calling the KHP phone number.

Results

Objective 1: To Provide a Demographic Description of the Youth Who Access KHP Services

Age.

Of the 230 phone participants and 228 chat participants who gave age data, 16.5% (phone) and 17.6% (chat) identified themselves as middle-school aged (12 and 13 years old) whereas 56.6% (phone) and 65.7% (chat) identified themselves as high-school aged (14 to 17 years old). The difference in proportions of middle-schoolers and high-schoolers was statistically significant for phone (z = -8.909, p < .0001) and chat (z = -10.449, p < .0001). Additionally, 26.9% (phone) and 17.7% (chat) identified themselves as emerging adults (18 to 25 years old). Although technically not adolescents, emerging adult participants were included in this study because emerging adulthood is viewed as developmental stage that is an extension of adolescence (Arnett, 2000; 2006).

Gender.

Approximately 73.8% of the phone participants and 87.4% of chat participants identified as female, and 23.2% of the phone participants and 10.5% of the chat participants identified as male. The remaining 2.6% of phone participants and 2.1% of chat participants identified with non-dichotomous gender identities (i.e., transgender, genderfluid, genderqueer, bigene (Fr.)). One phone participant was unable to articulate their gender identity when asked. There was a larger proportion of male users on the phone (53 out of 229) than on chat (24 out of 230), z = 3.64, p < .001.

Sexual orientation.

Of the 229 phone participants who responded to this item, 46 (20.4%) identified with non-heterosexual orientations. Of the 153 chat participants who responded to this item, 55 (35.9%) identified with non-heterosexual orientations. There was a larger proportion of participants with non-heterosexual orientations in the chat sample than in the phone sample: $z = 3.34$, $p < .001$.

Table 1

Frequencies of Participants With Various Racial, Ethnic, Or Cultural Identities

	Phone		Chat		Statistics Canada
Identity	*f*	%	*f*	%	%
Canadian	83	39.2	125	82.2	35.6
British	34	16	19	12.5	34.8
French	6	2.8	19	12.5	16.2
Québécois	10	4.7	23	15.1	0.6
First Nations, Aboriginal, or Métis	10	4.7	11	7.2	5.5
White, European, or Caucasian	101	47.6	61	40.1	15.5
South Asian	8	3.8	7	4.6	5.3
Asian	18	8.5	19	12.5	7.5
Black	17	8	8	5.3	3.3
South East Asian	13	6.1	5	3.3	2.5
West Asian	6	2.8	4	2.6	3.0
Latin American	8	3.8	4	2.6	2.0

Note: Participants could identify with more than one category; therefore percentage totals do not add up to 100%. Statistics Canada data N = 4324070 for 15-24 year old demographic.

Ethno-cultural identity.

The majority of phone participants identified as being from the dominant (White, western European descent) culture (67.9%) as did the majority of chat participants (67.8%). For phone, the next largest proportion identified as being from non-dominant cultures only (20.8%) followed mixed dominant/non-dominant heritage (11.3%). For chat, the second largest proportion identified as being from mixed dominant/non-dominant cultures (23.0%) followed by non-dominant only cultural identities (9.2%) followed by non-dominant cultures (37.1%), and mixed dominant/non-dominant cultures (10.6%). A more detailed description of individual cultures endorsed by clients is presented alongside Statistics Canada (2006) ethnic origins in Table 1.

First language.

The majority of both phone and chat samples identified one of Canada's official languages as their first language. Only 10.6% of the phone sample and 11.4% of the chat sample identified a non-official language as their first language. There was a larger proportion of participants with French as a first language in the chat sample (17.3%) than in the phone sample (6.0%), $z = 3.47$, $p < .001$. A more detailed description of first language endorsed by clients is presented alongside Statistics Canada (2011a) mother tongue data for ages 15 to 24 years in Table 2.

Language of service.

Of the total 232 phone participants, only 9 (3.9%) received service in French, whereas of the total 230 chat participants, 41 (17.8%) received service in French. This is a statistically significant difference ($z = 4.82$, $p < .0001$) suggesting a French language preference for chatting over calling KHP.

Table 2

Frequencies of Participants With Various First Languages

	Phone		Chat		Statistics Canada
First Language	*f*	%	*f*	%	%
English	181	83.4	107	71.3	64.2
French	13	6	26	17.3	20.5
Cantonese or Mandarin	5	2.3	3	2	3.5
Korean	2	0.9	1	0.7	0.6
Vietnamese	1	0.5	1	0.7	0.4
Arabic	2	0.9	1	0.7	1.2
Dutch	1	0.5	0	0	0.1
Creoles	1	0.5	0	0	0.9
Punjabi	2	0.9	1	0.7	1.3
Somali	1	0.5	0	0	0.1
Tagalog	2	0.9	1	0.7	0.9
Russian	1	0.5	0	0	0.5
Cubano	1	0.5	0	0	0
Romanian	1	0.5	0	0	0.2
Italian	1	0.5	0	0	0.3
Spanish	2	0.9	2	1.3	1.3
American Sign Language	0	0	1	0.7	0.02
German	0	0	2	1.3	0.7
Hindi	0	0	1	0.7	0.3
Urdu	0	0	1	0.7	0.7
Unspecified First Nations Language	0	0	1	0.7	

Persian	0	0	1	0.7	0.6
Total	217	100	150	100	

Generational status.

The distribution of phone participants' generational status was similar to that of the chat participants. Of the 214 phone participants who responded to this item, 11.9% identified themselves as immigrants, 34.4% were 1st generation Canadians, 10.1% were 2nd generation Canadians, and 43.6% were 3rd generation or more. Of the 146 chat participants who responded to this item, 8.9% were immigrants, 34.2% were 1st generation, 11.0% were 2nd generation, and 45.9% were 3rd generation or more. When immigrants and 1st generation Canadians are combined into a single group representing *relative newcomers*, they comprised 46.3% and 43.1% of the phone and chat samples, respectively. There were no statistically significant differences between phone and chat groups. Generational status of participants is compared to Statistics Canada data for the 15 to 24 year old demographic in Table 3.

Table 3

Generational Statuses of Participants and the General Population

	Phone		Chat		Statistics Canada
Gen. Status	*f*	%	*f*	%	%
Immigrant and 1st Generation		46.3		43.1	663405 (15.3%)
2nd Generation		10.1		11.0	857230 (19.8%)
3rd Generation or more		43.6		45.9	2803435 (64.8%)

Note: Statistics Canada data N = 4324070 for 15-24 year old demographic.

Newcomers were overrepresented in the phone sample ($z = 12.58$, $p < .0001$) and the chat sample ($z = 9.35$, $p < .0001$). Note that the generational status definitions used by Statistics Canada (Statistics Canada, 2011b) with their raw data differ from those used in this report and I have re-categorized the Statistics Canada data to fit with the definitions used in my report.

SES.

There was a technological failure with the KHP chat software that resulted in the CCQ-2 question regarding SES being deleted from the downloadable files. Therefore, SES data are presented only for the 213 phone participants who responded to this question, precluding the possibility of comparing across services. Of the phone participants, 28 (13.1%) identified as low SES (mother finished some high school or less), 66 (31.0%) identified as lower-middle SES (mother finished some university or college, or completed CGEP), 97 (45.6%) identified as upper-middle SES (mother finished college or university), and 22 (10.3%) identified as high SES (mother obtained a Master's degree or PhD).

Objective 2: To Describe the Nature and Level of Risk Involved in these Clients' Presenting Problems, Particularly as they Relate to Mental Health Symptoms

Risk level.

A total of 212 call recordings and chat transcripts for which participants gave consent to review were located in the KHP supervision database. Of these, 92 were audio recordings and 120 were chat transcripts. These recordings and transcripts were reviewed by trained research assistants and coded for objective risk level according to the presence of developmental and contextual risk factors mentioned in the counselling sessions. Of the combined phone and chat data, 62 (29.3%) received a high-risk categorization, 55 (25.9%) a medium-risk categorization,

and 95 (44.8%) a low-risk categorization. A breakdown of risk-level categorization for phone and chat data can be found in Table 4.

Table 4

Risk Level Categorization for KHP Clients

Risk Level	Phone		Chat	
	f	%	*F*	%
High	26	28.3	36	30.0
Medium	21	22.8	34	28.3
Low	45	48.9	50	41.7

No proportions of high-, medium-, or low-risk participants by service medium were significantly different from each other. The largest difference was between services for the low-risk categories; these proportions were not significantly different ($z = 1.05$, $p = .29$).

High-risk clients.

The recordings and transcripts of high-risk clients revealed at least one high-risk factor. Eight phone participants were coded for two high-risk factors and one participant was coded for three factors. Eight chat participants were coded for two high-risk factors. The most common high-risk factor among callers was having a formal mental health diagnosis whereas the most common among chatters was active self-harm. Details of high-risk categorizations for phone and chat clients can be found in Figure 1.

When clients discussed their mental health diagnoses, they were often complicated in that they had more than one diagnosis, were struggling to access treatment, or both. Some spoke

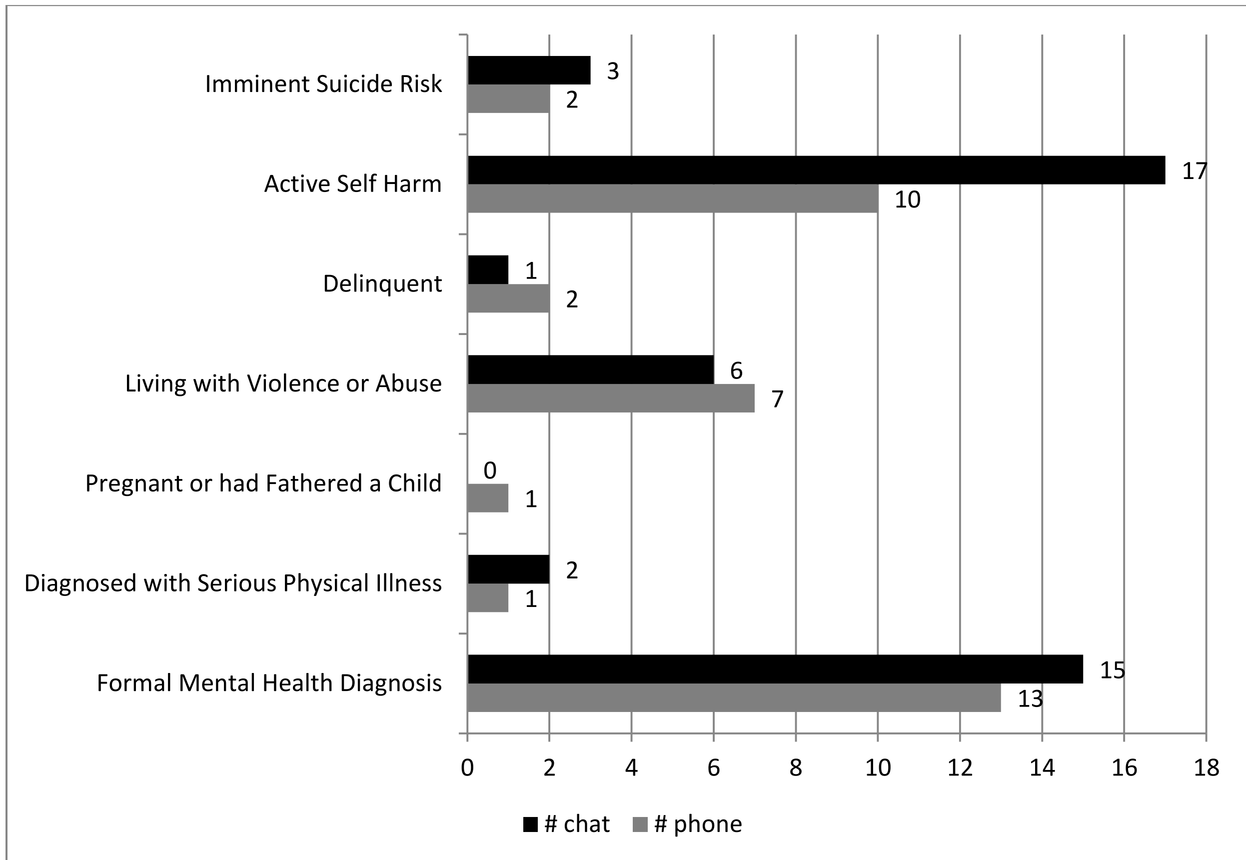


Figure 1. Frequencies of high risk phone and chat clients with specific risk factors. Phone n = 26, Chat n = 36.

about hospitalizations due to the severity of their mental health issues. Many clients who indicated they were self-harming also discussed diagnosed mental health problems. The following are excerpts from counselling calls in which clients discuss their mental health symptoms. Each call is identified by an 8-digit iCarol number, where "iCarol" refers to the software used to store and find calls in the KHP data storage system. Excerpt from chat transcripts are presented as-typed by counsellors and young people.

<u>Call 19695542iCarol</u>

Youth: When I was at the hospital, like, they wanted me to do like a DBT program.

Counsellor: Yeah. What do you know about DBT?

Youth: I don't know, 'cause when I was the hospital, they diagnosed me with borderline and I don't know what that is, and they were like, "you need DBT for that," and I was like "'kay…"

Counsellor: Oh... they diagnosed you?

Youth: Yeah.

Counsellor: And did they give you medication?

Youth: Yeah.

Counsellor: OK. And are you taking it, are you taking the medication?

Youth: Yeah.

Call 19794399iCarol

Youth: For the past few years I guess like I've had depression and everything

Counselllor: Mhmm, 'kay

Youth: But like more recently I guess I was in the hospital and they diagnosed me with like a whole bunch of like other things

Counsellor: Which kind of disorders did the people at the hospital diagnose you with?

Youth: Uh, I have borderline personality disorder and I have panic disorder that kind of came from, uh, some drug use I guess, and I have anxiety, depression.

Call 19811636iCarol

Youth: Um I struggle with an eating disorder and I went for a three hour assessment today to get into a day treatment program.

Youth: I guess I know that the lower in weight I get, the more suicidal I get.

Youth: I almost died from an overdose a couple years ago.

The following excerpts are from chat counselling sessions in which clients discuss their mental health symptoms.

Chat<Internals\\x13750192>

Youth: Jai comme aussi un autre prombleme jai deja faite des tentative de sucide et les idee sucidere commence a revenir mais de plus en plus jai de la misere a me controler jai recommencer a me couper

je fini par me couper

Chat<Internals\\x13801793>

Youth: I cut myself that's how i deal with it.

I listen too music it reminds me of my relationships .. Witch makes me so angry I cut.. :(

Counsellor: okay, what parts of your body do you usually cut?

Youth: legs and arms.

Counsellor: What do you use to cut your arms and legs/

Youth: Glass , razors , knife.

Another frequently coded high risk problem was when young people indicated that they were living with violence or abuse. The following excerpts from counselling sessions highlight their difficulties and suggest that these problems are multifaceted and often comorbid with other high- or medium-risk problems.

Chat<Internals\\x13781897>

Youth: I am dealing with suicidal thoughts and I am very mentally unstable also dealing with emotional abuse and before sexual and fiscal.

Chat<Internals\\x13783129>

Youth: There is still emotional abuse from my mother and step-father but no more sexual or physical abuse since I moved in with my dad

Call 19357363iCarol

Youth: I want to kill myself.

Counsellor: Okay...

Youth: And some part of me doesn't want to do it, but I really want to.

Counsellor: Have you talked to anybody?

Youth: I've seen a therapist, and I have since I was about 8 years old.

Counsellor: And, so what were you doing tonight?

Youth: I'm sitting at the exact spot that I always imagined I would like to die at.

Counsellor: Okay. So do you have a plan? Did you make a plan?

Youth: Yeah.

Counsellor: Okay. And what was your plan?

Youth: Well, I've had a lot of experience with self-harm and I figured out how to do it; I know exactly where to cut.

Counsellor: Okay, and what are you going to cut with?

Youth: I have a razor.

Counsellor: Okay, can you put the razor in another room, please, where it's not in your reach? Just for the time that we're talking?

Youth: Alright. (Long pause.)

Youth: Well, I've had a lot of experience with self-harm and I figured out how to do it; I know exactly where to cut.

Counsellor: And so you're sitting down right now, in the alley?

Youth: Yeah.

Counsellor: Okay, and from a scale of 1 to 10, 1 is no suicidal thoughts and 10 is you're going to commit suicide right now, where are you on this scale of 1 to 10?

Youth: A 9.

Counsellor: You did these things [moving] because you had to?

Youth: Well, not because I had to...I chose to. My mother, she was really abusive and I don't know who my father is, and I moved out and she signed for a lease and I've been living by myself and I haven't talked to her in almost a year.

Counsellor: So he said that the condom broke. Are you worried about that?

Youth: Yeah. Because I don't want to be 15 and have a child, and then having no way to support it because I know that my mother wouldn't have anything to do with it.

Counsellor: Okay, so do you know where you could go to get a pregnancy test and get tested for STIs as well, at the same time?

Youth: Um yeah, I actually have an appointment booked.

Counsellor: Okay, so you're pretty proactive about it.

Youth: Yeah. Well I want to know if I actually am pregnant because if I kill myself, I don't want to be killing an innocent human being as well.

Counsellor: And for tonight, what were you going to do? Were you going to carry out your plan right away?

Youth: Yeah.

Youth: Which also makes it really hard, considering I trusted him with doing that after I have been raped many times in my life, by multiple people.

Counsellor: Okay, and was this a long time ago?

Youth: Most of it was; one occurrence was about 4 months ago. (Long pause.)

Youth: She's [sister] a year younger than me and she actually has 2 kids from non-consensual intercourse type stuff.

Youth: Because even if I did try to tell her that I wasn't her mom, it would be too hard to see her considering I didn't want her, because my stepbrother raped me and he's also about 21 so...

Youth: Because I am quite the compulsive drinker...

Counsellor: Okay...

Youth: And I tend to get really upset when I'm drunk.

The above excerpts of counselling conversations with high-risk clients demonstrate the complexity of their issues and how they rarely present with a single problem, but rather comorbid issues often involving mental health problems, self-harm, and suicidal ideation. Due

to the severity and immediacy of their problems, high-risk clients could often be described as being at immediate risk for severe harm. All of them appeared to be acutely and deeply suffering.

Medium-risk clients.

Four phone participants were coded for two medium risk factors whereas one chat participant was coded for two medium risk factors. The most common medium risk factor for both callers and chatters was being suggestive of a diagnosable mental health problem.

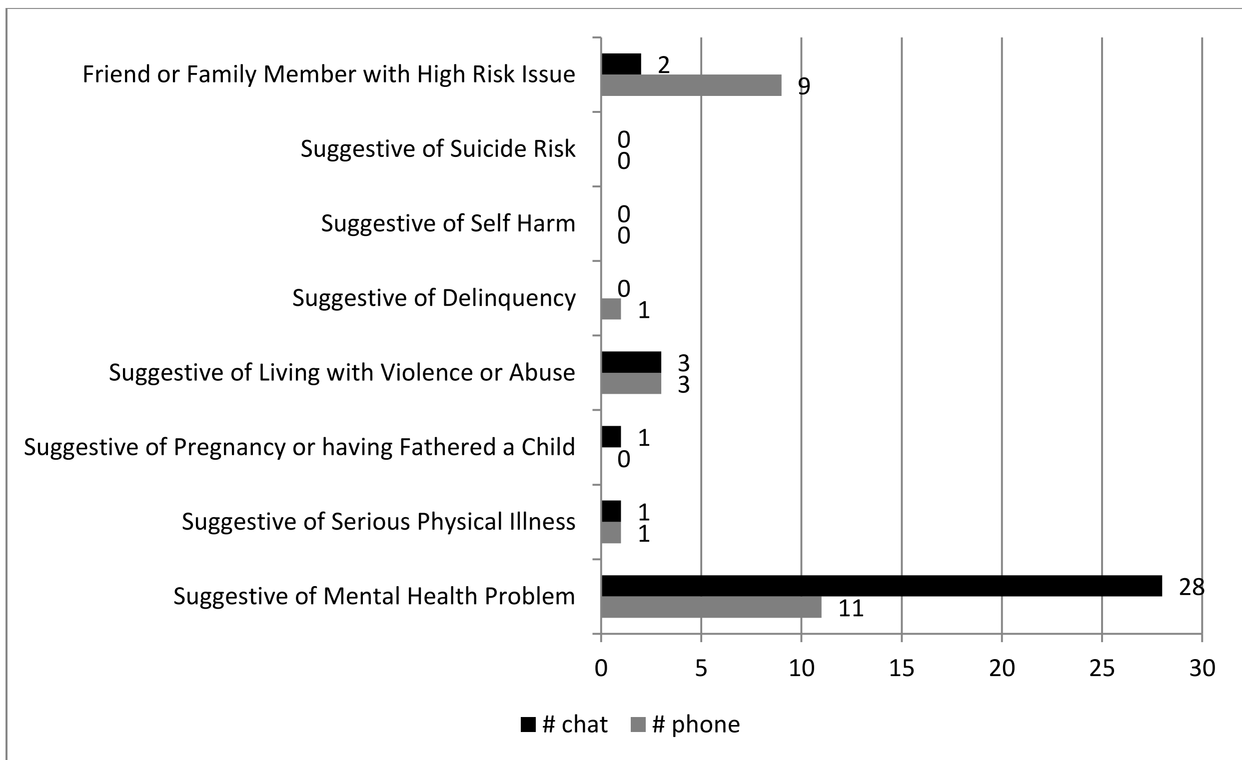


Figure 2. Frequencies of medium risk phone and chat clients with specific risk factors. Phone $n = 21$, Chat $n = 34$.

This code was triggered when clients indicated they believed they had a mental health problem, but did not mention a formal diagnosis nor did they mention being prescribed medication used to treat mental illness, which would imply a formal diagnosis. Details of medium-risk

categorizations for phone and chat clients can be found in Figure 2. The following excerpts of counselling sessions highlight some of the medium risk struggles mentioned by clients who suggested they were dealing with mental health problems. English translations of French chat excerpts can be found in Appendix D.

Chat<Internals\\x13712133>

Youth: De ma vie en entier... Je sais pas si je suis en dépression ... beaucoup de gens autour de moi pense que je le suis..

je pense au suicide constamment... Ca devient quotidian

Chat<Internals\\x13735309>

Youth: Plus simplement y'a des jours où j'ai juste envie de partir... J'en avais déjà parle a mes parents et ils mont mis l'étiquette de malade mentale

Maintenant j'ai juste l'impression que je suis mieux de tout garder pour moi, même si c'est dure

Counsellor: où avais-tu envie de partir ?

