

RESEARCH ARTICLE

“Live Chat” Clients at Kids Help Phone: Individual Characteristics and Problem Topics

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Abstract

Objective: Young people in Canada prefer to use the Internet over face-to-face contact when seeking help for problems of daily living and mental health problems. Kids Help Phone (KHP) provides on-demand, anonymous help to young people via telephone and *Live Chat* technologies. **Methods:** Two hundred thirty-two phone clients and 230 *Live Chat* clients responded to a questionnaire at this otherwise anonymous service, providing previously inaccessible data about their individual characteristics and characterizations of the problems for which they sought help. **Results:** There was a larger proportion of weighty problems (mental health and suicide) among chatters than callers. There were also more non-heterosexual youth, and those who identified as Asian and Black African or Caribbean, using *Live Chat* than phone. **Conclusions:** Implications for training *Live Chat* counsellors to respond effectively to chatters are discussed.

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

Résumé

Objectifs: Les jeunes gens du Canada préfèrent utiliser Internet plutôt que des contacts en personne quand ils cherchent de l'aide pour des problèmes de la vie quotidienne ou de santé mentale. Jeunesse, J'écoute offre aux jeunes sur demande une aide anonyme par téléphone ou par les technologies du clavardage en direct. **Méthodes:** Deux cent trente-deux clients par téléphone et 230 clients par clavardage direct ont répondu à un questionnaire à ce service néanmoins anonyme, et ont fourni des données auparavant inaccessibles sur leurs caractéristiques individuelles et les caractérisations des problèmes pour lesquels ils ont cherché de l'aide. **Résultats:** Il y avait une proportion plus importante de problèmes graves (santé mentale et suicide) chez les adeptes du clavardage que chez ceux du téléphone. Il y avait également plus de jeunes non hétérosexuels et de jeunes s'identifiant comme étant asiatiques ou noirs africains ou caribéens qui utilisaient le clavardage plutôt que le téléphone. **Conclusion:** Les implications pour la formation des conseillers du clavardage afin de répondre efficacement aux jeunes sont présentées.

Mots clés: consultation par téléphone, cyber-consultation, communication virtuelle, recherche d'aide, adolescence

Seventy percent of mental health problems have their onset in childhood or adolescence (Government of Canada, 2006). Although 1.2 million young people in Canada are affected by mental illness, less than 20% will receive appropriate treatment (Mental Health Commission of Canada, 2013). Adolescents in Canada make frequent use of emerging technologies (Steeves, 2014) and prefer to seek

help using the Internet rather than face-to-face (Greidanus, 2010), especially when seeking information or help about mental health (Rasmussen-Pennington, Richardson, Garinger & Contursi, 2013).

Kids Help Phone (KHP) is Canada's only professional, single-session, on-demand, free, bilingual, anonymous, and confidential counselling service available to any young

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person with phone or Internet access. KHP provides counselling and referrals to young people for any problems they chose to discuss. Telephone services are available 24 hours a day, seven days a week; however, the time-synchronous instant messaging service, *Live Chat*, is available only five days a week from 6 pm to 2 pm Eastern Time (ET). KHP guards confidentiality and does not trace phone calls or IP addresses. Counsellors are trained to prevent clients from disclosing identifying information before fully explaining their duty-to-report to ensure that young people retain control of their personal information and decisions that may occur as a result of them any situations wherein their safety is compromised. The 'KHP Promise' of anonymity and confidentiality is central to this organization's identity because young people cite fear of lack of confidentiality with adults that may result in unwanted trouble as a barrier to seeking help from them (Gilchrist & Sullivan, 2006; Coker et al., 2010).

Potentially marginalized groups experience barriers to seeking help for commonplace problems and more serious mental health problems that are not experienced by socially privileged peers. Gender and sexual orientation are risk factors with female, transgender, and non-heterosexual youth experiencing greater effects of marginalization than male or heterosexual youth (Jiwani, 1998; Caragata, 2003; D'augelli, Grossman & Starks, 2008; Lehmillier, 2012). Ethno-cultural identification and socioeconomic status (SES) are often inter-related risks for mental health problems and threats to well-being (Simich, Matier, Moorlag & Ochocka, 2009; Steele, Glazier & Lin, 2006). Of particular concern in Canada are Aboriginal youth (Smith, Varcoe & Edwards, 2005) as well as immigrant and first-generation youth (Hansson, Tuck, Lurie & McKenzie, 2012).

