The Processes and Effectiveness of Online Counselling and Therapy for Young People

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Abstract

This thesis by published works contributes to knowledge of the processes and effectiveness of online individual synchronous chat counselling. Through a series of qualitative and quantitative studies it explores the implementation of eheadspace, a youth focussed online mental health service for young Australians aged 12 to 25 years. The goal of the research was to further investigate this relatively under-researched treatment modality to identify factors that may affect treatment outcomes and thereby improve online counselling for young Australians.

The research used a sequential exploratory mixed methods design comprising five studies, including: a systematic review of the literature; a qualitative analysis of online clinician experiences; a cross-sectional study of online youth clients; a six-week pre- and post-test of client treatment outcomes; and a mixed qualitative/quantitative analysis of the relationship between counselling processes and treatment outcomes.

Study 1 was a systematic review of the literature that aimed to identify previous studies regarding the effectiveness of online counselling. The main finding of the systematic review was that only six previous studies had examined the effectiveness of online chat, producing mixed, but generally positive, results of effectiveness.

Study 2 was a qualitative exploration of 19 online clinicians' experiences of providing mental health care online. The aim of the study was to develop hypotheses regarding processes and effectiveness by exploring the experiences of online clinicians. This study found that online clinicians described performing various roles and using a variety of skills online, but favoured person-centred techniques.

Study 3 was a cross-sectional analysis of 1,033 online youth clients aged 16 to 25 years. The study aimed to identify the characteristics of young people who seek help from eheadspace. The main findings of the study were that online clients reported high levels of

psychological distress, low levels of life satisfaction, and low levels of hope, but held high expectations of treatment outcome.

Study 4 investigated six-week treatment outcomes for 152 clients, and aimed to examine the effectiveness of online counselling. After six weeks, psychological distress and life satisfaction were shown to be not significantly affected by the amount of online counselling received nor by having sought additional treatment. However, those who attended one or more online sessions reported significantly higher levels of hope six weeks later compared with those with no online counselling.

The fifth study analysed and rated the progress and depth of counselling from a sample of 49 session transcripts. This study aimed to determine the psychotherapy activities and processes used in online counselling for young people and how these related to client outcomes. This study found that online clinicians generally did not progress through all the stages of counselling in any great depth, but did find an association between greater progress and depth and improved treatment outcomes.

This thesis contributes significantly to our understanding of online counselling for young people. It is one of few comprehensive studies of an online service that explores online clinicians' experiences, client characteristics, treatment processes, and treatment outcomes. The results extend knowledge of how to improve the provision of mental health care online. Based on the research findings a brief online chat counselling model is proposed. The implications of the findings for online clinicians and online service delivery, and future directions for research, are discussed.

List of Papers for PhD by Published Works

Paper 1	Dowling, M., & Rickwood, D. (2013). Online counselling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. *Journal of Technology in Human Services, 31*(1), 1-21. doi: 10.1080/15228835.2012.728508	**Published**
Paper 2	Dowling, M., & Rickwood, D. (2014). Experiences of counsellors providing online chat counselling to young people. *Australian Journal of Guidance and Counselling, 24*(2), 183-196. doi: 10.1017/jgc.2013.28	**Published**
Paper 3	Dowling, M., & Rickwood, D. Exploring hope and expectations in the youth mental health online counselling environment. *Computers in Human Behavior*, *x*(x), x-x.	**Accepted**
Paper 4	Dowling, M., & Rickwood, D. A naturalistic study of the effects of synchronous online chat counselling on young people's psychological distress, life satisfaction, and hope. *Psychotherapy and Counselling Research, x*(x), 1-10. doi: 10.1002/capr.12037	**Accepted**
Paper 5	Dowling, M., & Rickwood, D. (2014). Investigating individual online synchronous chat counselling processes and treatment outcomes for young people. *Advances in Mental Health*, *12*(3), 216-224.	**Published**

Conference Presentations During PhD Candidature

International Conferences

Dowling, M. (2013, October). *Young people accessing online counselling: Who are they and what do they want?* Paper presented at the 2nd International Conference on Youth Mental Health, Brighton, England.

Australian Conferences

Dowling, M. (2011, October). *How young people seek help for bullying and what they learn for future help-seeking*. Paper presented at the 46th Annual Conference of the Australian Psychological Society, Canberra, Australia.

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Chapter 1: Overview

Contribution of the thesis as a whole

This thesis contributes to our knowledge and understanding of online counselling as a method of providing therapeutic interventions to young people. This research contributes in several areas: it increases our understanding of clinicians' perceptions of online counselling; improves our understanding of clients who seek help online; provides evidence of the effectiveness of brief online counselling sessions over a six week period; and describes the processes specific to online counselling and their relationship to treatment outcomes. Each of these areas of understanding fills a major gap in the developing research field into the growing therapeutic and counselling environment of online mental health interventions.