Youth: De l'autre côté

Call 19444019iCarol

Counsellor: You said you got kicked out of your house when you were 16. Maybe just because I'm curious but I cannot help it, what happened?

Youth: I was just living with my mom, and my dad was living in Calgary; like, I never had any contact with him really and um, I was just, I was really suffering from depression and stuff, and my mom would jump from guy to guy all the time and I just felt like I was never a priority in her life and so I started lashing out and it just became this constant power struggle between the both of us and it just got to the point where she could not handle it anymore and she just told me to leave. And I've been on my own since.

Counsellor: Oh, you live on your own? Wow.

Youth: I was really suffering from depression and stuff...

Call 19476262iCarol

Youth: And since then I couldn't control it.

Counsellor: How long has it been...is it a few months, a year? Do you have any timeline on it?

Youth: Like, 6 weeks.

Counsellor: Oh 6 weeks okay. So you have this compulsion to do that, and it's difficult for you to control. It comes into your head and it says to you, what?

Youth: I don't know, it's like I'm being controlled by aliens.

Counsellor: Ohh, okay. So it feels like you're controlled by aliens. Why do you think it's aliens though?

Youth: I don't know, have you ever thought that aliens have remote controls and they control what you do?

Counsellor: Are there other things that you're feeling this way, like you're being possessed or something?

Youth: I used to have a headbutting problem but then that went away.

Counsellor: Oh okay.

Call 19665322iCarol

Youth: Half a year ago, we got into a pretty big argument and my mom got involved too and she was just, taking his side so we were pretty much just sitting there and criticizing a lot of aspects of who I am, and my brother...like, I've always struggled with depression and anxiety, and I think I'm slightly bipolar, I don't know. Anyway, he was talking about that and he just goes, "you're sick in the head, you have borderline personality disorder, you need help, you're just sick in the head" and things like that, and it was really cruel.

Youth: Like, I've always struggled with depression and anxiety, and I think I'm slightly bipolar, I don't know.

The second most commonly coded item for medium risk clients occurred when they provide explicit evidence that a close friend or family member was dealing with a high risk problem. The following excerpts highlight the types of issues these clients discussed.

Chat<Internals\\x13769398>

Youth: Mon deuxième frère a volé de l'argent à mon père parce qu'il est dans le rouge et il essayé de se suicider ensuite.

Chat<Internals\\x13814423>

Youth: A few months ago my bf killed himself on my birthday

Chat<Internals\\x13875393>

Youth: I have a friend and I'm very worried for her mental health. She comes across depressed and she is very anxious. She has hurt her-self physically

Call 19375531iCarol

Youth: My friend, he's having suicidal thoughts and I need help to help him.

Youth: He says that he's been self-harming as well, so...he says that no one really cares about him, so I guess I'm the only person that really knows about this.

Call 19423944iCarol

Youth: That would show relation to my mother and although this didn't happen, my brother believes that my mom abused him but that never happened, and it's his schizophrenia that's making him remember things wrong, and so that's why he wrote a hate letter to my mom and my mom had to call the police. And then he wrote another letter a little bit later and told her again how much he hated her and that if she put a hand on me then he would kill her. So my mom called the police and the police dealt with that and I'm not allowed to see my big brother anymore.

Call 19548121iCarol

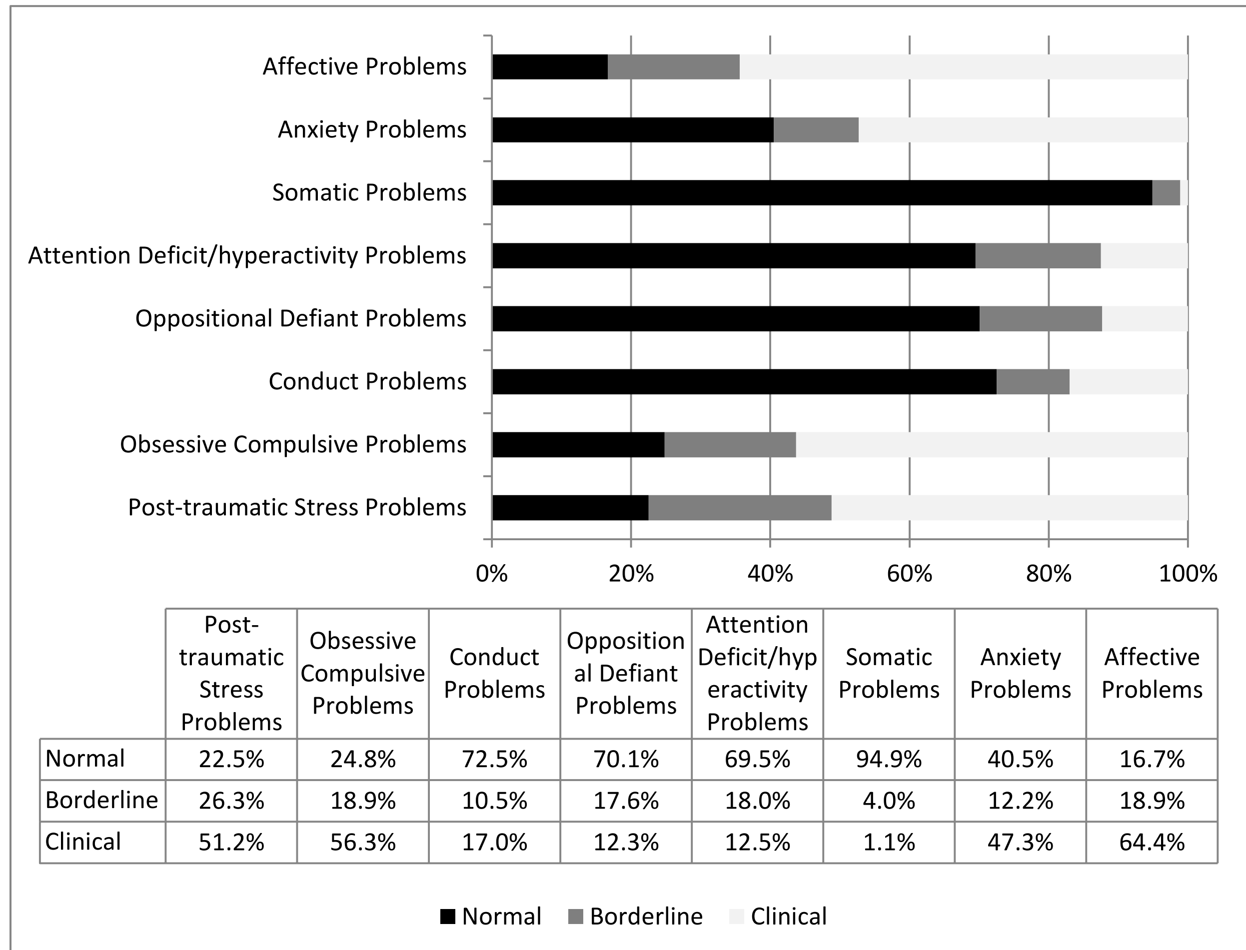
Youth: One of the people that comes to me for help is a friend but she's got a bunch of psychological problems and she's on her way to getting help and treatment. She needs to go to rehab because she cuts herself and she's tried to commit suicide.

Call 19692657iCarol

Youth: I have this friend and uhm..she's been talking to me about recently this past week, and she's been telling that she feels fat and she's depressed and that she's being bullied and that she wants to kill herself, and I don't know what to do and I don't know what to tell her and I know that crying with her is not the best solution. And she's been also, uhm, using blades and knives to cut herself, she send me pictures of her blood and stuff and I can't take it anymore

Medium-risk clients often reference a deep concern for a friend or family member dealing with a high-risk problem, or discuss the impact that the person's high-risk problem has

on them. Several of these clients referenced the suicide or attempted suicide of a loved one. Many others were struggling to cope with a friend or family member bringing intense and stressful mental health problems to them for help.



	Post-traumatic Stress Problems	Obsessive Compulsive Problems	Conduct Problems	Oppositional Defiant Problems	Attention Deficit/hyperactivity Problems	Somatic Problems	Anxiety Problems	Affective Problems
Normal	22.5%	24.8%	72.5%	70.1%	69.5%	94.9%	40.5%	16.7%
Borderline	26.3%	18.9%	10.5%	17.6%	18.0%	4.0%	12.2%	18.9%
Clinical	51.2%	56.3%	17.0%	12.3%	12.5%	1.1%	47.3%	64.4%

Figure 3. Frequencies of chat clients falling into the clinical (T-scores above 65), border line (T-scores between 60 and 65), and normal range (T-scores below 60) for YSR syndrome scales. Male and female participants are included in this figure.

Youth self report.

Many youth who queued up for chat counselling were not able to chat with a counsellor due to service limitations. Chat hours may have ended before it was their turn or they may have had to abandon the average 35-minute queue due to their own scheduling demands. Therefore,

there is a larger sample of participants having completed the YSR than there are chat participants. A total of 465 *potential chat clients* completed the YSR. Of these, 74 participants also completed some portion of the CCQ-2 and 44 completed full pre-post POPS scales. Eight of 465 YSRs were completed by participants who identified as having a non-dichotomous gender identity. Because the YSR has norms only for males and females, YSR scores for non-gender-dichotomous participants were calculated twice, using both male and female norms, and are reported separately from YSR scores for gender-binary participants. The largest frequencies of participants falling into the clinical and borderline ranges were in the *affective problems, post-traumatic stress problems,* and *obsessive compulsive problems* syndrome scales. Data for male and female chat participants falling into the clinical, borderline, and normal ranges for syndrome subscales on the YSR are presented in Figure 3.

The ASEBA does not contain norms for transgender youth or any other youth who do not fit into the gender dichotomy. Male and female norms are different for syndrome scales with some requiring more items endorsed and at higher levels than the other gender to reach borderline and clinical ranges. For four non-gender-dichotomous participants, gender norms did not change the number of scales for which borderline and clinical significances were reached. For the other four non-gender-dichotomous participants, switching from female to male gender norms increased the number of subscales for which they reached borderline or clinical ranges. The most endorsed syndrome scale was *affective problems*, with six participants scoring in the clinical range regardless of gender norms used for comparison. When female norms were used, one participant scored in the borderline range. When male norms were used, one other participant scored in the borderline range. The second-most endorsed syndrome scale was

anxiety problems (n = 7 clinical, 1 normal, regardless of gender norms used for comparison).

Detailed data for non-gender-dichotomous participants can be found in Table 5.

Table 5

Non-gender-dichotomous Participants YSR Syndrome Scales Scores Normed with Female and Male Comparison Groups

Participant	Post-traumatic Stress Problems	Obsessive Compulsive Problems	Conduct Problems	Oppositional Defiant Problems	Attention Deficit/ hyperactivity Problems	Somatic Problems	Anxiety Problems	Affective Problems	Total Clinical / Borderline
1 (F)	*69 (B)*	*68 (B)*	62 (N)	52 (N)	60 (N)	50 (N)	***70 (C)***	***83 (C)***	2c, 2b
1 (M)	***75 (C)***	***70 (C)***	60 (N)	53 (N)	60 (N)	50 (N)	***72 (C)***	***86 (C)***	4C
2 (F)	63 (N)	55 (N)	50 (N)	55 (N)	57 (N)	56 (N)	59 (N)	***78 (C)***	1C
2 (M)	57 (N)	58 (N)	50 (N)	56 (N)	57 (N)	60 (N)	64 (N)	***82 (C)***	1C
3 (F)	**88 (C)**	**83 (C)**	50 (N)	52 (N)	***70 (C)***	53 (N)	***80 (C)***	***83 (C)***	5C
3 (M)	**88 (C)**	**83 (C)**	50 (N)	52 (N)	***70 (C)***	53 (N)	***80 (C)***	***83 (C)***	5C
4 (F)	61 (N)	63 (N)	62 (N)	55 (N)	*68 (B)*	51 (N)	***73 (C)***	53 (N)	1C, 1B
4 (M)	*66 (B)*	61 (N)	*68 (B)*	61 (N)	57 (N)	52 (N)	***74 (C)***	*69 (B)*	1C, 3B
5 (F)	***91 (C)***	***80 (C)***	62 (N)	60 (N)	*68 (B)*	53 (N)	***78 (C)***	*69 (B)*	3C, 1B
5 (M)	***93 (C)***	***81 (C)***	60 (N)	61 (N)	*69 (B)*	56 (N)	***78 (C)***	***74 (C)***	4C, 1B
6 (F)	*68 (B)*	63 (N)	64 (N)	55 (N)	***73 (C)***	53 (N)	***63 (C)***	***75 (C)***	3C, 1B
6 (M)	*68 (B)*	63 (N)	64 (N)	55 (N)	***73 (C)***	53 (N)	***63 (C)***	***75 (C)***	3C, 1B
7 (F)	***85 (C)***	***87 (C)***	62 (N)	52 (N)	*66 (B)*	51 (N)	***70 (C)***	***95 (C)***	4C. 1B
7 (M)	***85 (C)***	***87 (C)***	60 (N)	53 (N)	*67 (B)*	52 (N)	***72 (C)***	***96 (C)***	4C, 1B
8 (F)	***88 (C)***	***70 (C)***	***76 (C)***	73 (N)	*68 (B)*	63 (N)	***73 (C)***	***85 (C)***	5C. 1B
8 (M)	***91 (C)***	***73 (C)***	***76 (C)***	73 (N)	*69 (B)*	*68 (B)*	***74 (C)***	***86 (C)***	5C, 2B

Note: T scores 70 and above indicate clinical range, between 65 and 69 indicate borderline range, and under 65 indicates normal range.

Mental health symptoms measured by the EMHSS-A.

A total of 465 young people responded to the YSR while waiting in queue to chat; however, not all of them received service from a counsellor either because they left the chat queue before receiving service or because the chat service closed for the night before it was their

Table 6
EMHSS-A Coding for Chat Participants

# Codes Triggered in Chat	Anxious Depressed	Withdrawn Depressed	Social Problems	Thought Problems	Attention Problems	Rule Breaking Problems	Somatic Complaints	Aggressive Behaviour
6	1 (2.3%)							
5	2 (4.5%)							
4	1 (2.3%)		1 (2.3%)					
3	2 (4.5%)	1 (2.3%)	3 (6.8%)	1 (2.3%)	1 (2.3%)			
2	14 (31.8%)	5 (11.3%)	1 (2.3%)	1 (2.3%)	3 (6.8%)	1 (2.3%)	1 (2.3%)	
1	12 (27.3%)	16 (36.4%)	11 (25%)	11 (25%)	3 (6.8%)	4 (9.1%)	1 (2.3%)	2 (4.5%)
0	12 (27.3%)	22 (50%)	28 (63.6%)	31 (70.4%)	37 (84.1%)	39 (88.6%)	42 (95.4%)	42 (95.5 %)
Total # Chats With Code	32 (62.7%)	22 (50%)	16 (36.4%)	13 (29.6%)	7 (15.9%)	5 (11.4%)	2 (4.6%)	2 (4.5%)

Note: 44 chats were coded for EMHSS-A ill mental health symptoms.

turn to chat with a counsellor. Of the 230 total chat participants who responded to the CCQ-2, 74 completed the YSR, 151 consented to review of their chat transcripts, and 52 did both. Of those 52, only 40 of their chats could be found in the KHP supervision software; therefore, only a small sample size of $n = 40$ could be used for EMHSS-A validation. EMHSS-A coding of their transcripts was compared to their scores on corresponding subscales of the YSR. Only the *anxious depressed, social problems,* and *attention problems* subscales were positively correlated with a medium or strong relationship ($r = .456$, .373, and .732 respectively, $p = .01$, .05, and .05 respectively). Therefore, the EMHSS-A was not applied to the other chat transcripts or call recordings in the present study. However, the EMHSS-A for these 40 participants plus an additional four chat participants (whose chats were coded before determining that their YSRs were incomplete) is reported here.

For these 44 participants, *anxious depressed* was the most frequently triggered code. 74.9% of participants received at least one *anxious depressed* code and one participant (1.9%) received six separate *anxious depressed* codes. *Withdrawn depressed* was the next most frequently endorsed code with 50% of participants receiving at least one *withdrawn depressed* code and one participant receiving three separates codes in this category. *Social problems* was the third-most frequently coded item with 36.4% of the participants receiving at least one code in this category and one participant receiving four separate codes in this category. A more detailed account of the EMHSS-A coding results is presented in Table 6.

Objective 3: To Assess and Compare the Perceived Effectiveness of KHP Counselling on Clients Using the Two Service Media.

POPS.

In total, 361 participants completed the POPS pre- and post-counselling. Of these, 232 were callers and 129 were chatters.

POPS reliability.

Table 7

Coefficient Alphas for POPS Subscales

Subscale	Number of Items	Pre-counselling α	Post-counselling α
Distress	3	.696	.684
Isolation	2	**-.240**	**-.006**
Perceived Problem Difficulty	3	.613	.712
Problem Clarity	3	.476	.637
Self-efficacy	3	.743	.833
Hope	2	.745	.800

Note: coefficient alphas detracting from the coherence of the scale are in boldface. These items have been removed from the POPS.

The estimated internal consistency for pre-counselling was α = .75; for post-counselling data, α = .87. Although alphas above .7 are considered sufficient to indicate internal validity (DeVellis, 2003), in both cases, the two items comprising the isolation subscale (‘Alone’ – *How alone do you feel in dealing with the problem or situation you are facing?* and ‘Talk’ – *How much do you feel like you can talk to people other than Kids Help Phone about your problem or situation?*) had negative inter-item correlations and low item-total correlations (lower than .3), suggesting these items were measuring something different from the scale as a whole (Briggs & Cheek, 1986). When these items comprising the isolation subscale were removed, for pre-

Table 8

Descriptive Statistics for POPS Subscales

Subscale	M_{pre}	SD_{pre}	M_{post}	SD_{post}	*p*	*t*	95% CI
Distress (phone)	1.45	1.29	3.44	1.43	<.0005	20.51	(2.18, 1.80)
Distress (chat)	2.19	1.00	3.39	1.39	<.0005	9.86	(1.44, 0.96)
Isolation*	-	-	-	-	-	-	-
Alone (phone	4.19	2.13	2.53	1.95	<.0005	9.63	(1.32, 1.99)
Alone (chat)	4.83	1.99	4.23	1.97	<.0005	3.45	(0.30, 1.09)
Talk (phone)	2.47	2.19	3.46	2.29	<.0005	7.33	(1.25, 0.72)
Talk (chat)	1.53	1.45	2.75	1.79	<.0005	8.15	(1.35, 0.82)
Perceived Difficulty (phone)	1.72	2.39	2.39	1.40	<.0005	8.43	(0.82, 0.51)
Perceived Difficulty (chat)	2.32	1.01	3.04	1.37	<.0005	5.29	(0.99, 0.45)
Problem Clarity (phone)	3.45	1.42	4.67	1.43	<.0005	12.02	(1.41, 1.02)
Problem Clarity (chat)	3.04	4.31	4.31	1.72	<.0005	9.53	(1.54, 1.01)
Self-efficacy (phone)	2.82	1.48	4.55	1.34	<.0005	18.41	(1.91, 1.54)
Self-efficacy (chat)	2.58	1.16	3.66	1.60	<.0005	8.90	(1.32, 0.84)
Hope (phone)	3.30	1.91	4.75	1.66	<.0005	12.35	(1.67, 1.21)
Hope (chat)	3.47	1.83	4.25	1.96	<.0005	6.25	(1.03, 0.53)

**Because the two items on this subscale did not comprise a unified concept, the descriptive statistics for the individual items are reported rather than those of the subscale. N for phone = 232, N for chat = 129.*

counselling data α = .80 and for post-counselling data α = .89. Coefficient alphas for all subscales can be found in Table 7. Because the items on the isolation subscale detracted from the coherence of the overall scale, they were removed from the POPS.

POPS descriptive statistics.

With the removal of the isolation subscale, the minimum possible score on the POPS was 0 and the maximum possible score was 98. Subscale scores were converted to scales with ranges from 0 to7. Total scores and subscale scores for phone and chat are reported in Table 8.

Combined Phone and Chat Sample and the CCQ-2

The change in methodology resulted in three CCQ-2 conditions. There were 170 participants who completed true pre-post versions of the CCQ-2 (41 callers and 129 chatters), 96 callers who completed the CCQ-2 in the counterbalanced A condition, and 95 callers in the counterbalanced B condition. Given the potential for retrospective accounting of previous emotional states to affect POPS scores, between-groups one-way analyses of variance (ANOVA) was used to determine whether there were differences between these groups with regards to pre-counselling, post-counselling, and change scores on the POPS. Descriptive statistics for POPS scores for each questionnaire type can be found in Table 9. There were statistically significant differences for pre-counselling, post-counselling, and change scores on the POPS for the three groups [F (2, 358) = 11.99, $p < .0005$, $\eta^2 = .06$ for pre-counselling POPS; F (2, 358) = 3.54, $p = .03$, $\eta^2 = .02$ for post-counselling POPS; F (2, 358) =7.37, $p = .001$, $\eta^2 = .04$ for POPS change scores]. There were statistically significant differences between the following means:

- Pre-counselling POPS – true pre-post and counterbalance A conditions ($p < .001$), counterbalance A and B conditions ($p = .017$)
- Post-counselling POPS – counterbalance A and B conditions ($p = .023$)

- Change POPS – true pre-post and counterbalance A conditions ($p = .016$), true pre-post and counterbalance B conditions ($p = .002$)

Table 9

Descriptive Statistics For POPS Scores Based On Questionnaire Type

				95% CI			
Questionnaire Type	n	*M*	*SD*	Lower	Upper	Min.	Max.
Pre-counselling POPS							
True pre-post	170	38.78	12.34	36.91	40.64	8	75
Counterbalance A	96	30.82	14.17	27.95	33.69	5	74
Counterbalance B	95	35.88	11.87	33.47	38.30	10	68
Total	361	35.90	13.12	34.54	37.26	5	75
Post-counselling POPS							
True pre-post	170	53.55	18.15	50.80	56.30	0	92
Counterbalance A	96	50.71	14.55	47.76	53.66	11	88
Counterbalance B	95	57.12	15.94	53.87	60.36	1	94
Total	361	53.73	16.80	51.99	55.47	0	94
POPS Change							
True pre-post	170	14.78	15.35	12.45	17.10	-24	56
Counterbalance A	96	19.89	13.03	17.25	22.53	-9	72
Counterbalance B	95	21.23	14.28	18.32	24.14	-14	57
Total	361	17.84	14.74	16.31	19.36	-24	72

Given the small to medium effect sizes and statistically significant differences between group means for pre-counselling, post-counselling, and change scores on the POPS, I considered counterbalancing condition a potential predictor in regression analyses involving the POPS or its subscales as dependent variables.