Objective

Young people make frequent use of Internet services for help seeking (Rasmussen-Pennington et al., 2013; KHP, 2009). The focus of this study was on understanding the characteristics of clients who choose to seek help using *Live Chat* compared to those who use the telephone. Because the concerns of clients who reach out via the Internet on child helplines are often more serious than those received on the telephone (Child Helpline International, 2005) and potentially marginalized groups may experience barriers to seeking help not experienced by dominant culture peers, we were interested in exploring the problem topics and individual characteristics of both groups.

Methods

This study was part of a larger service evaluation conducted within Kids Help Phone. The research was approved by the York University research ethics board.

Sample

Two hundred and thirty-two telephone clients and 230 *Live Chat* clients were surveyed immediately before and after counselling at KHP from May to September, 2014 during the hours that *Live Chat* was available. Telephone clients heard a pre-recorded message and *Live Chat* clients read a message inviting them to participate in the pre-counselling portion of a questionnaire. Subsequently, both groups of clients were invited by counsellors at the end of their contacts to participate in the post-counselling portion of the questionnaire. Telephone clients could complete both parts after their counselling sessions if they had not participated before counselling. This make-up function was not available for Internet clients, due to limitations with the technology. Clients under 12 and those in crisis or with a plan for immediate safety at the end of their counselling sessions were not invited to participate. Self-selection combined with the anonymity of the service did not allow for calculation of true representativeness of the sample; however, when compared to available KHP service data, the sample was representative in terms of clients' age, province/territory, gender, and community size. Any contact suspected of being a prank was removed from the dataset.

Measures

Counselling Client Questionnaire 2

Participants gave informed consent and responded to the Counselling Client Questionnaire, version 2 (CCQ-2) (Hanner, 2015). The CCQ-2 contains demographic questions, and questions about connections to other supports. The CCQ-2 was administered in real time by research assistants on the phone and was administered electronically on *Live Chat*. Because participants were permitted to skip any questions they did not wish to answer; sample sizes varied across analyses and are provided for each result.

Objective Appraisal of Risk Level

Two undergraduate and one Master's level research assistants coded call recordings and chat transcripts for objective risk level (Haner, 2010). To qualify for a high-risk classification, counselling conversations had to contain explicit evidence that the client was dealing with any of eight risk factors: a formal mental health diagnosis, imminent suicide risk, active self-harm, serious medical condition or disability, pregnancy, violence or abuse, poverty, or street involvement. A medium-risk classification was given if conversations contained implicit evidence of the client experiencing these risk factors or explicit evidence that a close friend or family member was living with one of the risk factors (except an adult family member dealing with pregnancy). A low-risk classification was given if there was no evidence of any of the risk factors.

Table 1. Sexual orientation of phone and chat participants

Orientation	Phone (n = 226)		Chat (n = 153)	
	n	%	n	%
Gay/lesbian	9	4.0	13	8.5
Straight/heterosexual	179	79.2	98	64.1
Bisexual	19	8.4	14	9.2
Asexual	3	1.3	2	1.3
Questioning	4	1.8	20	13.1
Identify differently	12	5.3	6	3.9

Table 2. Frequencies of participants with various racial, ethnic or cultural identities

Identity	Phone (n = 212)		Chat (n = 152)		Statistics Canada
	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 African or Carribean	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.
 *Significant at p < .0005.
 **Significant at p < .005
 ***Significant at p < .05

Results

Demographic Factors

The majority of clients were older adolescents: 17.6% of chatters and 16.5% of callers identified themselves as middle-school aged (12 and 13 years) whereas 65.7% of chatters and 56.6% of callers identified themselves as high-school aged (14 to 17 years old). Additionally, 17.7% (chatters) and 26.9% (callers) identified themselves as emerging adults. Although not technically adolescents, these participants were included in this study because emerging adulthood can be seen as an extension of adolescence (Arnett, 2000; 2006). The proportion of high-school aged participants who chose *Live Chat* was significantly greater than the proportion who chose the phone ($z = 2.502, p = .01242$).