Rationale: Need for this research

It is increasingly common for individuals to go online to seek help regarding mental health problems (Abbott, Klein, & Ciechomski, 2008). This is driven partly by the internet's broad accessibility to a wide range of clients, particularly underserviced populations such as those who live in rural and remote areas or without access to adequate transportation, those who are homebound due to physical or mental health challenges, and those who are hesitant about seeking help face-to-face or over the telephone (Barnett, 2005; Perle, Langsam, & Nierenberg, 2011). As internet-based interventions continue to increase in number, scope, and usage, it becomes more important for research to be conducted to determine how these interventions can be applied for the best possible outcomes.

The Australian Government, through the E-Mental Health Strategy for Australia (DoHA, 2012), is aiming to develop a "respected, evidence based, accessible, professionally recognised and integrated e-mental health service environment" (p. 5). The strategy proposes investing in and developing online mental health services so they become an integral part of the primary health care system. As such, it is important that research is available for policy

makers to determine the extent to which any online mental health service should be endorsed as an effective and successful intervention.

Online counselling services, in particular online synchronous chat services, are rapidly becoming a common modality for counselling and therapy. However, despite the rapid emergence of online chat as a treatment modality over the last 15 years, the research investigating its effectiveness is still in the early stages. Establishing the effectiveness of online counselling is necessary to determine the extent to which it should be endorsed as evidence-based therapy.

Aim of the thesis

The aim of this research was to investigate the processes and effectiveness of online counselling and therapy. This research project adds to the evidence base and helps to inform best practice for online clinicians. Firstly, the results of the research may be used to inform youth mental health services as to what types of young people are accessing mental health care, and what types of problems they are presenting with. This will aid the designing and targeting of online chat services. Secondly, this research examined whether or not online clinicians are able to apply standard models of counselling and therapy aiding in providing evidence as to what processes and techniques help young people online. Finally, the results provide evidence regarding the effectiveness of online counselling and therapy, providing information regarding the number of sessions attended related to changes in outcome measures. Overall, this research yields information regarding the effectiveness of online counselling and therapy in relation to the types of problems presented, and the unique challenges and opportunities for clinicians in working through this medium.

Structure of the thesis

This thesis is submitted in the format of thesis by published works. Overall, a sequential exploratory mixed methods design was used, starting with a qualitative phase,

followed by a quantitative phase, a combined qualitative/quantitative phase, and finishing with an overall integration of the findings. Included within the thesis are five distinct studies, including a systematic review of the literature, a qualitative analysis of online clinician experiences, a cross sectional study of online youth clients, a six-week pre- and post-test of client treatment outcomes, and a mixed qualitative/quantitative analysis of session transcripts and the relationship between counselling processes with treatment outcomes.

Following the Introduction (Chapter 1), the thesis presents a review of the literature (Chapter 2). This literature review summarises the research related to the provision of online counselling and therapy to young people. It provides background on young people's mental health and wellbeing, identifies the different varieties of online mental health interventions available, and summarises the efficacy and effectiveness of online chat counselling. The literature review then highlights the strengths and limitations of online chat as a counselling modality before exploring factors affecting client treatment outcomes, and thus provides a rationale for the current research. Chapter 3 describes the research methodology, providing a rationale for the research design and a discussion of the ethical concerns related to conducting research with young people. The chapter then discusses the methodology of each research paper and describes how they are linked together. Chapter 4 is a systematic review of the effectiveness of individual synchronous online chat counselling. Chapter 5 is a qualitative exploration of the perceptions of clinicians administering online chat treatment. Chapter 6 is a cross-sectional analysis of online chat clients. Chapter 7 is a six-week follow-up exploring changes in participant treatment outcomes after an online chat counselling intervention. Chapter 8 is a mixed qualitative/quantitative study exploring the processes of online chat sessions and how they are related to treatment outcomes. Finally, Chapter 9 presents the research findings, discusses factors that may be affecting treatment outcomes, and explores implications for online clinicians.

Chapter 2: Introduction

Chapter introduction

This chapter will review the literature related to treating youth mental health issues via individual online chat, the real-time text-based communication between clinician and client. A context for the research is provided by a review of the background issues of youth mental health and wellbeing, before moving on to discuss the different ways in which these issues may be addressed by online interventions. The review highlights gaps in the literature relating to the efficacy and effectiveness of online chat, and discusses the relative strengths and weaknesses of this treatment modality. Factors affecting treatment outcomes online are examined through the lens of a common factors model, highlighting areas for further research. A rationale for the current research and a description of the participating organisation is then provided.