POPS multiple regression model.

The following variables were considered potential predictors of post-counselling scores on the POPS: pre-counselling POPS score, service media type (phone vs. chat), counterbalance condition (true pre-post, counterbalance A or B), gender (male, female, or non-gender-binary), LGBQQA status (heterosexual vs. not heterosexual), cultural identity (identifying only with the dominant culture vs. identifying with at least one non-dominant culture), generational status (newcomer vs. non-newcomer), client-identified problem topic (mental health and well-being or suicide vs. other problems), and risk level (high-risk vs. not high-risk).

All assumptions for multiple regression analysis were met. Residuals were plotted and sufficiently approximated a normal distribution. All predictors other than pre-counselling POPS were categorical and therefore there was no concern about non-linear trends in these data. Studentized residuals were plotted against pre-counselling POPS and a linear relationship was found. Homogeneity of variance for each variable plotted by Studentized residuals was satisfactory. One case had Studentized residual of 3.38. Casewise diagnostics predicted a post-counselling POPS score of 31.61 for this participant; however, the raw score on post-counselling POPS was 80. Cook's distance for this case was 0.11. According to Tabachnick and Fidell (2007, p. 75), values over 1.0 are considered extreme, so this case was not excluded from the data. The Variance Inflation Factors (VIFs) for each variable were below 3 (min. = 1.04, max. =

2.84) with the exception of the two dummy coded variables for questionnaire counterbalance condition (values were 7.70 and 7.79). The two dummy coded variables for questionnaire

Table 10

Model 1: Regression Model Predicting Post-counselling POPS scores

Variable	*B*	*SE(B)*	*B**	*p*	
Pre-counselling POPS	.667	.099	.520	.005	(.47, .86)
Medium	-2.374	4.126	-.068	.000	(-10.53, 5.78)
Ethno-cultural Identity	.651	2.562	.018	.566	(-4.42, 5.72)
Sexual Orientation	-.349	2.971	-.009	.800	(-6.22, 5.53)
Problem Topic	-3.948	2.734	-.107	.907	(-9.35, 1.46)
Questionnaire Type (dummy coded counterbalance A = 1)	.185	4.401	.005	.151	(-8.52, 8.89)
Questionnaire Type (dummy coded counterbalance B =1)	3.012	4.379	.079	.966	(-5.65, 11.67)
Gender (dummy coded males = 1)	2.990	8.386	.069	.493	(-13.59, 19.57)
Gender (dummy coded females =1)	1.512	8.037	.037	.722	(-14.38, 17.40)
Risk Level	-.494	2.770	-.014	.851	(-5.97, 4.98)
Generational Status	-.043	.088	-.035	.859	(-.22, .13)

Note. R^2 for Model 1 = .329, $F(11,149) = 6.142$, $p < .0005$.

counterbalance condition were also moderately correlated with service medium (phone vs. chat) ($r = .45$ for both dummy variables) as all chat participants completed true pre-post questionnaires and only 40 of the 232 phone participants did. Therefore, I report two models: Model 1 contains

all the above mentioned predictors and model 2 contains all of the above mentioned predictors except questionnaire counterbalance condition.

The results of model 1 can be found in Table 10; $R^2 = .33$, $F(11, 149) = 6.07$, $p < .001$. Although pre-counselling POPS score was the only significant predictor of post-counselling POPS score, this model accounts for 32.6% of the variance in post-counselling POPS scores. These results indicate that contact with a KHP counsellor is associated with clients' perceptions of preparedness to deal with their problems regardless of service media or other individual factors. Clients who began counselling with high scores on the POPS tended to have higher scores on the POPS after counselling than did clients who began with low scores.

The results of model 2 can be found in Table 11; $R^2 = .323$, $F(8, 149) = 7.42$, $p < .001$. Again, pre-counselling POPS score was the only significant predictor of post-counselling POPS score and this model accounts for 32.2% of the variance in post-counselling POPS scores. The R^2 change of .004 was not significant (F (2, 121) = 1.06, $p = .348$). Removing questionnaire type from the model did not significantly worsen the model.

Subscales of the POPS.

All subscales were converted to correspond with a scale of 0 to 7. The subscales were distress, isolation (although because the scale was not cohesive, the two items are reported separately), perceived difficulty of the problem, problem clarity, self-efficacy, and hope. For each subscale high numbers are associated with good outcomes (preferred client experiences) whereas low numbers are associated poor outcomes (unwanted client experiences). Because only pre-counselling scores significantly predicted post-counselling scores on total POPS scores, simpler regression models were selected for each of the subscales. Because the differences in outcomes between the two service media were of key interest, for each of the subscales, a

hierarchical regression was conducted wherein model 1 post-counselling scores were regressed on pre-counselling scores whereas model 2 post-counselling scores were regressed on pre-counselling scores and service medium (phone or chat). Recall that mean pre- and post-counselling subscale scores and standard deviations are found in Table 8.

Table 11

Model 2: Regression Model Predicting Post-counselling POPS scores (with questionnaire type variable removed)

Variable	*B*	*SE(B)*	*B**	*p*	95% CI
Pre-counselling POPS	.676	.094	.527	<.005	(0.49, 0.86)
Medium	-3.645	2.554	-.104	.156	(-8.69, 1.40)
Ethno-cultural Identity	1.871	2.941	.052	.526	(-3.94, 7.69)
Sexual Orientation	-.842	2.886	-.022	.771	(-6.55, 4.87)
Problem Topic	-3.760	2.709	-.102	.167	(-9.12, 1.60)
Gender (dummy coded males = 1)	2.162	8.392	.050	.797	(-14.43, 18.75)
Gender (dummy coded females =1)	1.076	8.040	.026	.894	(-14.82, 16.97)
Risk Level	-.646	2.771	-.018	.816	(-6.13, 4.83)
Generational Status	-2.161	2.773	-.064	.437	(-7.64, 3.32)

Note. R^2 for Model 2 = .323, $F(8,149) = 7.420$, $p < .0005$.

Distress.

All assumptions for multiple regression analysis were met. Residuals were plotted and sufficiently approximated a normal distribution. Studentized residuals were plotted against pre-counselling distress scores and a linear relationship was found. Homogeneity of variance for each variable was also satisfactory. The Variance Inflation Factors (VIFs) for each variable were

1.09. Results for these models can be found in Table 12. Model 1 $R^2 = .14$, $F(1, 359) = 60.38$, $p < .001$; Model 2 $\Delta R^2 = .017$, $F(1, 358) = 7.42$, $p = .007$. The R^2 value for the second model is significantly larger than for the model containing only pre-counselling distress and therefore adding service medium as a predictor accounts for a significant proportion of the variance in post-counselling distress above that already accounted for by pre-counselling distress alone. According to this model, chatters' post-distress scores are on average 0.14 points lower than callers after controlling for pre-counselling distress.

Table 12

Hierarchical Regression Predicting Post-counselling Distress Scores

Variable	*B*	*SE(B)*	*B**	*p*	95% CI
Model 1					
Pre-counselling distress	.430	.055	.379	<.0005	(2.46, 2.92)
Model 2					
Pre-counselling distress	.475	.119	.419	<.0005	(0.36, 0.58)
Medium	-.405	.148	-.138	.007	(-.70, -.11)

Note. R^2 for Model 1 = .217, $F(1,359) = .99.260$, $p < .0005$, ΔR^2 for Model 2 = .011, $F(1, 358) = 4.872$, $p = .028$.

Isolation

The two items in the isolation subscale did not comprise a unified concept, nor did the subscale contribute to the overall validity of the POPS. Therefore, a regression model was not estimated using this item. Descriptive statistics for the two items associated with this subscale are reported alongside subscale statistics in Table 8. The two items are referred to as "Alone"

(“How alone do you feel in the problem or situation you are facing?”), and “Talk” (“How much do you feel like you can talk to people other than Kids Help Phone about your problem or situation?”). Although there was a significant positive change in callers’ beliefs that they could talk to someone other than KHP about their problem or situation (M_{change} = -1.66, *SD* = 2.62; *t*(231) = -7.33, *p* < .001), there was also a significant negative change in callers’ feelings that they were alone in dealing with their problems (M_{change} = 0.99, *SD* = 2.05; *t*(231) = 9.63, *p* < .001). For chatters, the results were slightly different. There was a significant positive change for chatters on the “Talk” item (M_{change} = 1.22, *SD* = 1.75; *t*(128) = -5.29, *p* <.001). There was also a significant negative change on the “Alone” item (M_{change} = -0.60, *SD* = 2.79; *t*(128) = -2.43, *p* = .017).

Perceived difficulty of the problem.

All assumptions for multiple regression analysis were met. Residuals were plotted and sufficiently approximated a normal distribution. Studentized residuals were plotted against pre-counselling distress scores and a linear relationship was found. Homogeneity of variance for each variable was also satisfactory. The Variance Inflation Factors (VIFs) for each variable were 1.07. Results for these models can be found in Table 13. Model 1 R^2 = .22, $F(1, 359) = 99.26$, $p < .001$; Model 2 $\Delta R^2 = .011$, $F(1, 358) = 4.87$, $p = .028$. The R^2 value for the second model is significantly larger than for the model containing only pre-counselling difficulty and therefore adding service medium as a predictor accounts for a significant proportion of the variance in post-counselling distress above that already accounted for by pre-counselling difficulty alone. According to this model, callers’ post-difficulty scores are on average 0.11 points lower than chatters after controlling for pre-counselling difficulty.

Table 13

Hierarchical Regression Predicting Post-counselling Perceived Difficulty of the Problem Scores

Variable	*B*	*SE(B)*	*B**	*p*	95% CI
<u>Model 1</u>					
Pre-counselling difficulty	.599	.060	.465	<.0005	(0.48, 0.79)
<u>Model 2</u>					
Pre-counselling difficulty	.564	.062	.438	<.0005	(0.44, 0.69)
Medium	.315	.143	.106	.028	(0.34, .060)

Note. R^2 for Model 1 = .222, $F(1,359)$ = .102.514, $p < .0005$, ΔR^2 for Model 2 = .0021, F (1, 358) = 0.934, $p = .335$.

Problem clarity.

All assumptions for multiple regression analysis were met. Residuals were plotted and sufficiently approximated a normal distribution. Studentized residuals were plotted against pre-counselling distress scores and a linear relationship was found. Homogeneity of variance for each variable was also satisfactory. The Variance Inflation Factors (VIFs) for each variable were 1.02. Results for these models can be found in Table 14. Model 1 $R^2 = .22$, $F(1, 359) = 102.51$, $p < .001$; Model 2 $\Delta R^2 = .002$, $F(1, 358) = 0.93$, $p = .335$. The R^2 value for the second model is not significantly larger than for the model containing only pre-counselling clarity, indicating that adding service medium as a predictor does not account for a significant proportion of the variance in post-counselling clarity above that already accounted for by pre-counselling clarity alone.

Table 14

Regression Model Predicting Post-counselling Problem Clarity Scores

Variable	*B*	*SE(B)*	*B**	*P*	95% CI
Model 1					
Pre-counselling clarity	.516	.051	.471	<.0005	(.416, .617)
Model 2					
Pre-counselling clarity	.509	.052	.465	<.0005	(.408, .611)
Medium	-.147	.152	-.045	.335	(-.445, .152)

Note. R^2 for Model 1 =.222, $F(1,359)$ = .102.514, $p < .0005$, ΔR^2 for Model 2 = .002, $F(1, 358) = 0.934$, p =*.335.*

Self-efficacy.

All assumptions for multiple regression analysis were met. Residuals were plotted and sufficiently approximated a normal distribution. Studentized residuals were plotted against pre-counselling distress scores and a linear relationship was found. Homogeneity of variance for each variable was also satisfactory. The Variance Inflation Factors (VIFs) for each variable were 1.01. Results for these models can be found in Table 15.

Table 15

Hierarchical Regression Predicting Post-counselling Self-efficacy Scores

Variable	*B*	*SE(B)*	*B**	*p*	95% CI
Model 1					
Pre-counselling self-efficacy	.538	.050	.496	<.0005	(0.44, 0.64)
Model 2					
Pre-counselling self-efficacy	.516	.048	.476	<.0005	(0.42, 0.61)
Medium	-.761	.138	-.244	<.0005	(-1.03, -0.49)

Note. R^2 for Model 1 = .244, $F(1,359)$ = .117.302, $p < .0005$, ΔR^2 for Model 2 = 0.059, $F(1, 358)$ = 30.535, $p < .0005$.

Model 1 $R^2 = .24$, $F(1, 359) = 117.30$, $p < .001$; Model 2 $\Delta R^2 = .059$, $F(1, 358) = 30.54$, $p < .001$. The R^2 value for the second model is significantly larger than for the model containing only pre-counselling self-efficacy and therefore adding service medium as a predictor accounts for a significant proportion of the variance in post-counselling self-efficacy above that already accounted for by pre-counselling self-efficacy alone. According to this model, chatters' post-self-efficacy scores are on average 0.24 points lower than callers after controlling for pre-counselling self-efficacy.

Hope.

All assumptions for multiple regression analysis were met. Residuals were plotted and sufficiently approximated a normal distribution. Studentized residuals were plotted against pre-counselling distress scores and a linear relationship was found. Homogeneity of variance for each variable was also satisfactory. The Variance Inflation Factors (VIFs) for each variable were

Table 16

Hierarchical Regression Predicting Post-counselling Problem Hope Scores

Variable	*B*	*SE(B)*	*B**	*p*	95% CI
<u>Model 1</u>					
Pre-counselling hope	.574	.041	.578	<.0005	(0.47, 0.63)
<u>Model 2</u>					
Pre-counselling hope	.554	.040	.585	<.0005	(0.48, 0.63)
Medium	-.587	.157	-.158	<.0001	(-0.90, -0.28)

Note. R^2 for Model 1 =.333, $F(1,359)$ = .180.363, $p < .0005$, ΔR^2 for Model 2 = .025, $F(1, 358) = 13.938$, $p < .0005$.

1.00. Results for these models can be found in Table 16. Model 1 $R^2 = .33$, $F(1, 359) = 180.36$, $p < .001$; Model 2 $\Delta R^2 = .025$, $F(1, 358) = 13.94$, $p < .001$. The R^2 value for the second model is significantly larger than for the model containing only pre-counselling hope and therefore adding service medium as a predictor accounts for a significant proportion of the variance in post-counselling hope above that already accounted for by pre-counselling hope alone. According to this model, chatters' post-hope scores are on average 0.16 points lower than callers after controlling for pre-counselling hope.

***Objective 4:* To Provide an Assessment of "What Works" in Terms of Counselling Techniques Using Type-to-type Technologies that, by Definition, Lack the Contextual and Emotional Cues Available in Face-to-face and Ear-to-ear Counselling.**

Analysis: Success of the counselling session was determined by participants' POPS score. The CIS was applied to chat counselling transcripts of participants with both the highest and lowest ratings of success (upper and lower deciles) on the POPS change score variable. In addition, the CIS rupture and repair items associated with high and low success was assessed.

Description of the top and bottom deciles of POPS change scores.

The chats were coded according to the CIS and further analysed using thematic analysis based on widely known counselling and intervention techniques and computer-mediated communication techniques. Coders were not aware whether the transcripts they coded came from the top or bottom deciles, or a mixture of both. To remove any potential bias, transcripts were de-identified so that the lead researcher did not know the names of the counsellors who facilitated the chats.

Top and bottom deciles.

Sixteen chats comprised the bottom decile and 16 chats comprised the top decile of POPS change scores. Of these, ten bottom decile chats and 13 top decile chats were from chatters who gave consent for the chats to be reviewed by the researchers. Therefore, these 23 chats were analyzed using the CIS. This scale focuses on ruptures and repairs in the therapeutic relationship and allows an examination of both what clients bring in terms of their ability to negotiate the counselling sessions and deal with their transference, and also how counsellors recognize ruptures in the relationships and work to repair them while also dealing with their own countertransference. A summary of the percentage of coverage for each CIS code for top and bottom decile chats is found in Table 17.

Table 17

Percentage Coverage of CIS codes for Chats in the Top and Bottom of Deciles of POPS outcomes.

Counsellor Node	Number of Top Decile Chats that Triggered Node (*n* = 10)	Mean Percentage Coverage of Top Decile Chats	Number of Bottom Decile Chats that Triggered Node (*n* = 12)	Mean Percentage Coverage of Bottom Decile Chats
Positive Interactions (Total)	10	44.05	12	45.12
PI0	1	1.48	0	0
PI1	10	23.84	12	23.09
P12	8	13.94	11	7.77
PI3	9	11.67	11	8.32
PI4	2	1.64	3	2.13
PI5	0	0	0	0
PI6		5.55	8	5.78
PI7	5	4.75	8	2.85
PI8	2	6.38	1	2.33
PI9	0	0	0	0
PI10	0	0	0	0
PI11	2	1.70	0	0
PI12	2	2.78	0	0
Negative Interactions (Total)	2	9.49	3	2.48
NI0	2	1.74	0	0
NI1	1	8.38	0	0

NI2	0	0	0	0
NI3	1	3.27	1	1.51
NI4	0	0	0	0
NI5	1	1.11	0	0
NI6	2	3.11	2	2.96
NI7	0	0	0	0
NI8	0	0	0	0

Clients' contributions to ruptures (CIS) – indirect ruptures.

Clients rupture markers were mostly characterized as "indirect." When there was a problem in the counselling relationship, clients most often indicated it through indirect comments rather than directly naming the issue. The most commonly demonstrated indirect rupture occurred when *clients were self-critical or self-blaming in response to a counsellor comment*. The following three examples demonstrate this common indirect rupture. The first example is from a chat with a 15-year-old female client who sought counselling because of suicidal ideation:

Chat<Internals\\x13707925>

Counsellor: You're not very close with them, okay. And what do you think about potentially trying to build some of those relationships up? Trying to get closer and more connected with others in your life? I mean, chances are pretty good that you and your sister will make up in some capacity going forward, since you're going to continue living together and having to interact... But even after the two of you re-connect, it might help you to feel more connected if there are others in your life that you care for, and vice-versa... What do you think?

Youth: im not very good with people

Counsellor: What do you mean?

Youth: i've tried to make friends but it never works

Counsellor: I don't think it's fair to yourself to say it never works... It sounds like you forged strong relationship with your best friend, and your boyfriend. (And also your sister!) Fights are a normal part of relationships unfortunately... But it doesn't mean there was anything wrong with the friends you made, it just means that bumps came up (as they always do).

Youth: i know but every time i try to make a new friend, it will sometimes work but then they get "too cool" for me and forget about me

Counsellor: Oh no, do they tell you that they feel they're "too cool"? Or is that the impression they give you? :(

Youth: well i kinda figure it out when they replace me with other people

Counsellor: You want to make new friends, okay. I think that could be helpful, too. :) Do you think making new friends will help you to feel better when you see the people from this situation around at school? Would it help bring those thoughts of suicide down?

Youth: probably. but they probably wont stay my friends for long

[Chat session continues…]

Counsellor: Reading and music and animals and soccer, okay. That's a good list! Are you involved in any activities around those things, where you could meet people? Like, volunteering with animals, or on a soccer team, or in band?

Youth: i do those things but it never really lasts

In the above example, the client is self-critical or self-blaming in response to most of the counsellor's utterances.

A second chatter demonstrates this common indirect rupture marker of being self-critical or self-blaming in response to a counsellor comment. In this case, the chatter is a 16-year-old female client seeking help for her disturbing thoughts regarding self-harm and suicide. In this case, the client asked directly at what point her thoughts would be considered abnormal, but did not want to disclose her thoughts to the counsellor:

Chat<Internals\\x13710741>

Counsellor: Ok so I will let you clarify your situation

Youth: I don't feel like it anymore. Thanks for wasting my time. I imagine that it's a good thing for you if I leave. Sorry if I was impolite. I'm not doing it on purpose, I'm just like that

In a third example of critical self-blame, this 18-year-old female client responds to a counsellor's suicide intervention by referring to herself as a coward:

Chat<Internals\\x13794956>

Counsellor: I hear you. But before giving up, don't you think there are other things that you could try?

Youth: I'm going to be a coward and respond with a no

In a fourth example, an 18 year-old female client responds to a counsellor's suicide intervention by putting herself down repeatedly. The abbreviation "fml" stands for "fuck my life."

Chat<Internals\\x13825152>

Counsellor: Ok, well if you are feeling suicidal and called 911 you would not be going to jail....
sounds like you really want to be taken seriously

Youth: I hate myself and my life and I have no reason to be alive

[Chat session continues…]

Counsellor: wow...so now I have EXTRA respect for you that you were able to reach out for support tonight :)
that takes a lot...I mean that....what motivated you to get on chat?

Youth: yeah. don't respect me too soon until you know me.

[Chat session continues…]

Counsellor: well, that is up to you, but I really hope that you consider telling someone who can help sooner than later...that 30% of you deserves to be 100%

Youth: fml

The common rupture of a client responding to a counsellor by being critical of herself is illustrated by the following example of a 17 year-old female client who calls herself "Barelyalive." In this example, the chatter is persistent and elaborative in her self-deprecation:

> ***Chat<Internals\\x13873477>***
> *Youth: It's just a lot of messed up things. My mother prefers her precious reputation over me, father is most likely bipolar, no one wants to be my friend (who would?), my brother complains about everything I know about myself. So I'm left feeling pathetic, and I'm taunted with the fact that I can just walk away from everything, but there wouldn't be anything at the end of the road.*
>
> *Counsellor: Oh wow... that is a lot going on in that...*
> *But with all of that, you are still taking steps to reach out, to KHP and thinking about telling your family, and you have talked to your doctor already... That tells me that there is a part of you that feels it is possible to get support and to deal with this...*
>
> *Youth: I don't know, the part of me that learns from society says that I need to get help, but I don't really feel like there is anything to help. I just feel like I'm just some messed up, spoiled child, and it's not like there's anyone that would even come close to me if I do get out of this. A huge part of me thinks that I just want some stupid attention*
>
> *Counsellor; hmmm... I'm curious, do you know what would help you? What would make things even just a little bit better for you do you think?*
>
> *Youth: It's really farfetched, and I feel like I'm just romanticizing depression, but love. I've just been missing it my whole life and just someone that really doesn't mind dealing with my demented self would help. But I know it can't be from my "family", so it's like the smallest chance. I don't know, I'm just too f*ed up.*
>
> *[Chat session continues…]*
>
> *Counsellor: Are you meaning suicide? Can you tell me on a scale of 1-10, 1 being not at all strong and 10 being the strongest they have ever been, where are the thoughts of suicide for you now?*
>
> *Youth: They've been constant. I'm just fucked up beyond repair, there's not really any other beneficial option.*

The second-most common client indirect rupture occurred when *young people responded to counsellors in an acquiescent manner*. They said what they thought the counsellors wanted to hear, or agreed with the counsellors, when likely their words did not reflect their true feelings.