Of the 230 chat clients who responded to the gender question, 24 identified as male, 201 as female, and five outside

of the gender binary. Of the 229 phone clients who responded, 53 identified as male, 169 as female, and seven outside of the gender binary. Those who identified outside of the gender binary used terms such as “transgender,” “gender-queer,” “genderfluid,” “pangender,” and “bigender.” There was a significantly larger proportion of male youth who chose the phone than who chose *Live Chat* ($z = 3.644, p = .00028$).

Table 1 displays the sexual orientations of participants: 35.9% of chatters and 20.4% of callers identified with non-heterosexual orientations. There was a larger proportion of non-heterosexual participants in the chat sample than in the phone sample ($z = 3.346, p = .00084$).

Table 2 displays the ethno-cultural identities of participants alongside Statistics Canada (2011) ethnic origins data. The majority identified with dominant Caucasian, western European, Canadian, or Québécois cultures (67.8% chatters,

Table 3. Frequencies of problem topics selected by phone and chat participants				
Problem topic	Phone (n = 219)		Chat (n = 153)	
	f	%	f	%
Bullying/harassment	9	4.1	6	3.9
Emotional abuse	2	0.9	7	4.6
Family relationships	32	14.6	15	9.8
Legal information and independent living	11	5.0	2	1.3
Mental/emotional health	44	20.1	39	25.5
Peer relationships	55	25.1	15	9.8
Physical health	0	0	2	1.3
Physical violence/abuse	5	2.3	1	0.7
School	12	5.5	3	2.0
Sexual health	10	4.6	4	2.6
Sexual orientation/ gender identity	4	1.8	7	4.6
Sexual violence/abuse	2	0.9	3	2.0
Self and social identity	5	2.3	2	1.3
Substance use, misuse, or addictions	6	2.7	2	1.3
Suicide/suicide related	10	4.6	23	15.0
Other	12	5.5	22	14.4

67.9% callers). Potentially marginalized groups were over-represented on the phone (South East Asian) and on *Live Chat* (Asian, Black African or Caribbean).

There were no statistically discernable differences between *Live Chat* and phone groups in terms of generational status; however, when immigrant and 1st generation participants were considered together as ‘newcomers,’ this group was overrepresented in both the *Live Chat* sample ($z = 9.3477, p < .0001$) and phone sample ($z = 12.581, p < .0001$).

Topic of Contact

Participants were asked to categorize the primary problems for which they sought help using the categorization scheme used by counsellors. Frequencies of topics reported are included in Table 3. “Suicide/suicide related” and “mental/emotional health” topics were combined and renamed “weighty topics.” Sixty-two of 152 chatters and 54 of 219 callers categorized their problems as weighty topics, indicating that a significantly larger proportion of chatters sought help for weighty topics than callers ($z = 3.2504, p = .000116$).

Connection to Other Supports

Participants were asked if they had spoken to anyone else about their problem before contacting KHP. Of the 157 chatters who responded, 97 (61.8%) had spoken to someone else. Of the 224 callers who responded, 133 (59.4%)

had spoken to someone else. Of those participants that had spoken to someone else about their issue before contacting KHP, most had spoken to a friend/peer (63.2% *Live Chat*, 58.8% phone) or sibling (62.0% *Live Chat*, 53.0% phone), followed by an adult family member (29.9% *Live Chat*, 34.6% phone). Chatters were significantly more likely to have spoken to someone perceived as a helping professional such as counsellors or therapists (13/97 vs. 4/138, $z = 3.2455, p = .00116$), social or health services providers (13/97 vs. 4/138, $z = 2.9755, p = .00288$), teachers or school guidance counsellors (16/97 vs. 5/133, $z = 3.3114, p = .00094$), psychologists (10/97 vs. 0/133, $z = 0.00016, p = .00016$), or psychiatrists (7/97 vs. 0/133, $z = 3.1463, p < .00005$).