Consider the following excerpt from the chat counselling session of a 15-year-old female client struggling with feelings of depression related to relationship problems with her friends. In this case, the counsellor provides a lot of information or suggestions to the client, who acquiesces using short statements:

Chat<Internals\\x13707925>

Counsellor: What did all of your previous friends have in common, do you think? Is there a way we could strategise for you to try to connect with a different type of person, to see if it gets a different result?
That's the tough thing... There's no way to screen out people who will hurt you before you really get to know them. You can try to get a feel for who they are, and what kind of friend they are by seeing how they interact with other people, or even by asking around about them.

Youth: i guess

[Chat continues]

Counsellor: Okay. Well, maybe if you're open to it spend some time tonight researching what kind of opportunities are available in your community... We're more likely to follow through with goals if we have a set plan and timeline in place. :)

Youth: okay

[Chat continues]

Counsellor: Okay. And what do you think about the idea of trying to connect with anyone who seems interesting, or who shares some of those interests you mentioned? And rather that focusing on one or two people you can try being friendly with multiple people and seeing if deeper friendships develop from that? Making close friends is a process, and it's going to take time.. But if you don't put yourself out there at all, it's unlikely you'll be able to even start that process with new people.

Youth: yeah, that would probably help

[Chat continues]

Counsellor: Alright, great!
So how do you feel about taking some time tonight to think about all of this and plan your next steps, and if any other thoughts or questions come up for you you can get in touch with us again?

Youth: yeah okay

The responses "yeah," "okay," and "I guess" appeared frequently when clients were acquiescent, according to the CIS. These responses betray a sense that the clients are saying what they imagine the counsellors want them to say; however, the clients do not appear to be truly invested or connected to the responses. Consider the following acquiescent responses from a 15-year-old female client dealing with unwanted traumatic memories of sexual abuse. In this case, the acquiescent responses are shortened to a single repeated word, "okay," represented by a single letter, "k":

Chat<Internals\\x13825152>

Counsellor: which means, when you start to feel overwhelmed and picture him on feel him, then you immediately focus on 3 things you can see, 3 things you can hear, and 3 things you can feel around you...then 2, 2, 2...then 1, 1, 1
you can also say the alphabet backwards...
these things might sound a bit funny...but what they do is stop your brain from getting dragged into that flashback....they can be really helpful

Youth: k

[Chat continues]

Counsellor: Ok...so you were feeling really overwhelme3d and you went somewhere to feel safer...that's awesome!

Youth: i guess

[Chat continues]

Counellor: that is a great plan...getting rest will definitely help your mind and body :)

Youth: k

[Chat continues]

Counsellor: I can't force you to do anything, Confused...there are different places out there who can and want to be helpful...I would encourage you to go home tonight, get some good rest, and think about what we talked about in the morning

Youth: k

Counsellor: your only job tonight is to keep yourself safe and calm
I'm really proud of you for talking about something so difficult
:)
are you still there?

Youth: yes

Counsellor: Ok, I want you to get yourself home safely now OK?
and remember, you can always call us 24/7

Youth: k

In each of these examples, the chat clients deliver acquiescent responses to the counsellors. In ten of these eleven cases, the response, which is one or two words long and in some cases a single word, is reduced to a single letter. These acquiescent responses tend to 'shut down' the counselling session. However, seeing responses limited to a single word or letter may indicate to counsellors that the client is acquiescing and allow them to alter their interventions accordingly.

KHP counsellors have been trained extensively to take a position of curiosity and to use open-ended questions. A common complaint among counsellors is reflected in this third-most common indirect rupture marker among chat clients – when *clients give short, non-elaborative responses to open-ended questions*. These responses seem very similar to the acquiescent responses above, but are delivered within a different context. Therefore, they require slightly different responses to repair the counselling relationship. In this first example, a 15-year-old female client has sought chat counselling for help with suicidal ideation:

Chat<Internals\\x13707925>

Counsellor: Last week, okay. And how are you dealing with all of this?

Youth: i tried to ignore it

Counsellor: You try to ignore it, okay. And how is that going? How does it help?

Youth: for a while i forget about it all

It is very early in this chat counselling session, and the counsellor has made a few attempts to get the client to elaborate on her situation by asking open ended questions. However, the client gives short responses in the form of sentence fragments rather than elaborating meaningfully on her situation:

Counsellor: Yeah.
So how can I be the most helpful for you tonight, with all of this going on?

Youth: i dont know

In this excerpt, the counsellor attempts to focus the client by getting her to describe what kind of help she is looking for in the session. The client states that she does not know:

Counsellor: And are there interests you want to be able to share with them?

Youth: yeah

Although not literally an open-ended question, in the above excerpt, the counsellor attempts to get the client to elaborate on the types of interests that the client may wish to share with her friends. However, the client gives a typical one word response to what is literally a closed-ended question. This example illustrates the danger of asking for elaborative information using what may be read as a closed-ended question.

Later in this chat, the counsellor tries again to elicit an elaboration from the client, this time by asking about her volunteer interests. But again, the counsellor's attempt is met with a short, non-informative response:

Counsellor: What kind of volunteer work would you be interested in?

Youth: i dont know, anything really

In another example, this time with a 14-year-old female client, a counsellor attempts to elicit information about the chatter's immediate environment. The following excerpt is an example of the danger of asking an open-ended question immediately followed by a closed-ended one, as clients tend to respond with a short, non-elaborative response to the last question asked rather than give additional information:

Chat<Internals\\x13825152>

Counsellor: Ok....that helps us have a more helpful talk right now :)
where are you? are you at home?

Youth: no

Later in the conversation, the counsellor applies some solution-focused therapy techniques by asking the client to rate herself on a Cantril ladder, to which the client indicates she is at a 30% on a particular construct. The counsellor then attempts to get the client to consider what is required for a very small shift of 1 to 2%. The client does not answer the question, but rather gives a short, non-informative response:

Counsellor: right...ok, so how can we help that 30% of you get bigger...like to 31% and then 32%?

Youth: help me stop

In another example, this time with an 18-year-old female client, the counsellor attempts to solicit information about the client's feelings about attending a new school. However, this client does not respond with a feeling, but rather gives a one-word, non-elaborative response:

Chat<Internals\\x13873598>

Counsellor: How do you feel about starting in a new school?

Youth: ok

Short, non-elaborative responses to open-ended questions are difficult for counsellors to

work with as they are often associated with a sense of 'being stuck.' Fortunately, unlike the other indirect rupture markers reported, these types of ruptures are well defined and easily detectable to counsellors working moment-to-moment in counselling sessions. Because indirect rupture markers may be difficult to detect (especially in chat counselling, which lacks visual and auditory cues), those who work in this medium require strategies to detect and respond to them.

Clients' contributions to ruptures (CIS) – direct ruptures.

Direct rupture comments were rarer than indirect rupture comments, but still figured prominently in clients' contributions to difficulties in the counselling relationship. In these cases, it was more obvious that there was a rupture in the counselling alliance, and clients often disengaged quickly after demonstrating explicitly that they were not happy with their counsellors. Although they were rare in general, there were a few types of direct rupture markers that occurred most frequently with chat clients. The most common was when a *client strongly refused or stated* that *they felt uncomfortable with a counsellor intervention*. The first example is from a 14-year-old female chatter with the nickname "Confused." In this example, the counsellor has already performed a risk assessment and determined that there was a need for emergency services to intervene immediately for the client to remain physically safe:

Chat<Internals\\x13825152>

Counsellor: I hear ya...I really think with how you have been feeling that the best thing is to call 911 so that someone can come and help you and connect you with other people who can start helping right awa
*away**

Youth: no

[Chat continues…]

Counsellor: If you give me your information, I can do that for you

Youth: I'm just going to go

Counsellor: Confused, you have the right to feel safe and be believed and listened to...by someone who can get to you and help tonight
I believe you and I want you to know that I think you are so strong for surviving and for reaching out

Youth: can I just talk to you

[Chat session continues…]

Counsellor: I'm gonna give you our number 1 800 668 6868 which you can call 24/7...or you can call Children's Aid in Ontario at anytime and tell them what is happening...someone who cares will come and help you

Youth: I hate the Children's Aid

Although this counsellor's intervention is not in-tune with the client's readiness to receive help, the above excerpt is considered here an example of a client repeatedly refusing the counsellor's intervention. The counsellor has likely rushed to this point of the intervention before the client was willing to take the step of involving emergency services; however, the client is refusing appropriate help in an emergency situation where the client cannot remain safe.

Consider the following example of a suicidal 17-year-old female. This client directly refuses the counsellor's offer of outside help by asserting that her parents will find out (an unwanted outcome that may cause her increased trouble):

Chat<Internals\\x13873477>

Counsellor: Is there a way you can call from outside the house? How would your parents find out if you called or not?

Youth: They track the cellphone bill, our house isn't sound proof anywhere and I'm sure they'd find out if I use the house phone, and Im not allowed outside.

In the above example, the client offers what seems like flimsy excuses given the severity of her concern (she is suicidal). Getting in trouble for using the phone or going outside when she is not allowed (recall she is 17 years-old) appears inconsequential compared to the outcome of suicide.

Because she used the excuses to discount the counsellor's offer of concrete and appropriate help, these utterances are viewed as direct ruptures.

The second-most common direct rupture occurred when *clients were sarcastic or caustic toward counsellors*. Consider the following examples:

Chat<Internals\\x13710741>

Counsellor: What happened then? And what is it that I could to do to help you?

Youth: What makes you believe that something happened? To answer your second question, I believed that you would know.

Chat<Internals\\x13711936>

Counsellor: ok...so being homeless leads to other consequences do they not?

Youth: No duh, I can figure that much out

[Chat session continues…]

Counsellor: I am not provided with that survey
in any case, counselling is not about providing advice

Youth: Again, that's stupid. Thank you for your time, but you're just further pissing me off

Chat<Internals\\x13750192>

Counsellor: also If you feel like cutting during the hardest times, you can always call us here at Kids Help Phone so that together we can help you

Youth: Thanks anyways

System: CONVERSATION TERMINATED

The third-most common direct rupture marker occurred when *clients suddenly terminated the chat because they were dissatisfied with their counselling sessions*.

Counsellors' contributions to ruptures (CIS) – negative interventions.

Although counsellors' contributions to chat counselling sessions were largely characterized by positive interventions, there were occasions when counsellors themselves

contributed to ruptures in counselling relationships. The most common negative interaction occurred when *counsellors intellectualized or failed to focus on the clients' concerns*. Consider the following example in which a 16-year-old female client was seeking information about her legal rights regarding her parents' ability to kick her out for changing her appearance:

Chat<Internals\\x13711936>

Youth: I've always wanted tattoos & piercings. Tattoos can wait. They're permanent, piercings are not

Counsellor: but i guess we dont' really have control over our parents other than to be able to influence them through conversations

Youth: My mother doesn't listen to anything I have to say if she's against it. To me, that's abusing her parental power over me.

Counsellor: unfortunately as children we don't have the same rights as adults.

Youth: I'm willing to discuss things, but she has to be open to listen you know?

Counsellor: our parents are responsible for raising us and instilling us with values

In the above example, the client expressed her frustration over not being listened to by her mother. The counsellor missed the client's concerns, however, and intellectualized about parental roles and responsibilities.

In the following example, a 13-year-old female client with a serious medical condition wished to discuss her fears about visiting the hospital to undergo tests and treatment. The counsellor neglected the client's affect completely and responded intellectually by explaining her parents' point of view and remarking on her parents' "approach" to her fears:

Chat<Internals\\x13815470>

Youth: Well, I have a condition where I have to make frequent trips to the hospital for tests and I am afraid of them and I always get really scared and then my parents always tell me how dissapointed they are in me and that I need to grow up

Counsellor: that is tough

for what it's worth

Youth: And I have one on Monday

Counsellor: going to the hospital for tests sounds like it could be a little scarey for sure

Youth: Yeah, it is

Counsellor: I mean health is number one
while i can't say for sure
perhaps your parents are worried too and that might be their way of trying not to worry you more or themselves
jusrt a thought
Is that posible?

Youth: Maybe, but they are always like: man if I were in your situation I would grow up and stop being such a baby

Counsellor: welol sometimes approach is everything isn't it
well

This counsellor has missed that the client wishes to continue discussing her feelings of fear around some medical tests and instead moved on to intellectualizing the client's parents' response. The counsellor's responses are out-of-step and not focused on the client's experience. Furthermore, the poor spelling, lack of capitalization, and quick hits on the return key suggest that the counsellor is not focused on this chat, but rushing through the responses.

The following example of counsellor intellectualization involves a 15-year-old female with intense body-image preoccupation and possible disordered eating:

Chat <Internals\\x13858875>

Counsellor: That's good!
Don't forget that you are trying to maintain your weight, not actively lose weight
Keep on eating well, allowing yourself to cheat once in a while, that won't make you put back on the pounds

Youth: Yeah but when I cheat- let's say I feel super bad after like super guilty and sad

Counsellor: Yes, that can happen if you have put a lot of effort and pride in your diet
They aren't good feelings….

That can lead towards eating disorders when people allow themselves to diet in excess

Youth: ok I understand better! Thanks for your help ☺ good night!

Counsellor: Take care of yourself. Good night

In the above example, the counsellor has intellectualized about disordered eating, moving very quickly into psychoeducation about eating disorders without focusing on the client's emotional experience. There is evidence that the intervention does not work for the client, as she acquiesced and quickly disengaged after only 22 utterances in the chat.

The following negative intervention involves a 13-year-old girl anticipating her nervousness about encountering her crush after the summer break. Although the counsellor did not intellectualize specifically, the counsellor is clearly not in-tune with the emotional needs of the client:

Chat<Internals\\x13866276>

Youth: i dont know if we will be in the same classes

Counsellor: However, you will be in the same school.

Youth: he lives outof town and our town doesnt have any places i could run into him.

Counsellor: And, you may share some of the same classes.

Youth: i guess so...
it just hurts so bad not to know if he likes me.
i liked him for 3 years now.

Counsellor: It sounds to me like you are going to have to wait 'cause you haven't seen him and things might have changed and over text he said he was busy?

In the above example, the counsellor was clearly not in-tune with the young chatter who was having difficulty tolerating being away from her crush over the summer. The counsellor missed opportunities to acknowledge the client's feelings. The time stamp of the last utterance took

place 2 minutes after the client last hit "enter." There is the definite sense that this counsellor is not in-sync with the concerns that the client has presented.

The second-most common negative intervention occurred when *counsellors pressed clients on a specific topic*. Consider the following example (also reported earlier) in which a 13 year-old girl wants to discuss her feelings about her crush, whom she will not see for the rest of the summer:

Chat<Internals//x13866276>

Counsellor: What do you think about waiting until school starts to see if he acts in the same way?
'Cause you don't seem to have a relationship outside of school...

Youth: i dont know if we will be in the same classes

Counsellor: However, you will be in the same school.

Youth: he lives outof town and our town doesnt have any places i could run into him.

Counsellor: And, you may share some of the same classes.

In the above example, the young client wishes to discuss her feelings. Just previous to utterance 16, the client was describing her feelings and inquiring if there were "signs" that a boy likes a girl. The counsellor missed her desire to discuss her feelings and continues to press the client about her return to school. The counsellor does so despite the client having said that they would not see each other for "2 months."

When considering counsellor contributions to ruptures in the counselling alliance, it may be more important to consider what they did not do rather than what they did do. The positive interventions scale of the CIS contains 12 items considered to contribute to a healthy working alliance, three of which were missing from all of the 22 transcripts coded. These items were when *counsellors believe the client was indirectly talking about the counselling relationship*,

when *counsellors admit their participation in the rupture process*, and when *counsellors self-disclose countertransference feelings*. Regarding the chat transcripts reflective of the bottom decile of effectiveness according to the POPS, there were two additional CIS codes which were not triggered: *when counsellors explain or redefine the tasks/goals of the session*, and *when counsellors make an interpretation*. See Table 18 for a breakdown of the percentage of coverage of each CIS code for the chat transcripts associated with the top and bottom deciles' outcomes associated with the POPS.

Discussion

In this study, I focused on four objectives: to provide a description of KHP clients, to describe the nature of their problems, to assess and compare the effectiveness of the two service media, and to provide a qualitative assessment of "what works" in chat counselling.

There is little research on the topic of synchronous chat counselling in general and for young people in particular. KHP provides a unique online service to young people seeking help in Canada in that it offers on-demand, free, confidential, and anonymous counselling using the chat medium whereas other national child helplines do not guarantee anonymity nor do they provide access to professional counsellors (rather, they are typically staffed by community volunteers) (Childline United Kingdom, 2016; Kindertelefoon, 2016; Crisis Text Line, 2016). Because young people, by nature of their youth, have a familiarity and facility with technology that is not possessed by their elders (Leung, 2003; McMahon & Pospisil, 2005), and because young people value confidentiality in help seeking, it is imperative that this service be studied and situated within the Canadian context. To better understand which young people access synchronous telephone and chat counselling and how they make use of these services, I collected information on the individual characteristics of KHP clients, the nature and level of risk involved in their presenting problems, the effectiveness of the services, and "what works" in terms of supporting the therapeutic relationship using type-to-type technologies that lack the contextual and emotional cues in face-to-face and ear-to-ear counselling.

Demographic Description of the Youth Who Access KHP Services

Age.

The first objective of this study was to describe the users of KHP's telephone and chat services. There were significantly more high-school-aged clients (56.6% of the phone sample, 65.7% of the chat sample) than middle-school-aged clients (16.5% phone, 17.6% chat) making use of the services. This discrepancy illustrates the phenomenon of youth being more likely to seek help outside the family as they mature and become more independent in high school before returning to value the input of their parents in emerging adulthood (Wintre et al., 1995). It may also indicate that younger adolescents are more likely to be supervised when using the phone or Internet and therefore have fewer opportunities for confidential help-seeking than their older peers. KHP data on the distribution of users show that a very small number of young children use the service (R. Howie, personal communication, Feb. 17 2016) with only 4.73% of the overall service users for phone and chat combined being under 12 group, 11.72% being ages 13 and 14, 63.53% being high-school aged, and 20.01% being emerging adults. Similarly, high-school aged young people make up the largest proportion of overall service users comprising 60.35% of phone clients and 73.88% of chat clients for all of 2014 confirming a tend towards making increased use of the service after the transition to high school. There is a larger proportion of chat clients who identified as high-school age than phone clients who identified as high-school age for the overall 2014 service data ($z = 22.94$, $p < .001$), suggesting that high-school age youth may have a preference for this medium. There was a smaller, yet meaningful proportion of service users for telephone and chat who are emerging adults. This is a remarkable finding given the name of the service, KHP, suggests strongly that the services are for children. Emerging adults grapple with the complexities of identity associated with becoming adults and therefore unlikely to want to be perceived as children; yet, 26.9% of the telephone sample and 17.7% of the chat sample identified as emerging adults. These findings indicate a need for on-

demand, confidential counselling services for this age group. This need has recently spurred the creation of KHP's sister service, Good 2 Talk (G2T), a telephone counselling service marketed specifically to post-secondary students in Ontario (Good2Talk, 2016). G2T is available in English and French (Allo J'écoute) with the same parameters as KHP. This line receives an average of 40 calls each day and there is demand to expand the service to accommodate post-secondary students in other provinces and territories.

Gender.

Female adolescents are more likely than their male counterparts to seek help in general and for mental health problems specifically (Chandra & Minkovitz, 2006); however, data compiled from dozens of national youth helplines suggest that male youth prefer to seek help on the Internet rather than the telephone (CHI, 2005). In the present study, I found a significantly larger proportion of male users on the phone than on chat. Further investigation of the larger service data for 2014 revealed that overall service data mimic the sample data closely with 74.0% of phone clients and 87.8% of chat clients identifying as female, 25.6% of phone clients and 10.8% of chat clients identifying as male, and 0.4% of phone clients and 1.4% of chat clients identifying as transgender or genderqueer. These findings may reflect a tendency for male youth to be less likely than people of other genders to seek help in general (Oliver, Pearson, & Coe, 2005). Alternately, and considering the high numbers of internalizing disorders found among the potential chat clients, these findings may reflect the distribution of female and male youth who develop internalizing rather than externalizing disorders (Freeman, King, Pickett, & Craig, 2011). A small number of phone and chat participants identified outside binary gender classifications. Although there are not reliable Canadian statistics available for comparison, an American study estimates that 0.03% of adults identifies as transgender (Gates, 2011). With

2.6% (phone) and 2.1% (chat) of the samples identifying outside of binary gender classifications, it may be that these young people are overrepresented in this sample. It is likely that non-gender conforming young people value the anonymity and confidentiality afforded to them through KHP.

Sexual orientation.

It is difficult to know the proportion of young people in Canada who identify as non-heterosexual as fear of discrimination likely contributes to underreporting. However, a Forum Research Poll estimates that 5% of the Canadian population and 10% of Canadians between 18 and 35 years old identify with non-heterosexual orientations (National Post, 2012). The proportion of non-heterosexual chat participants was significantly larger than that of non-heterosexual phone participants (20.4% vs. 35.9%). Non-heterosexual young people are at higher risk for mental health problems than their heterosexual peers (Williams & Chapman, 2011) and it may be that issues reflecting their experiences of marginalization drive these young people both to need and to seek help at greater rates than others. Their preference for chat may reflect a need to maintain increased confidentiality. For example, for young people who are not "out," there may be greater risk of being overheard on a phone conversation by family members from whom they fear lack of understanding, stigma, or even violence in response to their sexuality (D'Augelli, Hershberger, & Pilkington, 1998; D'Augelli et al., 2008). These young people may also be accustomed to seeking information and support for sexual orientation issues from websites. Therefore, their preference for the chat medium may reflect their high familiarity and comfort using online tools.

Ethnocultural identity.

The majority of KHP telephone and chat users identified as belonging to the dominant culture, consistent with their representation in society at large. Yet, certain groups were overrepresented in the KHP sample relative to their representation in the general population. There were more southeast Asian- and Black-identifying young people using the phone service than expected. Additionally, there were more Asian young people using the chat service than expected. Given the small size of the subsamples, it is inadvisable interpret the differences for each group; however, the relatively high proportion of ethnically diverse clients may suggest a need for cultural competency training for counsellors. It is important not to make assumptions regarding clients' cultural memberships or identities in counselling in general. However, in face-to-face counselling, professionals often use visual cues (physical characteristics, dress, accent, mannerisms, etc.) to facilitate discussion of cultural factors in clients' presenting problems. These cues are reduced on the phone and almost completely absent on chat. Given the importance of delivering culturally competent, sensitive, and safe therapeutic interventions (Arthur & Januszkowski, 2001; Collins & Arthur, 2007), it is important that telephone and chat practitioners develop ability and facility to inquire about cultural identity respectful ways using the chat technology.

Another notable difference was between the proportions of Québécois phone and chat service users. Québécois young people demonstrated a clear preference for chat over telephone with 23 of the total 33 Quebecois participants choosing chat over the phone. This finding was difficult to interpret because there are no valid hypotheses in the literature to suggest a reason for a cultural or French-language preference for chat over the phone service. Discussion with counselling staff at the KHP (Jeunesse J'écoute) office in Montréal suggests an organizational bias toward advertising the services on television and in print media in English. Therefore, it

may be that Québécois young people are more likely than their Anglophone counterparts to look for services using the Internet, leading them more naturally to an Internet-based chat service.

First language.

Although there were no significant differences in proportions between the sample data and Statistics Canada data for any first language, findings suggest that clients represent the diverse language makeup of Canada. No proportions were sufficiently large to suggest that services should be offered in any other languages than English or French; however, given the diversity of linguistic representation, these data provide an important reminder that counsellors must be alert that English or French may be a client's second language. It is difficult to decode the emotional tones of a telephone conversation without visual cues, and even more so on chat (missing emotional tone, intonation, speed, volume, timbre, etc…). KHP counsellors must make deliberate check-ins with clients to ensure optimal understanding. They must also take special steps in the chat medium to increase the likelihood of being understood. For example, enhanced telepresence techniques such as emotional bracketing, descriptive immediacy, and nonlexical verbalizations are tools specific to computer-mediated counselling and therapy that decrease misunderstandings (Fang, et al., 2013).

Generational status.

Immigrant and first-generation clients were grouped together as "newcomers" and comprised 46.3% of the phone sample and 43.1% of the chat sample. These proportions are significantly larger than expected given the proportions of these groups in the Canadian population. The implications of these findings for counselling are important. Newcomer young people face unique barriers to service, together with mental health and well-being challenges that

are not experienced by peers whose families have lived in Canada for several generations (Beery, 1999). Access to first contact health services can be especially problematic (Sanmartin & Ross, 2006), perhaps due to suspicion of government run services, stigma against help seeking (especially for mental health problems), and even lack of knowledge about available services. Such clients may face acculturation issues as well as the stress of balancing their desires to fit in with dominant-culture peers with their desires to remain connected to their culture of origin, as well as parental expectations for their identities (Beery, 1999). Access to an anonymous and confidential service such as KHP may be particularly important for these young people who are likely to report feeling less autonomy and self-esteem and more stress than peers whose parents were born in Canada (Wintre et al., 2000).

SES.

The distribution of SES for phone clients (chat data were unavailable due to a technology failure) was rather spread-out, indicating that clients from the range of SES make use of KHP telephone services. This is an important finding because it suggests that young people from low-income families are capable of demonstrating resilience by reaching out for help. This finding also suggests that young people from affluent families reach out in times of need for on-demand, anonymous counselling. Although the challenges faced by these disparate economic groups are unique (Luthar & Sexton, 2004), this finding reminds professionals that all young people face developmental and contextual challenges and require help and guidance from trustworthy and competent adults.

Description of the Nature and Level of Risk Involved in Clients' Presenting Problems

Risk level.

The Ontario Health Study (Offord, 2001) suggests that approximately 20% of young people suffer from a serious mental health problem and there are certainly more youth struggling in the sub-clinical ranges for mental health disorders. In this study, risk level was determined using an objective coding scheme that required explicit mention of at least one of nine developmental or contextual problems associated with an increased risk of mental illness vulnerability later in life. Although the majority of client contacts on both the phone and chat were categorized as low risk (48.9% and 41.7% respectively), there were still large proportions of clients categorized as medium and high risk. The seriousness of the developmental and contextual problems with which these young people were grappling is striking. Half of high-risk callers and almost half of high-risk chatters revealed in their counselling sessions that they had received a formal mental health diagnosis. These diagnoses included various mood disorders, personality disorders, and eating disorders. Many of these clients discussed difficulty accessing meaningful treatment and several mentioned unhelpful experiences with being hospitalized previously. By virtue of reaching out to KHP, these young people demonstrated that KHP fills a gap in traditional mental health services by being available when they could not access help from other services or preferred KHP service to emergency mental health services. Providing young people with an on-demand, anonymous, and free counselling service they can access via telephone or online chat gives them a life line to professional support when dealing with a mental health crisis such as suicidal ideation (two of 26 high-risk callers and three of 36 high-risk chatters in this study) or a self-harm episode (ten of 26 high-risk callers and 17 of 36 high-risk chatters in this study). It also provides them with professional support when on a waiting list for face-to-face services or when struggling to cope between appointments with their regular practitioner. Finally, KHP also provides a safe place for these young people to rehearse or test

future conversations with their regular practitioners involving topics about which they may fear being judged or which may trigger a duty-to-report, which could result in unwanted trouble for the young person.

Living with violence or abuse was also a frequently coded high-risk factor with six out of 26 high-risk callers and seven out of 36 high-risk chatters explicitly mentioning violence or abuse in their counselling sessions. As with the suicide and self-harm categories, those living with violence or abuse frequently discussed comorbid high-risk problems, indicating that their stress levels and risk for problems later in life were quite high. Familial violence is a complicated problem for young people as they often have ambivalent feelings toward the perpetrator who may be a parent or other familial adult upon whom they depend for their physical welfare (Goodwin-Brown et al., 2003). Many young people deal with feelings of guilt and responsibility for causing the violence (Stuewig & McCloskey, 2005; Ellenbogen, Trocome, Wekerle, & McLeod, 2015), worry about getting the adult family member in trouble (Mallory, Brubacher, & Lamb, 2011), or are concerned that other family members would be adversely affected by their disclosure (McElvaney, Greene, & Hogan, 2012).

Medium-risk clients were also struggling to cope. The most common medium-risk problem occurred when clients mentioned a mental-health problem, but did not explicitly disclose a formal diagnosis. In most of these situations a strong case could be made that the client was truly suffering with a diagnosable mental health problem; however, coders selected the more conservative medium-risk code. When reading the examples of medium-risk codes that were suggestive of a mental-health problem, the formality of a diagnosis seems unimportant in relationship to the clients' suffering. It is clear from these excerpts that clients whose transcripts triggered this code would benefit from intervention from a mental-health professional and that

many of them needed a formal assessment. Although they may not have explicitly discussed a depressive disorder, several discussed suicidal feelings and were considering some form of self-harm (or returning to an old self-harm practice). Some did use words such as "depression" and "anxiety;" however, no formal diagnosis was mentioned. It is likely that these clients were dealing with clinical levels of disordered mood. One client discussed symptoms consistent with psychosis. Eating and borderline personality disorders were also mentioned.

Clients whose transcripts triggered the suggestive-of-a-mental-health-problem code highlight two issues associated with mental-health literacy and stigma in Canada. The first is that although mental-health and psychiatric terminology have made their way into the common vernacular, terms such as depression, anxiety, borderline personality disorder, and bipolar disorder are not clearly understood by the general public. Even if they are understood, they are not consistently used to communicate a valid diagnosis of a mental-health syndrome. There is concern associated with loose use of these terms because it may increase stigma and inappropriate self-diagnosis. When people are not aware of the clinical criteria for diagnosis, as well as the considerable amount of training undergone by professionals who are licensed to make diagnoses, young people may inappropriately label themselves or others or be mislabelled by people within the various systems they inhabit. The second and related problem is that once these terms are in popular use, there is a risk that they will be used as insults or to deliberately hurt and confuse a young person. This problem was highlighted in an excerpt from the phone session titled "Call 19665322" wherein a young client states:

> *Half a year ago, we got into a pretty big argument and my mom got involved too and she was just, taking his side so we were pretty much just sitting there and criticizing a lot of aspects of who I am, and my brother...like, I've always struggled with depression and anxiety, and I think I'm slightly bipolar, I don't know. Anyway, he was talking about that*

> *and he just goes, "you're sick in the head, you have borderline personality disorder, you need help, you're just sick in the head" and things like that, and it was really cruel.*

When young people are labelled with a derogatory term, they can internalize the label and experience shame, making it harder for them to seek help and be open to change (Moses, 2009; Kranke, Floersch, Kranke, & Munson, 2011). Dealing with identity labels is one of the reasons counsellors at KHP practice aspects of narrative therapy. The process of re-authoring in narrative therapy involves a scaffolding process whereby the counsellor encourages the client to perceive the problem as something outside of themselves rather than something inside of themselves (Zimmerman & Dickerson, 1996). A key counselling tool in this process is to use language that externalizes a problem rather than internalizes it. For example, a counsellor might say, "How long has depression been messing with you?" (externalizing language) in response to a client saying, "I am depressed" (internalizing language).

These high-risk and medium-risk problems must not be interpreted as individual weaknesses. According to developmental-systemic theory, thoughts of suicide, tendencies to self-harm, and mental-health problems including personality disorders can be conceptualized as responses to the stressful environments that young people have experienced in the reciprocating systems in which they have been developing. KHP provides another, healthier system, in which counsellors respond thoughtfully, compassionately, and with expertise in mental health. In essence, KHP counsellors respond in a way that is likely very different from the family, school, peer, and larger cultural systems' responses. By providing these responses, we hope that typical patterns of reciprocal responding that are unhealthy can be interrupted in the young clients and replaced with healthier patterns.

Youth self report.

The YSR was completed by 465 potential chat clients as they waited to receive counselling. Results indicated that very large proportions of potential chat clients experience symptoms of affective problems, obsessive compulsive problems, post-traumatic stress problems, and anxiety problems in the clinical range (64.4%, 56.3%, 51.2%, and 47.3% respectively) and borderline range (18.9%, 18.9%, 26.3%, and 12.2% respectively). Although not diagnostic on its own, the YSR is commonly used by psychologists and is associated with accurate measurement of ill mental-health symptoms. These results suggest that the majority young people seeking chat counselling at KHP struggle with diagnosable depressive and anxiety disorders. Less than a third of all contacts were indicative of young people dealing with a high-risk problem (and even fewer of them explicitly mentioned a formal mental-health diagnosis). Despite this finding, there were considerably more young people with potentially diagnosable mental health problems than one would expect given their representation in the adolescent population as Statistics Canada reports 9% of females and 5.3% of males in the 15-24 year-old age group as qualifying for a mental health disorder within the last 12 months (Statistics Canada, 2013b).

The finding that all eight non-gender-dichotomous participants who completed the YSR were in the clinical range for at least three YSR syndrome scales reflects the mental health struggles of gender non-confirming young people. All of these eight participants were in the clinical range for either affective problems or anxiety problems and six of them were in the clinical range for both affective and anxiety problems. Most also had elevated levels of post-traumatic stress problems and obsessive-compulsive problems. Gender non-conforming young people likely have lived experiences including traumatogenic experiences of marginalization, discrimination, and violence that leave them potentially vulnerable to mental-health problems

(Budge et al., 2013; Lannert, 2015). Although they may not contact KHP to specifically discuss problems related to their gender identity, their common experiences with marginalization and oppression often lead to high prevalence of mental health problems such as adjustment disorders, anxiety, depression, and post-traumatic stress disorder (Dean et al., 2000). These mental health challenges may affect their abilities to hear or read counsellors' words in the spirit in which they are intended. As do many people dealing with depression or anxiety, these clients may be particularly susceptible to cognitive distortions (Beck, 1976, 2008; Mathews & MacLeod, 2005). Considering that the chat medium relies on the ambiguous type-to-type method of communication, there is reason to be concerned about the wording of counselling support being misinterpreted or misunderstood by young people seeking counselling help online. Unlike face-to-face, and ear-to-ear environments where there are more visual and auditory clues to meaning in communication, text-to-text counselling has both a greater likelihood of being misunderstood in communication and fewer opportunities for recognition that the counselling relationship is ruptured, as well as fewer opportunities to repair those ruptures when they do happen. Given the high prevalence of clinical mental health symptoms associated with depressive and anxiety disorders of chat clients, counsellors must find ways to become highly attuned to misunderstandings and to check often that they are both being understood as well as understanding their clients. Non-gender-conforming clients and others from potentially marginalized groups may experience ill mental-health symptoms at an increased rate and their experiences with marginalization may leave them even more prone to cognitive distortions that can increase misunderstandings in type-to-type counselling sessions. KHP counsellors should become familiar with cognitive distortions common to clients with anxiety and depression and be

mindful of how those distortions may contribute to ruptures in the therapeutic alliance.

Perceived Effectiveness of KHP Counselling on Clients Using the Two Service Media

Once the isolation subscale was removed, the POPS demonstrated good internal consistency as a tool for measuring counselling outcomes at KHP. Clients experienced positive change on the overall POPS with only pre-counselling scores on the POPS statistically predicting post-counselling scores. In general, KHP counselling appears to be effective in decreasing distress and perceived difficulty of clients' problems and increasing clients' clarity about their problems, self-efficacy, and hope. These results lend evidence for the validity of technology-based counselling interventions. Even without face-to-face contact, sufficient interpersonal connection appears to be possible between counsellors and clients to produce measurable effectiveness with five out of six counselling outcomes in the KHP logic model.

The results of the two items reflecting isolation present a challenge for interpretation. The "Alone" and "Talk" variables did not comprise a single concept of isolation, indicating that for KHP clients, the ability to identify more people with whom they could talk about their problems or situation was not associated with a decreased feeling of being alone with their problems or situations. Also, phone clients reported feeling more alone in dealing with their problems or situations after their counselling session than before (chat clients also experienced this change, although the effect was non-significant). This result may have occurred because the KHP promise of confidentiality and anonymity lends itself to feelings of isolation. Although young people contacting the service may wish to keep the content of their sessions private, KHP anonymity may actually contribute to a deepened sense of being alone with one's struggles. Despite both callers and chatters reporting being able to identify more people with whom they could discuss their issues, they would not have actually engaged in these conversations at the end

of a single session of counselling. The knowledge of potential future connection without having yet experienced it may also contribute to an increased sense of being alone. This sense may have also been further heightened by the simple act of terminating the counselling session. It is likely that clients approached counselling feeling alone and then engaged in a healthy counselling relationship in which counsellors displayed warmth, empathy, genuine concern, and trustworthiness. It may be that many of these young clients do not have many relationships in which they are compassionately respected and the termination of such a counselling relationship (which by its single-session nature had no promise of future connection) would likely result in increased feelings of loneliness. Isolation appears to be a more complicated construct than originally conceived. If identifying other safe people in clients' social systems continues to be part of the KHP model of counselling, counsellors should consider going beyond merely identifying these individuals with their clients. Asking clients to formulate plans for talking to these people, role-playing those conversations, and facilitating clients in imagining how they will feel after they have spoken to those people may have a more positive effect on their feelings of being alone with their problems after counselling sessions are terminated.

"What works" in type-to-type counselling.

When counselling goes poorly – clients' contributions (CIS.)

When there was a problem in the counselling relationship, clients most often indicated their discord through indirect rupture markers rather than direct ruptures. These indirect ruptures are identified when clients indirectly express a form of emotional disengagement from their counsellors, from some aspect of the counselling process, or from their internal experiences (Safran, Muran, Stevens, & Rothman, 2008). This phenomenon seems reasonable given the limitations of the medium and the power imbalance between young people and adults and

between counsellors and clients. The most common indirect rupture type occurred when *clients were self-critical or self-blaming in response to a counsellor comment*. This phenomenon may reflect the self-criticism and self-blame that can accompany depression and suicidal ideation (Beck, 1976, 2008), which were qualities associated with a large proportion of chatters. It is difficult for clients with depressive or anxiety disorders to break out of cognitive distortions that contribute to and maintain their mental health problems. KHP counsellors typically practice aspects of narrative therapy, such as re-authoring and externalization of the problem, which may be helpful in responding to these types of ruptures. In the chats associated with the poorest outcomes, however, the counsellors did not respond to these ruptures using narrative techniques. It may be that these counsellors require additional training and support for these situations. They may also benefit from training in a type of intervention that focuses more intensely on cognitive distortions, such as cognitive-behavioral therapy (CBT).

Clients whose counselling sessions were the least successful also tended to *respond to counsellors in an acquiescent manner*. This response type is particularly concerning given that some young people naturally acquiesce to adults in general, but particularly to those in authority. There is an inherent power imbalance in the counselling relationship, so counsellors must be on guard to acquiescent statements. It can be especially difficult to determine whether a young person is acquiescing in the type-to-type environment, given that this is a phenomenon that counsellors are accustomed to detecting by use of vocal tone, silences, intonation, and timbre. The words, “yeah,” “okay” (and its derivatives), and the phrase “I guess” were frequently associated with acquiescing and are likely cues to counsellors that they should check in with their clients around this phenomenon. Counsellors in the type-to-type environment must challenge themselves to frequently and consistently check in with their clients to see whether

they are acquiescing or truly invested in the direction of the counselling conversation. According to Mitchell and Murphy (2009), this checking can be done using "presence techniques" such as emotional bracketing, descriptive immediacy, descriptive imagery, and time presence.

KHP counsellors have been trained extensively to take a position of curiosity and to use open-ended questions. Despite this practice, the third-most common indirect rupture by clients occurred when *clients gave short, non-elaborative responses to open-ended questions.* These responses tended to be slightly longer than *acquiescent responses* discussed above. They are particularly frustrating to counsellors because open-ended questions are designed specifically to illicit elaborative responses (KHP, 2016). “I don’t know” or its initials, “idk,” were frequently coded as *short, non-elaborative responses to open-ended questions*. They require a different response than when a client acquiesces, which is typically to check in explicitly with the client. Short answers to open-ended questions may indicate that counsellors are ‘working too hard’ and often indicate that clients are ‘stuck.’ Clients may genuinely not know what to say, be avoiding thinking about situations that make them uncomfortable, or have difficulty accessing their thoughts or putting them into words. It can help to acknowledge and normalize this difficulty in answering some questions put forth by counsellors. Counsellors must resist the urge to solve their clients’ problems or suggest answers for them. Counselling, by its nature, requires that counsellors tolerate discomfort. Type-to-type counsellors may wish to consider the online equivalent to ‘letting the silence be.’ Counsellors must become comfortable waiting for clients to respond and may choose to offer an empathic sustain such as “Hmmm,” or “Ahhh” or respond with an indication that they will wait while clients formulate a more full response. Fang et al. (2013) indicate that empathic sustains belong to the enhanced telepresence category of "non-

lexical verbalizations." Counsellors may type out vocal noises typically made in conversation that add meaning to their communication. Fang and colleagues even suggest that counsellors may deliberately "misspell or stumble over their words, repeat themselves, utter partial words, and restart phrases or sentences" (p. 10). In these cases, punctuation can also be used to express tone and emotion.

Although less frequent, clients with poor counselling outcomes also made direct ruptures as coded by the CIS. Direct ruptures provide a particular difficulty in KHP counselling, regardless of whether it is done on the phone or online. In KHP counselling, clients can disengage from the session immediately and without warning. They do not have to gather their belongings and walk to the door, during which time a therapist would have an opportunity to say something to entice them to stay and work out the relationship problem. The most common direct rupture occurred when *clients strongly refused or stated that they felt uncomfortable with a counsellor intervention*. Within the KHP context, this rupture happened most notably when counsellors tried to force the idea of intervention by emergency services before the client was ready. As with indirect rupture markers, direct rupture markers are not indicative of a client being ‘difficult’ or ‘inappropriate’ within the counselling session. Rupture markers indicate that there is a lack of synchronicity in the therapeutic relationship. Rupture indicators signal to helping professionals that clients are experiencing transference or the professional is experiencing countertransference. The majority of chat clients state that their primary reason for choosing KHP over talking to someone else is the guarantee of anonymity and privacy (KHP, 2012b), and so suggesting to quickly involve a service that will break confidentiality can provoke a strong reaction in clients. When clients directly refuse such interventions, it can be a sign that counsellors are working too hard. Suggestions are most often refused when they are

counsellor-generated instead of solutions being generated by clients with scaffolding support from counsellors (deShazer et al., 2007). The solution-focused framework typically utilized by KHP counsellors was not being used in these cases where *clients strongly refused or stated that they felt uncomfortable with a counsellor intervention*. Counsellors who meet with strong refusals may need to consider taking a more tentative and curious stance rather than succumbing to their desire to 'rescue' their clients.

Clients being sarcastic or caustic towards counsellors was also a rupture marker of note. A client being sarcastic or caustic may actually be a positive phenomenon in the counselling relationship. Unlike when clients make indirect ruptures, sarcasm is a more direct and obvious expression of emotion, and so such remarks are easier to identify and respond to. One helpful response may simply be to acknowledge the client's difficult emotional state and invite them to tolerate it or work through it with the counsellor. In such cases, it may be beneficial for counsellors to consider the utility of short phrases such as "Wait, please" or "I'm sorry" to increase the likelihood of the client remaining online in the chat while the counsellor formulates more meaningful responses. Acknowledging in a non-judgmental way that the client is dissatisfied and asking to explore their transference may facilitate continuing the counselling conversation in a helpful way.

Clients also expressed dissatisfaction by *suddenly terminating their chats*. Although not formally a part of the CIS, this direct rupture marker is worth noting because it is unlike anything experienced in face-to-face counselling (although sudden hang-ups do happen in telephone counselling). This phenomenon is not unlike when a caller suddenly hangs up in ear-to-ear counselling. Unfortunately, when this situation happens in chat, it can feel abrupt and counsellors may struggle with feelings of having missed a cue that there was a relationship

rupture earlier in the chat. Whereas there is ample time to intervene with clients as they stand up and walk toward the office door in face-to-face counselling, chat disengagement can be instantaneous and without warning. Alternatively, such a direct rupture may actually be indicative of a unique strength of KHP counselling. KHP is unique with its guarantee of anonymity and the ability to immediately disengage with a counsellor without fear of any follow up and may actually be experienced as empowering to a young client. Struggling young people may be challenged with unwanted interference of adults in their social systems, whereas KHP clients have the option of immediate disengagement with the ability to return to a new counselling session (likely with a different counsellor) at a later time and on their own terms. Whereas face-to-face practitioners must address such ruptures with their ongoing clients, KHP counsellors have the luxury of letting go of the counselling session with the assumption that this client is welcome to return again anonymously and according to their own feelings of empowerment and engagement.

When counselling goes poorly – counsellors' contributions (CIS.)