In terms of having any previous formal mental health supports, of the 150 chatters who responded, 23.3% had previous contact, 6.7% had previous contact and were on a wait list, 13.3% had current contact, 5.3% had current contact and were on a wait list, and 0.7% were on a wait list only. Of the 222 phone participants who responded, 29.3% had previous contact, 6.3% had previous contact and were on a wait list), 24.3% had current contact, and 3.6% had current contact and were on a wait list. Whereas 33.3% of callers reported having never had formal mental health support, 50.7% of chatters reported the same. This difference was statistically discernable ($z = 2.8418, p < .00452$).

Participants were asked, “Do you now or have you previously had a mental health diagnosis? If yes, what is/was the diagnosis? Who gave it to you?” Only diagnoses provided by a psychologist or medical doctor were considered valid. Of the 154 chatters who responded, 37 (24.03%) reported a valid mental health diagnosis whereas 77 of 221 callers (34.8%) reported the same. Diagnoses included mood, anxiety, and personality disorders.

Risk Level

Ninety-two audio recordings and 120 *Live Chat* transcripts for which participants gave consent for review were retrieved. Of these contacts, 26 (28.3%) callers and 36 (30.0%) chatters were categorized as high-risk, 21 (22.8%) callers and 34 (28.3%) chatters were medium risk. There was a larger proportion of callers categorized as medium-risk because of having a friend or family member with a high-risk factor ($z = 2.9556, p = .00308$) and a larger proportion of chatters with the medium-risk factor of being suggestive of a formal mental health diagnosis ($z = -2.853, p = .00438$).

Whereas many callers were explicit about being formally diagnosed with mental health problems, fewer chatters discussed symptoms but did not mention a formal diagnosis. The following excerpts from two *Live Chat* transcripts highlight some of their mental health struggles:

Youth 1: 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 quotidien

Youth 2: Plus simplement y'a des jours où j'ai juste envie de partir... J'en avais déjà parlé 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 2: De l'autre côté

Discussion

We wanted to deepen our understanding of young people who use *Live Chat* and how they differ from telephone clients. A larger proportion of adolescents chose *Live Chat* over the phone, indicating a preference for emerging technologies. Certain potentially marginalized groups including sexual minority youth and those who identify outside of the dominant culture were also overrepresented in the *Live Chat* sample. Young people who identified as non-heterosexual preferred *Live Chat* to the phone (35.9% vs. 20.4%) and were represented in larger numbers than would be expected given their representation in the Canadian population (National Post, 2012). Non-heterosexual young people are at greater risk for mental health problems than their heterosexual peers (Williams & Chapman, 2011) and it may be

that issues reflecting their experiences of marginalization drive them to seek help at greater rates. Their preference for chat may reflect a need for increased privacy, given the risk of being overheard on the phone by family members from whom they fear stigma or even violence in response to their sexuality (D'Augelli et al., 2008).

There were more Asian and Black African or Caribbean young people using *Live Chat* than expected; however, given the small size of the subsamples, these data should be interpreted cautiously. The high proportion of ethnically diverse clients may suggest a need for cultural competency training for *Live Chat* counsellors because clues to clients' cultural membership (e.g., physical dress, accent, mannerisms) are largely absent in this medium. Given the importance of delivering culturally sensitive and safe therapeutic interventions (Arthur & Januszkowski, 2001; Collins & Arthur, 2007), it is important that *Live Chat* counsellors develop ability and ease in inquiring about cultural identities using this technology.

Although there were not significant differences in the risk levels associated with *Live Chat* and phone clients, chatters more often discussed weighty problems such as mental health and suicide. Chatters were less likely than callers to have ever had contact with a formal mental health service; however, they were more likely to have discussed the problem for which they sought help from KHP with a helping professional. These results lend support to the finding that topics discussed on *Live Chat* are often of a more serious nature than on the phone (CHI, 2005). Providing young people with anonymous and free counselling services they can access privately from their smartphones gives them a lifeline when dealing with mental health crises such as suicidal ideation (three of 36 high-risk chatters) or self-harm episodes (17 of 36 high-risk chatters). This service can provide them with professional support when on a waiting list or struggling to cope between appointments. It is likely that more chatters were dealing with a diagnosable mental health problem than reported formal diagnoses. Several chatters disclosed intense suicidal feelings and were considering self-harm. Several chatters used the words “depression,” “anxiety,” “eating disorder,” “and borderline personality,” but formal diagnoses were not confirmed. One client discussed symptoms consistent with psychosis. These results highlight the mental health struggles of *Live Chat* clients as being potentially more frequent and more severe than those of callers in general. They also highlight the need for *Live Chat* counsellors to manage the frequency and intensity of these weighty issues using a medium that is associated with more ambiguous communication than the phone. This challenge is important to highlight in training counsellors, as people dealing with depression or anxiety may be especially sensitive to cognitive distortions (Beck, 1976; 2008) and therefore likely to misinterpret neutral or positive typed communication as negative without vocal cues to suggest warmth of tone or positivity.