When counselling sessions went poorly, counsellors appeared to have contributed with certain negative interventions. The most common negative contributions from counsellors occurred when *counsellors intellectualized or failed to focus on the clients' concerns* and when *counsellors pressed clients on a specific topic*. Given the lack of clarity and propensity toward misunderstandings in the text-to-text environment, it is easy to understand how these particular rupture styles happened with the most frequency. Pressing on a specific topic is often an example of counsellors not focusing on clients' concerns. Intellectualization and lack of focus are often indicators of counsellor countertransference or fatigue but may also represent misunderstandings in the type-to-type medium. Counsellors report feeling fatigued and

overwhelmed during chat counselling, often due to the abundance of serious mental health concerns and suicidality brought to chat sessions (Haner, 2015). Finding ways to practice appropriate self-care, debriefing, and ensuring sufficient time to recuperate between chat sessions is important to reduce counsellors' feelings of fatigue and insufficiency. Yet doing so is difficult in practice. KHP is modelled on a typical call centre philosophy and counsellors' time spent in different activities is closely monitored and reported. Counsellors report feeling micromanaged in terms of their time management and also experience pressure to return to the next counselling session because the centre's technology keeps them informed of how many potential chatters are waiting in queue to receive counselling. Currently, the chat queue is capable of accommodating up to eight potential clients, while any additional young people hoping to chat must continue refreshing their browser until a space in the queue opens up. Since chat counselling opened at KHP in December of 2011, the queue has been consistently full every moment that it is open. Reports from the KHP Director of Youth Online Services and Senior Workforce Specialist indicate that a mean of 756 of potential users were turned away each month in 2014 (M. Verburg & R. Howie, personal communication, February 17, 2016).

When considering counsellor contributions to ruptures in the counselling alliance, it may be important to consider what counsellors did not do in addition to what they did do. All counselling sessions in the lowest decile of counselling outcomes lacked two positive interventions: *when counsellors explain or redefine the tasks/goals of the session* and *when counsellors make an interpretation*. Explaining or redefining the tasks/goals is the most concerning as it is a key component of the BSFT model practiced at KHP. The lack of explaining or redefining the goals of a session indicates neglect on the part of counsellors to ensure that the goals for counselling sessions were co-established and agreed upon by

counsellors and clients. Without the co-creation of a goal, the two people involved in the counselling process are likely to be out of synch throughout the counselling session and have more miscommunications throughout than dyads that do agree upon a goal for the session. The co-creation of goals is particularly important in the chat environment where clients often begin their sessions with a direct statement indicative of severe mental health concerns associated with depression and anxiety or by stating that they are suicidal. It is easy for counsellors to assume that when clients present as suicidal that the goal is to prevent the suicides or to get the clients access to other help that will keep them safe. However, given the anonymous nature of KHP services, it is unlikely that clients arrive at KHP with the intention of being connected to emergency services. It is important, therefore, for counsellors to check in with these clients about their hopes or goals for the session to ensure that counsellors and clients are not working toward incompatible goals, which risks alienating the clients. Likewise, with severely depressed or anxious clients, counsellors may fall into the trap of trying to connect them with longer term, more formalized mental health services, when in reality clients may be looking for support and connection in the moment. They may wish to simply process emotions, a situation, or generate possible solutions to a problem tangentially related to their mental health status.

Implications for Phone and Chat Counselling with Young People

KHP is unique among all helping services that young people may access in Canada by virtue of its commitment to anonymity and confidentiality. In the same way, it is unique among all national child helplines. Yet results from my study have implications both for the Canadian context and for other helping organizations that use synchronous chat for counselling or crisis support. Therefore, one deliverable associated with my research is a counselling manual for synchronous chat with young people (Haner, 2016). It is to be used in training KHP counsellors

to work in the chat medium. The manual will also be shared with other national child helplines and youth-facing organizations using synchronous chat.

Individual factors of clients.

Age, gender, sexual orientation, racial-ethnocultural affiliation, generational status, and socioeconomic status are all individual identity factors of clients that may need to be considered to inform more broadly defined culturally competent and culturally safe counselling practices (Collins & Arthur, 2007; Arthur & Januszkowski, 2001; Smye & Browne, 2002; Case, 2015). Findings from my study highlight the need for counsellors to train not only in cultural awareness and safety and to thoroughly and regularly examine their own privilege, but to also regularly consider the multiple ways in which these identity factors may intersect and affect clients' abilities to seek help, participate in counselling, and consider various options within solution-focused and narrative models of counselling practice. More importantly, counsellors must be acutely aware of the assumptions they make in terms of identity factors based on the lack of cues afforded to them by virtue of using the telephone and online chat as service media. Because counsellors cannot see their clients in either instance (and cannot hear them on chat), they lack visual cues about identity factors such as physical characteristics, clothing, facial expressions, and mannerisms that may otherwise inform their ability to infer aspects of clients' identities. Many long-term counsellors at KHP report having developed a keen sense of hearing. They report being able to identify regional accents, which often give them a clue about clients' identities and provide an opportunity to inquire about identity factors. They also report the ability to listen for clues in the background of telephone counselling sessions such as family members speaking in another language, unsupervised young children, street noise, and other environmental factors that may be clues to identity and likewise provide natural opportunities to

further inquire about identity and how it may play a role in clients' help seeking and problem solving. However, when using synchronous chat as a counselling medium, these clues are completely removed and natural opportunities to inquire about identity are reduced. This lack of visual and auditory clues is likely to result in counsellors assuming dominant group memberships unless clients specifically mention identity factors or counsellors are trained to routinely inquire about them.

Facial expressions and mannerisms may also be cues for interpreting clients' emotional states and responses. Therefore, counsellors must be trained specifically in enhanced telepresence techniques (e.g., Mitchell & Murphy, 2009; Fang et al., 2013). The new KHP chat manual therefore includes specific training on enhanced telepresence as well as specific keyboarding techniques such as formatting for emotional clarity and emphasis, a glossary of common acronyms, appropriate use of emoticons with young people, and cultural differences in emoticon use (e.g., Park, Baek, & Cha, 2014). The manual also contains several examples and an exercise to explore respectful ways to explicitly inquire about identity issues.

Nature and level of risk involved in clients' presenting problems.

Results from my study provided evidence to support anecdotal reports that chat counselling is associated with more frequent mental-health and suicide-related topics than telephone counselling and that chat clients frequently experience clinical levels of ill mental-health symptoms. In particular, this sample displayed a high frequency of suicidal ideation and self-harm behaviours. These findings highlight the need to provide training specific to managing these specific types of crises using the chat medium. The chat counselling manual (Haner, 2016) provides this training and is aligned with best practices in suicide intervention and risk assessment (Living Works, 2014; Herron, Patterson, Nugent, & Troyer, 2016). Counsellors are

to also be trained extensively in self-care practices to protect them against the effects of burnout and vicarious trauma that may arise from chronic exposure to counselling conversations involving such trauma (Voss Horrell, Holohan, Didion, & Vance, 2011).

“What works” in type-to-type counselling.

The results of my study emphasize a focus on the counselling alliance or relationship; in particular, recognizing ruptures in the counselling relationship and being able to repair these ruptures when they happen are of key importance in counselling success. The most common client rupture was an indirect rupture wherein *clients were self-critical or self-blaming in response to a counsellor comment*. When this finding is considered along with the high incidence of symptoms associated with mood and anxiety disorders among chat clients, the importance of training chat counsellors to respond effectively to cognitive distortions associated with these disorders is apparent (Beck, 1976, 2008). The chat counselling manual provides direct instruction in narrative therapy techniques such as re-authoring externalization of the problem as well as information about cognitive distortions and instruction for providing psychoeducation about them to young people.

Other common indirect rupture markers from clients occurred when they *responded to counsellors in an acquiescent manner* or *gave short, non-elaborative responses to open-ended questions*. The chat counselling manual provides explicit instruction in how to recognize acquiescence and respond to closed responses, including multiple examples from chat counselling transcripts, as well as examples of responses that appropriately challenge these responses and provide a safe space for clients to respond more authentically. Opportunities to practice such responses are also provided. Enhanced telepresence techniques are likely to be helpful in negotiating these circumstances and are highlighted specifically as potentially helpful

responses to acquiescent statements (Mitchell & Murphy, 2009). Likewise, empathic sustains and other non-lexical responses are emphasized in counsellor training as tools to increase empathic communication and open up communications so that clients feel safe and encouraged to provide informative and honest responses (Fang et al., 2013).

Direct rupture markers such as when *clients strongly refused or stated that they felt uncomfortable with a counsellor intervention*, clients *were sarcastic or caustic towards counsellors*, or *suddenly terminated their chats* are also addressed in the chat counselling manual. In these situations, it is important for counsellors to recognize the developmental typicality of challenging authority figures for young people. A developmental-systemic theoretical approach is outlined in the chat counselling manual and counsellors are requested to consider the developmental stages of their clients and how they may form an accurate assessment of developmental considerations. BSFT and narrative approaches that emphasize the importance of emotional processing before moving to problem-solving and solution generation are also emphasized (de Shazer et al., 2007; Zimmerman & Dickerson, 1996) (and practice opportunities are provided) to allow counsellors to accustom themselves to the reality of emotional disinhibition and reduced empathy present on the Internet that may contribute to clients participation in direct ruptures such as those mentioned above (Tidwell & Walther, 2002). Counsellors are also encouraged to practice recognizing their countertransference reactions and be open to using short, conciliatory statements such as “I’m sorry” and “Wait please” to buy the time required to encourage young people to remain online long enough to explore ruptures and continue their counselling conversations.

Counsellors are also encouraged to consider the negative interactions that were commonly enacted by other counsellors in the least successful chat counselling sessions in this

study. When *counsellors intellectualized or failed to focus on the clients' concerns* and when *counsellors pressed clients on a specific topic* were the most common counsellor contributions to ruptures in the counselling relationship. Given that chat counsellors report feeling fatigued and depleted during 'heavy' chat counselling sessions, these negative interactions are not surprising. In the chat counselling manual, counsellors are instructed to be vigilant about their own self-care so that they are more likely to be able to manage countertransference reactions during these sessions. It is important for supervisors to also ensure that time is built into schedules (especially in centres that are built on a telephone centre format) for counsellors to regularly take breaks, debrief, and recuperate between chat counselling sessions.

Counsellors must also be instructed on behaviours that are associated with counselling success, which in this study occurred *when counsellors explained or redefined the tasks/goals of the session* and *when counsellors made an interpretation*. Goal setting is an important element of BSFT models and, given the lack of clarity associated with computer mediated communication, the chat counselling manual emphasizes the importance of clearly articulating goals and checking in throughout sessions to ensure that goals have not shifted and are clearly tied to what is discussed in chat counselling. Interpretations may be more difficult for counsellors to integrate into chat counselling as synchronous chat is typically single-session and practiced from BSFT models or narrative therapy models and interpretations are rooted in psychoanalytic and psychodynamic practices. However, it may be possible for chat counsellors to challenge themselves to incorporate interpretation or at least understand interpretation's value within the context of chat counselling when it occurs more naturally. Interpretation is essentially the practice of offering a potential insight that relates problematic thoughts, feelings, or behaviours of clients to their underlying assumptions, schemas, or unconscious processes (Auld,

Hyman, & Rudzinski, 2005). It may be that chat counsellors can offer tentative suggestions permitted within BSFT and narrative models rather than classical interpretations associated with psychoanalytic and psychodynamic models.

Limitations

Limitations of the present study are primarily due to KHP's commitment to client confidentiality. This study was limited to two points of data collection: immediately before and immediately after the counselling sessions. It is not possible to collect data for baseline measurement as youth who use the service do so on-demand and do not make appointments ahead of time. It is likewise impossible to conduct follow-up measurement because doing so would require the use of technology or methods that would violate KHP's promise of confidentiality and anonymity (e.g., requesting contact information, tracing telephone numbers or Internet Protocol addresses). I recognize and respect KHP's concern for confidentiality because if this trust were violated at any point, the reputation of the service would be lost, and adolescents would be much less likely to use KHP when they need its services most. Since this study was limited to two points of online data collection, it was necessary to choose only the most essential questions to maintain participant interest and facilitate completion of the questionnaires.

This study was also limited by the use of self-report questionnaires, which are susceptible to both positive and negative response biases. In the case of KHP clients, however, social-desirability bias may be reduced due to participants'' awareness of the confidential and anonymous nature of the service.

Finally, because counselling staff members were involved in participant recruitment, they may have been focused on service delivery and neglected to invite every client to participate in the research during the data collection period. Some counselling staff members expressed discomfort in recruiting those clients in acute crisis so these clients may have been less likely to be invited to participate in the survey by counsellors after their sessions even if their crises had

resolved and they would have been less likely to self-select into the survey before their counselling sessions.

Directions for Future Research

My research focused on the telephone and chat counselling at one Canadian organization providing single-session, on-demand, free, anonymous, and confidential telephone and chat counselling in English and French. Because KHP is a unique service for young people within Canada, findings may not be entirely generalizable to other contexts. Therefore other researchers interested in adolescent help-seeking and emerging technologies may consider performing similar studies at other national child helplines to determine whether potentially marginalized groups are likewise overrepresented or if KHP's commitment to anonymity provides a uniquely safe and trustworthy place to seek help that is particularly attractive for these groups. Within the Canadian context, investigating the experiences of Aboriginal young people, especially those in remote areas, would provide much needed insight as to whether telephone and chat counselling may be a useful support to young people in this particular community. There are many reasons why anonymous and confidential services may be of particular help to Aboriginal young people in the remote north such as this population's unique experience of oppression and history of colonization, lack of privacy associated with small communities, and lack of traditional mental health services available in-person. Thus, future research could investigate how to tailor emerging technologies to the needs of this population.

Of related interest is the investigation of how and why young people come to trust the KHP promise of anonymity and confidentiality as well as a continued deeper description of the clients who use this service so that awareness campaigns can be targeted to reach those young people most in need of this kind of anonymous and confidential support. With ongoing and

frequent changes to technology such as smartphones, tablets, and other hand-held devices that access the Internet and voice over Internet protocol (VoIP), it will be important for telephone and chat counselling service providers to track how technology changes influence clients' perceptions of the anonymity and confidentiality of their services. Future research should include type of device, Internet/VoIP provider, and client understanding of their privacy as potential predictors of outcomes and participation in counselling service use.

Researchers interested in counselling and psychotherapy processes and outcomes may also wish to focus on computer-mediated communication in these professional contexts and investigate how other variables such as attention (e.g., it is common to have more than one window open on a computer device and so attention during a chat counselling session may be divided, whereas in face-to-face sessions attention is focused on the counselling interaction), reading and writing ability, and past experiences of computer-mediated communication (e.g., cyberbullying victimization) may affect young people's abilities to engage in chat counselling. KHP may conduct a program evaluation measuring not only client outcomes, but also counsellors' perceptions of their competence and actual competence with chat counselling techniques after staff are trained using the new chat counselling manual.

Conclusion

The use of emerging technologies in counselling and psychotherapy is increasing (Ritterband, Gonder-Frederick, & Cox, 2003; Gupta & Agrawal, 2012) and youth show clear preferences for social media when seeking help for problems in their lives (Greidanus, 2010). The results of this research further the understanding of how to support adolescents in Canada who do not access face-to-face services either by choice or because they face barriers to these services. The findings provide guidance for professional staff who counsel in strategies to

increase their counselling competencies using these media. Finally, because KHP is a unique service (as it is the only help-seeking tool available to youth in Canada that both uses professional intervention staff and guarantees anonymity), knowledge that illuminates "what works" in this environment may influence the outreach programs of other adolescent mental health services with a goal of removing barriers to services for youth. In particular, knowledge mobilization about the effectiveness of these services may encourage isolated, distressed, and marginalized youth to reach out for help. Furthermore, mobilization of this knowledge within the international child helpline community may guide front-line staff at child helplines in supporting distressed young people around the world.

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Appendix A: Client Questionnaires

Internal use – R/SPSS: ___________________

Telephone Counselling Client Questionnaire – (N.B. Scaling items marked [rc] must be reverse coded.)

Informed Consent (pre-counselling)

Hello, you are talking with a Kids Help Phone research assistant – just so you know, I'm not a counsellor. While you are waiting in queue to talk to a counsellor, callers aged 12 and over have an opportunity to give us some information about how they are doing before talking to a counsellor. We hope to talk to some callers before and after counselling so we can see how helpful our service is and learn how to make it better for children and youth across Canada. You will NOT lose your place in the line to speak to a counsellor. We *really* appreciate your taking the time to give us feedback, but it might not be a good time for you right now. You may prefer to wait for a counsellor with the regular hold music. Otherwise, I'm going to tell you a bit about the project and you can ask any questions you might have.

1. Are you 12 years old or older? a. Yes b. No

NB. If caller is under 12 say: Thank you for your interest, but we are only doing surveys with people who are 12 or older at this time. I'll transfer you back to the counselling queue so that you can speak to a counsellor as soon as possible. Have a good night.

2. Are you interested in hearing about the survey? a. Yes b. No

Over the next few weeks Kids Help Phone will be asking callers to answer some questions about their experience with our telephone counselling service. We will use everyone's answers to help us understand and look at ways to improve this service. This is not a test; there are no right or wrong answers. Your participation is voluntary and you may stop at any time. If you change your mind and don't want to do the survey any more, just ask and I'll throw out your answers.

Your answers are totally anonymous. We will not take down any identifying information about you. The counsellor you speak with will not know any of your answers. The survey will take about 2 minutes.

There are no expected risks for your participation, but if there are any questions you don't want to answer just ask to skip them. If, for any reason, you find these questions upsetting, I'll check in to see if you would like to be transferred back to hold music. After you speak with a counsellor, you'll be invited to do another short survey to let us know how the call went. We will be comparing how people feel before and after talking to a counsellor. Counsellors will not be able to find out what you said because we are in a separate office from them and they don't get to see anyone's survey. But we will post our general findings on the Kids Help Phone teen website in the fall if you want to find out what we learned. And just so you know, we keep all the surveys in a locked cabinet in our national office. After 7 years, we will destroy them.

Finally, I'll just tell you that this research has been approved by the York University Human Participants Review Subcommittee. If you have any questions about the research in general, your role in the research, or about your rights as a participant, just ask and I'll give you names, phone numbers, and

emails of the right people to answer your questions.

3. Do you have any questions before we begin? a. Yes b. No

Notes, if any: ____

4. Do I have your permission to start? a. Yes b. No (reason, if given): ______________

Pre-Counselling Survey

I'll need a way of matching up your surveys if you choose to give us feedback after speaking to a counsellor. Please pick a codename or password so we can match up your two surveys. You can use your first name if you want. Do not give me your last name so that you can stay anonymous.

PIN: ________

5. Can you tell me how old are you?
    a. 12
    b. 13
    c. 14
    d. 15
    e. 16
    f. 17
    g. 18
    h. 19
    i. 20
    j. 21+
    k. Don't know/couldn't answer
    l. Client chose not to answer

NB. If client is under 12 say: Thank you, but we're only doing surveys with callers age 12 and over right now. I'm going to transfer you back into the queue to speak to a counsellor. Thanks for speaking to me and have a good night.

6. What gender do you best identify with?
    a. Female
    b. Male
    c. Trans/Genderqueer
    d. Don't know/couldn't answer
    e. Client chose not to answer

I'm going to ask you to rate some of your feelings and experiences using a scale from 0 – 7. All of these questions are about how you are doing RIGHT NOW.

(Distress)

7. [rc] On a scale of 0 – 7, where 0 is not at all upset and 7 is extremely upset, how do you feel right now?

0 1 2 3 4 5 6 7

Not at all upset Extremely upset

8. [rc] On a scale of 0 – 7, where 0 is no emotion and 7 is extreme emotion, how strongly are you feeling your emotions right now?

0 1 2 3 4 5 6 7

No emotion — Extreme emotion

9. [rc] On a scale of 0 – 7, where 0 is not at all stressed and 7 is extremely stressed, how stressed out are you right now?

0 1 2 3 4 5 6 7

Not at all stressed — Extremely stressed

10. [rc] On a scale of 0 – 7, where 0 is not at all and 7 is completely, how much would this problem or situation affect your life if you don't get some help for it?

0 1 2 3 4 5 6 7

Not at all — Completely

(Isolation)

11. On a scale of 0 – 7, where 0 is completely alone and 7 is not at all alone, how alone do you feel in dealing with the problem or situation you are facing?

0 1 2 3 4 5 6 7

Completely alone — Not at all alone

12. On a scale of 0 – 7, where 0 is I feel like I can't talk to anyone and 7 is I feel like there are lots of people I can talk to, how much do you feel like you can talk to people other than Kids Help Phone about your problem or situation?

0 1 2 3 4 5 6 7

I can't talk to anyone else — There are lots of people I can talk to

(Personal Strengths and Resources)

13. On a scale of 0 – 7, where 0 is not at all aware and 7 is very aware, how aware are you of any personal strengths or resources you have that will help you to deal with the problem or situation you are facing?

0 1 2 3 4 5 6 7

I don't know of any personal strengths that will help — I definitely have personal strengths that will help

(Difficulty)

14. [rc] On a scale of 0 – 7, where 0 is not at all difficult and 7 is extremely difficult, how difficult is the problem or situation for which you need help?

0 1 2 3 4 5 6 7

Not at all difficult Extremely difficult

15. [rc] On a scale of 0 – 7, where 0 is no help and 7 is a lot of help, how much help do you need to move forward with your problem or situation?

0 1 2 3 4 5 6 7

No help A lot of help

16. [rc] On a scale of 0 – 7, where 0 is the easiest problem and 7 is the hardest problem you've ever dealt with, how hard is the problem you are calling about?

0 1 2 3 4 5 6 7

Easiest problem Hardest problem

(Clarity)

17. On a scale of 0 – 7, where 0 is not clear at all and 7 is extremely clear, how clearly can you see what the problem or situation is that you need to deal with?

0 1 2 3 4 5 6 7

Not clear at all Extremely clear

18. [rc] On a scale of 0 – 7, where 0 is very easy and 7 is very hard, how easy or hard is it for you to put your problem or situation into words right now?

0 1 2 3 4 5 6 7

Very easy Very hard

19. On a scale of 0 – 7, where 0 is having no idea and 7 is having a strong idea, how much do you know what to do about your problem or situation right now?

0 1 2 3 4 5 6 7

No idea Strong idea

(Self-efficacy)

20. On a scale of 0 – 7, where 0 is not at all capable and 7 is extremely capable, how capable are you of dealing with this problem or situation?

0 1 2 3 4 5 6 7

Not at all capable Extremely capable

21. On a scale of 0 – 7, where 0 is can't cope at all and 7 is very able to cope, how well can you cope with problem or situation you are dealing with?

0 1 2 3 4 5 6 7

Can't cope at all Very able to cope

22. On a scale of 0 – 7, where 0 is completely unable to deal and 7 is extremely able to deal, how well can you deal with the problem or situation you are facing?

0 1 2 3 4 5 6 7

Completely unable to deal Very able to deal

That is all for the rating scales. Thank you so much for sharing this information with us. Unless you have any questions for me, I'm going to transfer you back into the queue to talk to a counsellor.

23. Do you have any questions? a. Yes b. No
(If yes, please note.)
____
____
____

When you are done talking to a counsellor, you'll be asked to give us some feedback about how the call went and answer a few more questions. If you agree, you'll be asked for the codename or password you told me when we started this survey. The codeword you chose was _________________.

Thank you again for talking with us. Please hold while I transfer you back into the queue to speak to a counsellor.

Telephone Counselling Client Questionnaire

Informed Consent(post-counselling)

Hello, you are talking with a Kids Help Phone research assistant – just so you know, I'm not a counsellor. Your counsellor transferred you because you said it would be okay to ask you some questions about our telephone counselling service. We *really* appreciate your taking the time to give us feedback. I'm going to tell you a bit about the project and you can ask any questions you might have.

1. Does this sound okay? a. Yes b. No

2. Did you do a quick survey before you spoke to a counsellor today? a. Yes b. No

(If yes, say: What codename or password did you use in that survey?) ______________________

(If yes, say: Can you please confirm how old you are?) _________

NB. If caller is under 12 say: Thank you for your interest, but we are only doing surveys with people who are 12 or older at this time. I'll transfer you back to the counselling queue so that you can speak to a counsellor as soon as possible. Have a good night.

Over the next few weeks Kids Help Phone will be asking callers to answer some questions about their experience with our telephone counselling service. We will use everyone's answers to help us understand and look at ways to improve this service. This is not a test; there are no right or wrong answers. Your participation is voluntary and you may stop at any time. If you change your mind and don't want to do the survey any more, just ask and I'll throw out your answers.

Your answers are totally anonymous. We will not take down any identifying information about you. The counsellor you just spoke with will not see your answers. The survey will take about 10 minutes.

There are no expected risks for your participation, but if there are any questions you don't want to answer just ask to skip them. If, for any reason, you find these questions upsetting, I'll check in to see if you would like to stop or be transferred back to the counselling service. Counsellors will not be able to find out what you said because we are in a separate office from them and they don't get to see anyone's survey. But we will post our general findings on the Kids Help Phone teen website in the fall if you want to find out what we learned. And just so you know, we keep all the surveys in a locked cabinet in our national office. After 7 years, we will destroy them.

Finally, I'll just tell you that this research has been approved by the York University Human Participants Review Subcommittee. If you have any questions about the research in general, your role in the research, or about your rights as a participant, just ask and I'll give you names, phone numbers, and emails of the right people to answer your questions.

3. Do you have any questions before we begin? a. Yes b. No

Notes, if any: ____

4. Are you okay to do the survey? a. Yes b. No, reason, if given: _______________

5. One more thing before we start: We'd like to look at what counsellors do right when young people tell us that counselling was helpful and what they do not-so-well when young people tell us that counselling wasn't very helpful. To do that, a researcher would need to review your counselling session recording. These recordings are usually made and then destroyed after the counsellor receives supervision from their clinical manager. But if a researcher is going to review the recording, it needs to be saved for a while. The recordings we save for research are stored on an encrypted hard drive in a locked location in our national office. Are you okay with the researcher reviewing the counselling session to look at what the counsellor does well and not-so-well? a. Yes b. No, reason, if given: _______________

NB. If the client states "no," say: That's totally fine. I've noted that we do not have your permission to use your actual counselling session in the research, but that we can use your survey(s). Thank you for letting us know.

NB. If client states "yes," say: Thank you. Letting the researchers listen to your call will help us to learn how to improve our telephone counselling services.

6. Do I have your permission to start? a. Yes b. No, reason, if given: _____________

I'm going to ask you to rate some of your feelings and experiences using a scale from 0 – 7. All of these questions are about how you are doing NOW THAT YOU'VE SPOKEN TO A COUNSELLOR.

(Distress)

7. On a scale of 0 – 7, where 0 is not at all upset and 7 is extremely upset, how do you feel right now?

0 1 2 3 4 5 6 7

Not at all upset Extremely upset

8. On a scale of 0 – 7, where 0 is no emotion and 7 is extreme emotion, how strongly are you feeling your emotions right now?

0 1 2 3 4 5 6 7

No emotion Extreme emotion

9. On a scale of 0 – 7, where 0 is not at all stressed and 7 is extremely stressed, how stressed out are you right now?

0 1 2 3 4 5 6 7

Not at all stressed Extremely stressed

10. On a scale of 0 – 7, where 0 is not at all and 7 is completely, how much would this problem or situation affect your life if you don't get some help for it?

0	1	2	3	4	5	6	7
Not at all							Completely

(Isolation)

11. On a scale of 0 – 7, where 0 is completely alone and 7 is not at all alone, how alone do you feel in dealing with the problem or situation you are facing?

0	1	2	3	4	5	6	7
Completely alone							Not at all alone

12. On a scale of 0 – 7, where 0 is I feel like I can't talk to anyone and 7 is I feel like there are lots of people I can talk to, how much do you feel like you can talk to people other than Kids Help Phone about your problem or situation?

0	1	2	3	4	5	6	7
I can't talk to anyone else							There are lots of people I can talk to

(Personal Strengths and Resources)

13. On a scale of 0 – 7, where 0 is not at all aware and 7 is very aware, how aware are you of any personal strengths or resources you have that will help you to deal with the problem or situation you are facing?

0	1	2	3	4	5	6	7
I don't know of any personal strengths that will help							I definitely have personal strengths that will help

(Difficulty)

14. On a scale of 0 – 7, where 0 is not at all difficult and 7 is extremely difficult, how difficult is the problem or situation for which you need help?

0	1	2	3	4	5	6	7
Not at all difficult							Extremely difficult

15. On a scale of 0 – 7, where 0 is no help and 7 is a lot of help, how much help do you need to move forward with your problem or situation?

0	1	2	3	4	5	6	7
No help							A lot of help

16. On a scale of 0 – 7, where 0 is the easiest problem and 7 is the hardest problem you've ever dealt with, how hard is the problem you are calling about?

0 1 2 3 4 5 6 7

Easiest problem Hardest problem

(Clarity)

17. On a scale of 0 – 7, where 0 is not clear at all and 7 is extremely clear, how clearly can you see what the problem or situation is that you need to deal with?

0 1 2 3 4 5 6 7

Not clear at all Extremely clear

18. On a scale of 0 – 7, where 0 is very easy and 7 is very hard, how easy or hard is it for you to put your problem or situation into words right now?

0 1 2 3 4 5 6 7

Very easy Very hard

19. On a scale of 0 – 7, where 0 is having no idea and 7 is having a strong idea, how much do you know what to do about your problem or situation right now?

0 1 2 3 4 5 6 7

No idea Strong idea

(Self-efficacy)

20. On a scale of 0 – 7, where 0 is not at all capable and 7 is extremely capable, how capable are you of dealing with this problem or situation?

0 1 2 3 4 5 6 7

Not at all capable Extremely capable

21. On a scale of 0 – 7, where 0 is can't cope at all and 7 is very able to cope, how well can you cope with problem or situation you are dealing with?

0 1 2 3 4 5 6 7

Can't cope at all Very able to cope

22. On a scale of 0 – 7, where 0 is completely unable to deal and 7 is extremely able to deal, how well can you deal with the problem or situation you are facing?

0 1 2 3 4 5 6 7

Completely unable to deal Very able to deal

This has been really helpful. Thank you for answering those scaling questions. Because Kids Help Phone is anonymous and confidential, they don't actually know what kinds of people use the help line. These next few questions will help us to understand who uses the service, which will help Kids Help Phone do things like hire counsellors with specific experiences and skills.

Demographics

Age (skip if client did the pre-counselling survey)

23. How old are you?

a. 12
b. 13
c. 14
d. 15
e. 16
f. 17
g. 18
h. 19
i. 20
j. 21+
k. Don't know/couldn't answer
l. Client chose not to answer

Gender (skip if client did the pre-counselling survey)

24. What gender do you best identify with?

a. Female
b. Male
c. Trans/genderqueer
d. Don't know/couldn't answer
e. Client chose not to answer

Sexual Orientation

25. What sexual orientation do you best identify with?

a. Gay/Lesbian
b. Straight/heterosexual
c. Bisexual
d. Asexual
e. Questioning
f. Other: ______________________
g. Don't know/couldn't answer

h. Client chose not to answer

Geography

26. What province or territory do you live in?

a. British Columbia
b. Alberta
c. Saskatchewan
d. Manitoba
e. Ontario
f. Quebec
g. New Brunswick
h. Nova Scotia
i. Prince Edward Island
j. Newfoundland and Labrador
k. Yukon
l. Northwest Territories
m. Nunavut

27. Do you mind telling us the name of town, city, or area you live in? You will still be anonymous.
NB: If "no," say: Okay, can you tell me what kind of community it is?

a. City or large town (>10, 000 people)
b. Rural area or small town (<10, 000 people)
c. A First Nations community (reserve) or Métis Settlement
d. Other: ___________________

28. Who do you live with? (Qualitative answer groups into the following categories.)

a. Parent(s)
b. Other adult family member, no parents
c. Foster care
d. Group home
e. Homeless/street involved
f. Peers, with their parent(s)
g. Peers, with no parent(s)
h. Don't know/couldn't answer
i. Client chose not to answer

Generational Status

29. How long has your family been in Canada? (Qualitative answer groups into the following categories.)

a. Client is an immigrant [Immigrant client]

b. Client born in Canada; two immigrant parents [First Generation Client]

c. Client born in Canada; one Canada-born parent, one non-Canada-born parent [First Generation Client]

d. Client born in Canada; both parents born in Canada; 3+ grandparents not born in Canada [2nd Generation Client]

e. Client born in Canada; both parents born in Canada; 2+ grandparents born in Canada [3rd Generation+ Client]

Languages

30. What is your first language? ______________________________

31. Are any other languages are spoken at home? ______________________________

32. People are often described as belonging to different racial, ethnic, or cultural groups, for example, Filipino, Jamaican, English, or Inuit. To which ethnic or cultural group(s) do you see yourself as belonging? (Qualitative answer groups into the following categories. Multiple responses permitted.)

a. Canadian

b. British

c. French

d. Quebecois

e. First Nations, Aboriginal or Metis

f. White, European or Caucasian

g. South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)

h. Asian (e.g., Korean, Chinese, Japanese)

i. Black (e.g., African or Caribbean descent)

j. South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)

k. West Asian to Middle Eastern (Armenian, Egyptian, Iranian, Lebanese)

l. Latin American (e.g., Mexican, South American, Central American)

m. Other (please specify):_________________

n. Don't know/couldn't answer

o. Client chose not to answer

33. People sometimes belong to different religious or spiritual groups, or see themselves as believing in a certain religion or spiritual philosophy. Which religious or spiritual beliefs are parts of your identity? (Qualitative response groups into the following categories. Multiple responses permitted.)

a. Christianity
b. Judaism
c. Muslim
d. Hindu
e. Atheist
f. Agnostic
g. Other: _______________

We're almost done. The rest of the survey will only take a few more minutes. Thanks for hanging in there with me. These questions are about your relationship with Kids Help Phone.

Relationship with Kids Help Phone

34. Approximately how many times have you contacted Kids Help Phone using the phone, chat, or "Ask Us Online"? ____

35. Approximately how many times have you contacted Kids Help Phone using the phone?
____

36. How long ago was the first time you contacted Kids Help Phone?
____

37. How do you prefer to contact Kids Help Phone?

a. Telephone
b. Chat
c. Ask Us Online
d. No preference

Why did you choose the telephone today?

____

38. Think about the problem or situation that prompted you to contact Kids Help Phone. Did you talk to anyone else about this problem or situation before you called/chatted?

a. No
b. Yes
- If yes, to whom?
  a. Friend/peer
  b. Sibling
  c. Parent/ guardian/ adult family member
  d. Teacher/ school guidance counsellor
  e. Faith-based support/leader
  f. Family doctor
  g. Social or health service professional (social worker, public health nurse)
  h. Counsellor/ therapist
  i. Psychologist
  j. Psychiatrist
  k. Other supportive adult
  l. Other: _____________________
  m. Don't know/couldn't answer
  n. Client chose not to answer

39. Have you ever gone to see a professional counsellor or therapist besides Kids Help Phone?

a. Yes, in the past
b. Yes, currently
c. No
d. Don't know/couldn't answer
e. Client chose not to answer
- If yes, for what problem/situation? _____________________________

40. Are you currently on a waiting list for professional counselling or therapy?

a. No
b. Yes
- If yes, how long have you been on a wait list? _____________________________

41. Do you now have or have you previously had a mental health diagnosis?

a. No
b. Yes
- If yes, what is/was the diagnosis? _____________________________
- Who gave it to you? ___________________________

The Problem/Situation

42. What problem or situation did you contact Kids Help Phone about today? (Qualitative response groups into the following categories.)

a. Bullying/harassment

What is the client's role?	What is the type of bullying?
Target	Verbal
Bystander	Physical
Bullying behaviour	Social/exclusion
	Cyber/online exploitation
	Cyber-sexting

b. Emotional abuse

Acquaintance	Online stalking	Other adult	Other family	Parent/guardian
Peer	Self	Stalking	Stanger	undisclosed

c. Family relationships

Domestic violence	Family change – moving
Family change – remarriage/blending families	Family change – separation/divorce/custody
Neglect	Other
Parent/guardian – absence	Parent/guardian – cultural differences/conflicts
Parent/guardian – expectations to succeed	Parent/guardian – getting along/communication
Siblings	

d. Legal info/independent living

Other	Child welfare or justice system information
Employment and employment supports	Financial information or supports
Food	Homelessness
Housing	Involved with social services
Leaving home/moving/emancipation	Online privacy

e. Mental/emotional health

Anxiety	Concern for others MH/EH	Depression	Disordered eating
Grief and loss	Mood disorder	Personality disorder	Psychosis
Self-care	Self-esteem	Self-injury	Traumatic incident/symptoms

f. Peer relationships

Breakup	conflict	Dating/love	Making friends	Online interactions	Other	Peer pressure

g. Physical health

Concern for other's physical health	Health and nutrition	Illness/medical related
Living with special needs	Menstruation	Physical disability

h. Physical violence/abuse

Acquaintance	Other adult	Other family	Parent/guardian	Partner
Self	Sibling	Stranger	undisclosed	

i. School

Academic problems	Not attending/dropping out	Organization/time management	Other
Planning for the future	School transitions	Social/behavioural problems with teachers/peers	Stress management

j. Sexual health

Age of consent	Contraception/STIs	Development/puberty	Pregnancy/abortion	Prostitution	Sexual activity

k. Sexual orientation/gender identity

Coming out	Discrimination(homo/transphobia)	Finding a community	Finding partner/relationships
Transitioning	Other	Questioning/identification	

l. Sexual violence/abuse

Perpetrator?	Parent/guardian	Sibling	Other family	Other adult	
Partner	Peer	Acquaintance	Stranger	Self	undisclosed
Type?	Sexual abuse	Sexual assault	Sexual interference	Sexual harassment	
Witness to sexual violence/abuse					

m. Self and social identity

n. Substance use, misuse, or addictions

Alcohol	Concern for other's problem	Experimentation with alcohol/drugs	Illegal drugs
Internet or gaming	Other	Pornography	tobacco

o. Suicide/suicide related

Friend/child in community	Other family/adult	Parent/guardian	Partner	Self-ideation/attempt

p. Thank-you

q. Complaint

r. Information about KHP

s. Graduated caller

t. Adult – above age of service

u. Other ________________________

v. Client chose not to answer

43. What did you want to get out of your call with a counsellor today? (Qualitative response groups into the following categories.)

a. Issue-based

b. Emotional processing or emotional management

c. Other (information about KHP, etc…) ____________________________________

NB: Please note verbatim statement.

____

____

____

____

44. Did your counsellor suggest you speak with an adult support or community-based agency?

a. Yes, adult

b. Yes, agency

c. Yes, both

d. No

e. Not sure

f. Client chose not to answer

45. Do you plan to follow up?

a. Yes, adult

b. Yes, agency

c. Yes, both
d. No
e. Not sure
f. Client chose not to answer

46. Would you contact Kids Help Phone again if you needed help?
a. No
b. Yes

47. Would you recommend Kids Help Phone to a friend?
a. No
b. Yes

48. Is there anything else you would like us to know in general – or about how we can make our telephone service better?

____

____

Kids Help Phone Marketing Research Questions (not attached to the proposed study but included in the questionnaires)

49. Is any member of your family in the military?
- a. No
- b. Yes
- ● If yes, whom? ______________________________

50. [Did youth identify as LGBT?]
- a. No
- b. Yes
- ● *If yes, think about the past month:* Have you been bullied and/or harassed in the past month?
- a. No
- b. Yes
- ● If yes, about how often? ______________________________
- ● If yes, do you perceive the bullying to be related to your LGBT identity or unrelated? ______________________________

Chat Counselling Client Questionnaire (Informed Consent – pre-counselling)

Welcome to our Live Chat Counselling Service!

If you need to reach a counsellor quickly, please call us at 1-800-668-6868, or if it's an emergency, call 911.

required info *[please note that KHP has designated these fields as mandatory to access the service.]*

*Nickname (not your real name): ____

*Are you (drop-down menu): 1. Male, 2. Female, 3. Transgendered, 4. Other

*How old are you: ____

*Province/Territory: ____

*What kind of community do you live in? 1. City or large town (more than 10, 000 people), 2. Rural area or small town (less than 10, 000 people), 3. A First Nations community or Métis settlement,
4. Other: ____________

Optional Info

There are ___ calls in queue ahead of you. While you are waiting in queue to talk to a counsellor, chatters aged 12 and over have an opportunity to give us some information about how they are doing before chatting with a counsellor. We hope to talk to some chatters before and after counselling so we can see how helpful our service is and learn how to make it better for children and youth across Canada. You will NOT lose your place in the line to speak to a counsellor. We *really* appreciate your taking the time to give us feedback, but we realize it might not be a good time for you right now.

Over the next few weeks Kids Help Phone will be asking chatters to answer some questions about their experience with our Internet counselling service. We will use everyone's answers to help us understand and look at ways to improve this service. This is not a test; there are no right or wrong answers. Your participation is voluntary and you may stop at any time. If you change your mind and don't want to do the survey any more, just close that tab and we'll throw out your answers.

Your answers are totally anonymous. We will not ask for any identifying information about you. The counsellor will not see your answers. The survey will take about 2 minutes.

There are no expected risks for your participation, but if there are any questions you don't want to answer just skip them. If, for any reason, you don't want to do the survey any more, you can just close that browser window and you'll still be in the queue to speak to a counsellor. After you chat with a counsellor, you'll be invited to do another short survey to let us know how the chat went. We will compare how people feel before and after chatting with a counsellor. Counsellors cannot find out what you said because we use separate technology from the chat service. We will post our general findings to the Kids Help Phone teen website in the fall if you want to find out what we learned. And just so you know, we keep all our data on a password-protected hard drive in our national office. After 7 years, we put it into long-term storage.

This research has been approved by the York University Human Participants Review Subcommittee.

If you have questions about the research, you can email the lead researcher at research@kidshelpphone.ca. Her name is Dilys and she is monitoring the email address right now. So you'll get a response in just a few minutes. You will remain anonymous if you contact this email address.

Or if you prefer, you can contact Ms. Alison Collins-Mrakas, Manager, Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail acollins@yorku.ca). Please note that this is not an anonymous telephone line or email.

Do we have your permission to do the survey with you? a. Yes b. No

- If yes – continue to survey.
- If no – No problem! Have a good chat with the counsellor.

We're going to ask you to rate some of your feelings and experiences using a scale from 0 – 7. All of these questions are about how you are doing RIGHT NOW.

1. On a scale of 0 – 7, where 0 is not at all upset and 7 is extremely upset, how do you feel right now?

0 1 2 3 4 5 6 7

Not at all upset Extremely upset

2. On a scale of 0 – 7, where 0 is no emotion and 7 is extreme emotion, how strongly are you feeling your emotions right now?

0 1 2 3 4 5 6 7

No emotion Extreme emotion

3. On a scale of 0 – 7, where 0 is not at all stressed and 7 is extremely stressed, how stressed out are you right now?

0 1 2 3 4 5 6 7

Not at all stressed Extremely stressed

4. On a scale of 0 – 7, where 0 is not at all and 7 is completely, how much would this problem or situation affect your life if you don't get some help for it?

0 1 2 3 4 5 6 7

Not at all Completely

5. On a scale of 0 – 7, where 0 is completely alone and 7 is not at all alone, how alone do you feel in dealing with the problem or situation you are facing?

0 1 2 3 4 5 6 7

Completely alone Not at all alone

6. On a scale of 0 – 7, where 0 is I feel like I can't talk to anyone and 7 is I feel like there are lots of people I can talk to, how much do you feel like you can talk to people other than Kids Help Phone about your problem or situation?

0 1 2 3 4 5 6 7

I can't talk to anyone else — There are lots of people I can talk to

7. On a scale of 0 – 7, where 0 is not at all aware and 7 is very aware, how aware are you of any personal strengths or resources you have that will help you to deal with the problem or situation you are facing?

0 1 2 3 4 5 6 7

I don't know of any personal strengths that will help — I definitely have personal strengths that will help

8. On a scale of 0 – 7, where 0 is not at all difficult and 7 is extremely difficult, how difficult is the problem or situation for which you need help?

0 1 2 3 4 5 6 7

Not at all difficult — Extremely difficult

9. On a scale of 0 – 7, where 0 is no help and 7 is a lot of help, how much help do you need to move forward with your problem or situation?

0 1 2 3 4 5 6 7

No help — A lot of help

10. On a scale of 0 – 7, where 0 is the easiest problem and 7 is the hardest problem you've ever dealt with, how hard is the problem you are calling about?

0 1 2 3 4 5 6 7

Easiest problem — Hardest problem

11. On a scale of 0 – 7, where 0 is not clear at all and 7 is extremely clear, how clearly can you see what the problem or situation is that you need to deal with?

0 1 2 3 4 5 6 7

Not at all clear — Really clear

12. On a scale of 0 – 7, where 0 is very easy and 7 is very hard, how easy or hard is it for you to put your problem or situation into words right now?

0 1 2 3 4 5 6 7

Very easy — Very hard

13. On a scale of 0 – 7, where 0 is having no idea and 7 is having a strong idea, how much do you know what to do about your problem or situation right now?