Limitations

Because of counsellor involvement in recruitment, clients in crisis or struggling with severe problems, as well as dissatisfied clients may be underrepresented in this sample. There were differences in the methods across the two service media: whereas live research assistants could assist phone participants with the response demands of the questionnaire, there was no support available for *Live Chat* clients, which may account for the small response sets for certain questions.

Conclusion

The use of emerging technologies in counselling and psychotherapy is increasing (Ritterband et al., 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 suggest that chatters are more likely than callers to be sexual minorities, Asian, or Black African or Caribbean in their personal identities. Chatters are also more likely to contact KHP for weighty problems such as mental health or suicide. Although they are less likely to have formal mental health supports in general, they are more likely to have already spoken to a helping professional about the issues for which they were seeking help. These findings suggest that counsellors must be prepared to overcome the limits of text-based communication to inquire about identity issues and work with clients who may be predisposed to perceive neutral or positive written communications as negative due to issues with mood and anxiety.

Acknowledgements / Conflicts of Interest

The authors have no financial relationships to disclose.

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Child and Adolescent Psychiatrist

Background:

This is an exceptional opportunity for a dynamic and motivated Child and Adolescent Psychiatrist to take a leadership role in developing a new Child and Youth Mental Health Program for the region.

Located just over an hour north of Toronto, the Child and Youth Mental Health Program (CYMH) is a strategic priority for this Regional Health Centre serving a catchment area of about 450,000 people.

The Regional CYMH Program will provide a comprehensive range of interrelated services including acute mental health inpatient care (new 8 bed unit), acute outpatient services, acute crisis services, a day hospital program and coordination with a wide range of service providers across the region. In collaboration with the adult mental health service the CYMH Program will work to effectively manage transition from young adult to adult services. The Child and Youth Mental Health Program supports a culture of innovation, family centered service and evidence based interventions, and will be moving into redeveloped space in late 2016.

Position Overview:

Working in partnership with health and community services, School Boards and the designated regional Lead Agencies (2) to provide care across the continuum, the Psychiatrist will provide psychiatric services including evidence-based assessment, treatment and consultation in line with the mission and values of the Regional Health Centre. As a key member of the Child and Youth Mental Health Program, the Psychiatrist will supervise the assessment and treatment of children with mental health concerns, provide consultation and make treatment decisions as part of the team of clinicians working with children and families involved in the service. Other attributes of the position include:

- Program supported by Clinical Chief, Management Team, Nurses, Social Workers, Occupational Therapists, Recreational Therapists and a Psychologist
- 8 bed inpatient unit in development, interim 4 bed unit in operation

- Full pediatric medical support
- Successful and sought after Family Medicine Teaching Program with teaching opportunity and faculty appointment at the University of Toronto
- Hospital based activity is fully supported with no overhead cost
- Joining a team of 7 Adult Psychiatrists
- Option to establish private community office
- Remuneration:
- Combination of on-call stipend, sessional fees and OHIP billings provide for exceptional income potential
- No overhead expenses
- Office space and administrative support provided in the hospital

Qualifications:

A demonstrated leader with a vision and a collaborative approach to treatment, you are a natural communicator who will act as the primary liaison with key stakeholders. Previous experience developing similar programs preferred.

Suitable candidates should have a minimum of three years of clinical experience as a Child and Adolescent Psychiatrist and hold FRCP(C) designation, or eligible to obtain one, as well as a physician management education program (or are willing to complete).

In accordance with immigration requirements, preference given to Canadian citizens and Permanent Residents.

Interested candidates please contact:

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