0	1	2	3	4	5	6	7

No idea Strong idea

14. On a scale of 0 – 7, where 0 is not at all capable and 7 is extremely capable, how capable are you of dealing with this problem or situation?

0	1	2	3	4	5	6	7

Not at all capable Extremely capable

15. On a scale of 0 – 7, where 0 is can't cope at all and 7 is very able to cope, how well can you cope with problem or situation you are dealing with?

0	1	2	3	4	5	6	7

Can't cope at all Very able to cope

16. On a scale of 0 – 7, where 0 is completely unable to deal and 7 is extremely able to deal, how well can you deal with the problem or situation you are facing?

0	1	2	3	4	5	6	7

Completely unable to deal Very able to deal

That is all for the 0 – 7 rating scales. Thank you so much for sharing this information with us.

We'd like to ask you some more questions about how you are feeling in general. This part of the survey is totally optional and will take another 5 - 10 minutes. Again, the counsellor will not be able to see your responses. This part of the survey will help us to understand the mental health symptoms (for example, of depression or anxiety) of our chatters.

Are you okay to do the rest of the survey? a. Yes b. No

- If yes – continue to YSR portion of the survey.
- If no – No problem! Have a good chat with the counsellor.

[Insert YSR questions here.]

Thank you again for sharing this information with us. When you are done chatting with a counsellor, you'll be asked to give us some feedback about how the chat went and answer a few more questions. If you have any questions about the research, remember that you can email us at research@kidshelpphone.ca.

Chat Counselling Client Questionnaire (Informed Consent – post-counselling)

We *really* appreciate your taking the time to give us feedback.

We'd like to ask you to answer some questions about your experience with our chat counselling service. If you did a survey with us before chatting, you'll see that we ask some of the same questions and some different ones. We will use everyone's answers to help us understand and look at ways to improve this service. This is not a test; there are no right or wrong answers. Your participation is voluntary and you may stop at any time.

Your answers are totally anonymous. We will not ask for any identifying information about you. The counsellor you chatted with will not see your answers. The survey will take about 10 minutes.

There are no expected risks for your participation, but if there are any questions you don't want to answer just ask to skip them. If, for any reason, you don't want to do the survey any more, you can just close your browser window. If you do that before finishing the survey, we won't use your survey in our research. We will post general findings on the Kids Help Phone teen website in the fall if you want to find out what we learned. And just so you know, we keep all our data on a password-protected hard drive in our national office. After 7 years, we put it into long-term storage.

This research has been approved by the York University Human Participants Review Subcommittee.

If you have questions about the research, you can email the lead researcher at research@kidshelpphone.ca – Her name is Dilys and she is monitoring the email address right now. So you'll get a response in just a few minutes. You will remain anonymous if you contact this email address.

Or if you prefer, you can contact Ms. Alison Collins-Mrakas, Manager, Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail acollins@yorku.ca). Please note that this is not an anonymous telephone line or email.

Do we have your permission to do the survey with you? a. Yes b. No

- If yes – proceed with text
- If no – No problem. Have a good night.

One more thing before we start: We'd like to look at what counsellors do right when young people tell us that counselling was helpful and what they do not-so-well when young people tell us that counselling didn't help. To do that, a researcher would need to review your chat. Chats are normally kept for 6 months then destroyed after the counsellor receives supervision from their clinical manager. But if a researcher is going to review the chat, it needs to be saved for up to 2 years. The chats we save for research are stored on an encrypted hard drive in our national office. After 2 years, we archive this data in our national office.

Are you okay with the researcher reviewing the counselling session to look at what the counsellor does well and not-so-well? a. Yes b. No

I'm going to ask you to rate some of your feelings and experiences using a scale from 0 – 7. All of these questions are about how you are doing NOW THAT YOU'VE SPOKEN TO A COUNSELLOR.

1. On a scale of 0 – 7, where 0 is not at all upset and 7 is extremely upset, how do you feel right now?

0 1 2 3 4 5 6 7

Not at all upset Extremely upset

2. On a scale of 0 – 7, where 0 is no emotion and 7 is extreme emotion, how strongly are you feeling your emotions right now?

0 1 2 3 4 5 6 7

No emotion Extreme emotion

3. On a scale of 0 – 7, where 0 is not at all stressed and 7 is extremely stressed, how stressed out are you right now?

0 1 2 3 4 5 6 7

Not at all stressed Extremely stressed

4. On a scale of 0 – 7, where 0 is not at all and 7 is completely, how much would this problem or situation affect your life if you don't get some help for it?

0 1 2 3 4 5 6 7

Not at all Completely

5. On a scale of 0 – 7, where 0 is completely alone and 7 is not at all alone, how alone do you feel in dealing with the problem or situation you are facing?

0 1 2 3 4 5 6 7

Completely alone Not at all alone

6. On a scale of 0 – 7, where 0 is I feel like I can't talk to anyone and 7 is I feel like there are lots of people I can talk to, how much do you feel like you can talk to people other than Kids Help Phone about your problem or situation?

0 1 2 3 4 5 6 7

I can't talk to anyone else There are lots of people I can talk to

7. On a scale of 0 – 7, where 0 is not at all aware and 7 is very aware, how aware are you of any personal strengths or resources you have that will help you to deal with the problem or situation you are facing?

0 1 2 3 4 5 6 7

I don't know of any personal strengths that will help I definitely have personal strengths that will help

8. On a scale of 0 – 7, where 0 is not at all difficult and 7 is extremely difficult, how difficult is the problem or situation for which you need help?

0	1	2	3	4	5	6	7

Not at all difficult — Extremely difficult

9. On a scale of 0 – 7, where 0 is no help and 7 is a lot of help, how much help do you need to move forward with your problem or situation?

0	1	2	3	4	5	6	7

No help — A lot of help

10. On a scale of 0 – 7, where 0 is the easiest problem and 7 is the hardest problem you've ever dealt with, how hard is the problem you are calling about?

0	1	2	3	4	5	6	7

Easiest problem — Hardest problem

11. On a scale of 0 – 7, where 0 is not clear at all and 7 is extremely clear, how clearly can you see what the problem or situation is that you need to deal with?

0	1	2	3	4	5	6	7

Not at all clear — Really clear

12. On a scale of 0 – 7, where 0 is very easy and 7 is very hard, how easy or hard is it for you to put your problem or situation into words right now?

0	1	2	3	4	5	6	7

Very easy — Very hard

13. On a scale of 0 – 7, where 0 is having no idea and 7 is having a strong idea, how much do you know what to do about your problem or situation right now?

0	1	2	3	4	5	6	7

No idea — Strong idea

14. On a scale of 0 – 7, where 0 is not at all capable and 7 is extremely capable, how capable are you of dealing with this problem or situation?

0	1	2	3	4	5	6	7

Not at all capable — Extremely capable

15. On a scale of 0 – 7, where 0 is can't cope at all and 7 is very able to cope, how well can you cope with problem or situation you are dealing with?

0	1	2	3	4	5	6	7

Can't cope at all — Very able to cope

16. On a scale of 0 – 7, where 0 is completely unable to deal and 7 is extremely able to deal, how well can you deal with the problem or situation you are facing?

0	1	2	3	4	5	6	7
Completely unable to deal							Very able to deal

17. What sexual orientation do you best identify with?

a. Gay/Lesbian
b. Straight/heterosexual
c. Bisexual
d. Asexual
e. Questioning
f. Other: _____________________
g. Don't know

18. Who do you live with?

a. Parent(s)
b. Other adult family member, no parents
c. Foster care
d. Group home
e. Homeless/street involved
f. Peers, with their parent(s)
g. Peers or siblings, with no parent(s)
h. Don't know

19. How long has your family been in Canada?

a. I was born outside of Canada
b. I was born in Canada; both my parents were born outside of Canada
c. I was born in Canada; one of my parents was born in Canada and one was not
d. I was born in Canada; both my parents were born in Canada; 3 or 4 of my grandparents were born outside of Canada
e. I was born in Canada; both my parents were born in Canada; at least 2 of my grandparents born in Canada [3rd Generation + Client]

20. What is your first language? _____________________________

21. Are any other languages are spoken at home? _____________________________

22. People are often described as belonging to different racial, ethnic, or cultural groups, for example, Filipino, Jamaican, English, or Inuit. To which ethnic or cultural group(s) do you see yourself as belonging? [Choose as many as apply to you.]

a. Canadian

b. British

c. French

d. Quebecois

e. First Nations, Aboriginal or Metis

f. White, European or Caucasian

g. South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)

h. Asian (e.g., Korean, Chinese, Japanese)

i. Black (e.g., African or Caribbean descent)

j. South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)

k. West Asian to Middle Eastern (Armenian, Egyptian, Iranian, Lebanese)

l. Latin American (e.g., Mexican, South American, Central American)

m. Other (please specify):_________________

n. Don't know

23. People sometimes belong to different religious or spiritual groups, or see themselves as believing in a certain religion or spiritual philosophy. Which religious or spiritual beliefs are parts of your identity? [Choose as many as apply to you.]

a. Christianity
b. Judaism
c. Muslim
d. Hindu
e. Atheist
f. Agnostic
g. Other: _______________

We're almost done! The rest of the survey will only take a few more minutes. Thanks for hanging in there with us! These questions are about your relationship with Kids Help Phone.

24. Approximately how many times have you contacted Kids Help Phone using the phone, chat, or "Ask Us Online"? ____

25. Approximately how many times have you contacted Kids Help Phone using the phone?
____

26. How long ago was the first time you contacted Kids Help Phone?
____

27. What is your preferred way to contact Kids Help Phone?

a. Telephone
b. Chat
c. Ask Us Online
d. No preference

Why did you choose chat today?

____

28. Think about the problem or situation that prompted you to contact Kids Help Phone. Did you talk to anyone else about this problem or situation before you chatted?

a. No
b. Yes

- If yes, to whom?

a. Friend/peer
b. Sibling

c. Parent/ guardian/ adult family member
d. Teacher/ school guidance counsellor
e. Faith-based support/leader
f. Family doctor
g. Social or health service professional (social worker, public health nurse)
h. Counsellor/ therapist
i. Psychologist
j. Psychiatrist
k. Other supportive adult
l. Other: ______________________
m. Don’t know

29. Have you ever gone to see a professional counsellor or therapist?

a. Yes, in the past
b. Yes, currently
c. No
d. Don’t know/couldn’t answer
e. Client chose not to answer
- If yes, for what problem/situation? _______________________________

30. Are you currently on a waiting list for professional counselling or therapy?

a. No
b. Yes
- If yes, how long have you been on a wait list? _______________________________

31. Do you now have or have you previously had a mental health diagnosis?

a. No
b. Yes
- If yes, what is/was the diagnosis? _______________________________

32. What problem or situation did you contact Kids Help Phone about today? (Qualitative response groups into the following categories.)

a. Bullying/harassment

What is the client's role?	**What is the type of bullying?**
Target	Verbal
Bystander	Physical
Bullying behaviour	Social/exclusion
	Cyber/online exploitation
	Cyber-sexting

b. Emotional abuse

Acquaintance	Online stalking	Other adult	Other family	Parent/guardian
Peer	Self	Stalking	Stanger	undisclosed

c. Family relationships

Domestic violence	Family change – moving
Family change – remarriage/blending families	Family change – separation/divorce/custody
Neglect	Other
Parent/guardian – absence	Parent/guardian – cultural differences/conflicts
Parent/guardian – expectations to succeed	Parent/guardian – getting along/communication
Siblings	

d. Legal info/independent living

Other	Child welfare or justice system information
Employment and employment supports	Financial information or supports
Food	Homelessness
Housing	Involved with social services
Leaving home/moving/emancipation	Online privacy

e. Mental/emotional health

Anxiety	Concern for others MH/EH	Depression	Disordered eating
Grief and loss	Mood disorder	Personality disorder	Psychosis
Self-care	Self-esteem	Self-injury	Traumatic incident/symptoms

f. Peer relationships

Breakup	conflict	Dating/love	Making friends	Online interactions	Other	Peer pressure

g. Physical health

Concern for other's physical health	Health and nutrition	Illness/medical related
Living with special needs	Menstruation	Physical disability

h. Physical violence/abuse

Acquaintance	Other adult	Other family	Parent/guardian	Partner
Self	Sibling	Stranger	undisclosed	

i. School

Academic problems	Not attending/dropping out	Organization/time management	Other
Planning for the future	School transitions	Social/behavioural problems with teachers/peers	Stress management

j. Sexual health

Age of consent	Contraception/STIs	Development/puberty	Pregnancy/abortion	Prostitution	Sexual activity

k. Sexual orientation/gender identity

Coming out	Discrimination(homo/transphobia)	Finding a community	Finding partner/relationships
Transitioning	Other	Questioning/identification	

l. Sexual violence/abuse

Perpetrator?	Parent/guardian	Sibling	Other family	Other adult	
Partner	Peer	Acquaintance	Stranger	Self	undisclosed
Type?	Sexual abuse	Sexual assault	Sexual interference	Sexual harassment	
Witness to sexual violence/abuse					

m. Self and social identity

n. Substance use, misuse, or addictions

Alcohol	Concern for other's problem	Experimentation with alcohol/drugs	Illegal drugs
Internet or gaming	Other	Pornography	tobacco

o. Suicide/suicide related

Friend/child in community	Other family/adult	Parent/guardian	Partner	Self-ideation/attempt

p. Thank-you
q. Complaint
r. Information about KHP
s. Graduated caller
t. Adult – above age of service
u. Other ________________________
v. Client chose not to answer

33. What did you want to get out of your call with a counsellor today?

____
____
____
____

When you think back was what you wanted:

a. Issue-based (I wanted to deal with my problem or issue, problem-solve, or come up with a plan/solution.)
b. Emotional processing or emotional management (I needed to talk, get support, deal with my feelings.)
c. Other (information about KHP, etc…) _____________________________________

34. Did your counsellor suggest you speak with an adult support or community-based agency?

g. Yes, adult
h. Yes, agency
i. Yes, both
j. No
k. Not sure
l. Client chose not to answer

35. Do you plan to follow up?

g. Yes, adult
h. Yes, agency
i. Yes, both
j. No
k. Not sure
l. Client chose not to answer

36. Would you contact Kids Help Phone again if you needed help?

c. No

d. Yes

37. Would you recommend Kids Help Phone to a friend?

c. No

d. Yes

38. Is there anything else you would like us to know in general or about how to make our chat service beter?

____

____

Kids Help Phone Marketing Research Questions (not attached to the proposed study but included in the questionnaires)

39. Is any member of your family in the military?

- c. No
- d. Yes
- ● If yes, whom? ______________________________

40. [Did youth identify as LGBT?]

- c. No
- d. Yes
- ● *If yes, think about the past month:* Have you been bullied and/or harassed in the past month?
- c. No
- d. Yes
- ● If yes, about how often? ______________________________
- ● If yes, do you perceive the bullying to be related to your LGBT identity or unrelated? ______________________________

41. *(For chat only)* Did/will you save a copy of your chat?

a. No

b. Yes

42. Have you ever reread a chat?

a. No

b. Yes

● If yes, why? ______________________________

Appendix B

Evidence of Mental Health Symptoms Scale for Adolescents (EMMSS-A)

Syndrome Category	Item # on YSR	Item
Anxious Depressed	14	Cries a lot
	29	Fears
	30	Fears school
	31	Fears doing bad
	32	Must be perfect
	33	Feels unloved
	35	Feels worthless
	45	Nervous, tense
	50	Fearful, anxious
	52	Feels too guilty
	71	Self-conscious
	91	Talks or thinks of suicide
	112	Worries
	81*	Hurt when criticized
	106*	Anxious to please
	108*	Afraid to make mistakes
Withdrawn Depressed	5	Enjoys little
	42	Rather be alone
	65	Refuses to talk
	69	Secretive
	75	Shy, timid
	102	Lacks energy
	103	Sad
	111	Withdrawn
Somatic Complaints	47	Nightmares
	51	Feels dizzy
	54	Overtired
	56a	Aches, pains
	56b	Headaches
	56c	Nausea
	56d	Eye problems
	56e	Skin problems
	56f	Stomachaches
	56g	Vomiting
	49**	Constipated
Social Problems	11	Too dependent
	12	Lonely
	25	Doesn’t get along
	27	Jealous
	34	Others out to get him/her

	36	Accident-prone
	38	Gets teased
	48	Not liked
	62	Clumsy
	64	Prefers younger kids
	79	Speech problems
Thought Problems	9	Can't get mind off thoughts
	18	Harms self
	40	Hears things
	46	Twitching
	58	Picks skin
	66	Repeats acts
	70	Sleeps less
	76	Sleeps less
	83	Stores things
	84	Strange behavior
	85	Strange ideas
	100	Trouble sleeping
	59**	Sex parts in public
	60**	Sex parts too much
	92**	Sleep talks/walks
Attention Problems	1	Acts young
	4	Fails to finish
	8	Can't concentrate
	10	Can't sit still
	13	Confused
	17	Daydreams
	41	Impulsive
	61	Poor schoolwork
	78	Inattentive
	80	Stares blankly
	2*	Odd noises
	7*	Brags
	15*	Fidgets
	22*	Difficulty with directions
	24*	Disturbs others
	49*	Difficulty learning
	53*	Talks out of turn
	60*	Apathetic
	67*	Disrupts discipline
	72*	Messy work
	73*	Irresponsible
	74*	Shows off
	92*	Underachieving
	93*	Talks too much

	100*	Fails to carry out tasks
	109*	Whining
Rule Breaking Behavior	2	Drinks alcohol
	26	Lacks guilt
	28	Breaks rules
	39	Bad friends
	43	Lies, cheats
	63	Prefers older kids
	67	Runs away
	72	Sets fires
	73	Sex problems
	81	Steals at home
	82	Steals outside home
	90	Swearing
	96	Thinks of sex too much
	99	Uses tobacco
	101	Truant
	105	Uses drugs
	106	Vandalism
	98*	Tardy
Aggressive Behavior	3	Argues a lot
	16	Mean to others
	19	Demands attention
	20	Destroys own things
	21	Destroys others things
	22	Disobedient at home
	23	Disobedient at school
	37	Gets in fights
	57	Attacks people
	68	Screams a lot
	86	Stubborn, sullen
	87	Mood changes
	88	Sulks
	89	Suspicious
	94	Teases a lot
	95	Temper
	97	Threatens others
	104	Loud
	6*	Defiant
	76*	Exploitative
	77*	Easily frustrated

*specific to TRF
**specific to CBCL

Appendix C

<u>Collaborative Interactions Scale– Patient Utterances</u>

Patient Utterances	
Direct Rupture Marker (DRM)	Patient expresses a resentment or dissatisfaction in regard to the therapist or some aspect of the therapy process in an aggressive and accusatory fashion.
DRM0	Non-specific (all other DRMs must be ruled out)
DRM1	Patient doesn't agree with therapist about therapy tasks or goals.
DRM2	Patient criticizes therapist as a person or for his/her competence.
DRM3	Patient strongly refuses a therapist intervention or feels uncomfortable.
DRM4	Patient complains about lack of progress.
DRM5	Patient doubts about current session.
DRM6	Patient doubts about being in therapy.
DRM7	Patient complains about parameters of therapy (e.g., session time).
DRM8	Patient doubts about feeling better.
DRM9	Patient is sarcastic toward therapist.
Indirect Rupture Marker (IRM)	Patient indirectly expresses a form of emotional disengagement from the therapist, from some aspect of the therapy process, or from his/her internal experience.
IRM0	Non-specific (all other IRMs must be ruled out)
IRM1	Patient talks in wordy manner and/or spends inordinate amount of time talking about other people and their doings or overly elaborates nonsignificant stories and so on.
IRM2	Patient changes topic or tangentially answers to therapist intervention.
IRM3	Patient short answers to therapist open question.
IRM4	Patient denies evident feeling state (e.g., anger, fear, shame).
IRM5	Patient intellectualizes about his/her inner experience.
IRM6	Patient alludes to negative sentiments or concerns about therapeutic relationship through a thematically linked discussion of out-of-session events or relationships
IRM7	Patient interacts in an acquiescent manner.
IRM8	Patient uses self-enhancing strategies or self-justifying statements.
IRM9	Patient is self-critical or self-blaming.
Collaborative Process (CP)	The utterance is not rated as a DRM or IRM.
CP0	Non-specific (all other CPs must be ruled out)
CP1	Patient talks about new significant fact, introduces a topic or elements within a topic.
CP2	Patient talks about his/her feelings and/or thoughts, makes clear intensity or quality of his/her feelings or attitude.
CP3	Patient talks about meaning of events or connects topic to a topic or to a schema, etc.

Collaborative Interactions Scale – Therapist Utterances

Negative Interactions (NI)	Therapist intervention has negative emotional content (i.e., aggressive), does not focus on the concrete experience of the patient (i.e., intellectualization), or lacks clarity (i.e., vague).
NI0	Non-specific (all other NIs must be ruled out)
NI1	Therapist seems to impose his/her worldview or gives unwanted advice.
NI2	Therapist seems to compete with patient.
NI3	Therapist seems to press patient on specific topic.
NI4	Therapist seems doubtful about strategies.
NI5	Therapist changes offhand topic.
NI6	Therapist intellectualizes or is not focused on patient experience.
NI7	Therapist talks in technical jargon.
NI8	Therapist is hostile.
Positive Interventions (PI)	Therapist intervention is emotionally attuned, focuses on concrete experience, and clear.
PI0	Non-specific (all other PIs must be ruled out)Q
PI1	Therapist focuses on the here and now of the relationship.
PI2	Therapist explores different patient states.
PI3	Therapist provides a feedback to the patient.
PI4	Therapist suggests a patient emotion.
PI5	Therapist believes that patient is indirectly talking about relationship.
PI6	Therapist furnishes an empathic sustain to patient.
PI7	Therapist makes a clarification.
PI8	Therapist makes a confrontation.
PI9	Therapist admits his/her participation in rupture process.
PI10	Therapist self-discloses countertransference feelings.
PI11	Therapist explains or redefines tasks/goals of therapy.
PI12	Therapist makes an interpretation.

Appendix D

English Translations of French Chat Excerpts

Chat<Internals\\x13712133>

Youth: Of my life as a whole... I do not know if I have depression ... a lot of people around me think I do..

I think of suicide constantly... It becomes a daily occurrence

Chat<Internals\\x13735309>

Youth: More simply there are days where I just want to leave... I have already talked to my parents and they labelled me as mentally ill

Now I have just the impression that I am better to keep everything to myself, even if it is hard

Counsellor: Where do you want to go?

Youth: To the other side

Chat<Internals\\x13769398>

Youth: My second brother has stolen money from my father because he is in the red and he tried to commit suicide then.