Youth mental health and wellbeing

Prevalence. Mental health problems are currently estimated to affect almost half of all people within their lifetime (R. Kessler, Berglund, et al., 2005; Merikangas et al., 2010; Slade et al., 2009). Furthermore, between one-fifth (Slade et al., 2009) and one-quarter (R. Kessler, Chiu, Demler, Merikangas, & Walters, 2005) of all people will meet the criteria for a mental disorder during any 12-month period. Of those people experiencing mental disorders, 77.7% of cases are considered to be mild or moderate, while 22.3% have serious conditions causing significant impairment to general functioning (R. Kessler, Chiu, et al., 2005). As can be seen in Figure 2.1, this equates to over 3.5 million Australians every year. However, it is adolescence and young adulthood that are the critical periods for mental disorders, with most mental disorders having their peak period of incidence during these life stages (Patel, Flisher, Hetrick, & McGorry, 2007). Adolescence and young adulthood are distinct life stages, with adolescents (12-18 years) developing a sense of self and personal identity, while young adults

(19-25 years) need to form intimate, loving relationships with other people (Erikson &

Erikson, 1998).
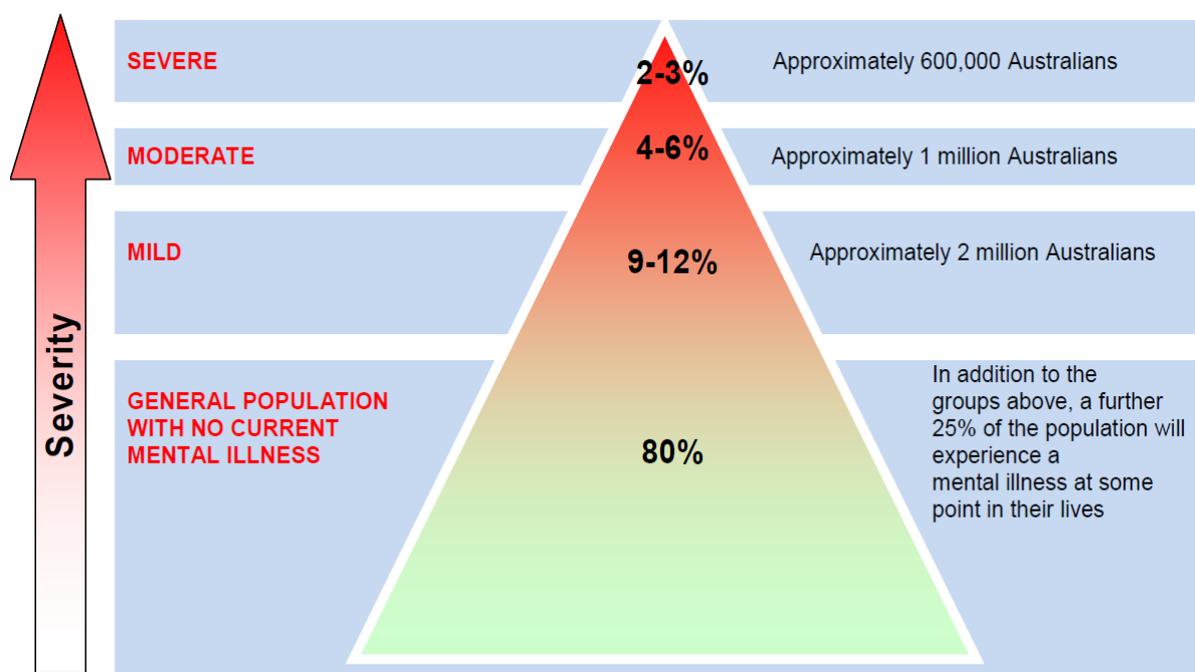
Figure 2.1. 12-month prevalence estimates of mental illness in the Australian population by

severity level, based on diagnosis, disability, and chronicity. Adapted from "Council of

Australian Governments National Action Plan for Mental Health 2006-2011" by COAG,

2011, retrieved from https://www.coag.gov.au/node/512.

Mental disorders are most prevalent amongst young adults; three quarters of all

lifetime disorders start by 24 years of age (R. Kessler, Berglund, et al., 2005; Merikangas et

al., 2010; Slade et al., 2009). For young Australians aged 16-24 years, anxiety disorders are

the most common mental disorder (15%), followed closely by substance use disorders (13%),

and then affective disorders (6%) (ABS, 2010). As such, there is a strong argument that

interventions designed to prevent or provide early treatment should be aimed at young people

(R. Kessler, Berglund, et al., 2005).

Impact. The presence of a mental disorder has a significant impact upon an

individual's quality of life. If left untreated, the effects can persist well into adulthood,

resulting in increased health-risk behaviours, and poorer economic and social outcomes (Patel et al., 2007). For example, adolescents with Depressive Disorder (Major Depression or Dysthymia) are three times more likely to smoke cigarettes and twice as likely to use marijuana (Sawyer, Miller-Lewis, & Clark, 2007). Furthermore, research has shown that young people who had been diagnosed with a mental disorder between the ages of 18 and 25 experienced reduced workforce participation, lower income, and lower economic living standards by age 30 (Gibb, Fergusson, & Horwood, 2010).

Moreover, the high prevalence of mental disorders has considerable impact not just on the individual, but also on national economies, including direct costs (e.g., counselling, medication, and hospitalisation) and indirect costs (e.g., loss of worker productivity, reduced labour supply, disability support payments, and unpaid care) (WHO, 2006). For example, during the 2004-5 financial year, Australia spent AUD$4.1 billion on mental health services (e.g., inpatient and outpatient services, prescription medication, community mental health services and research), or 8% of all total health expenditure (AIHW, 2010). Furthermore, it has been estimated that psychological distress in employees costs the Australian economy AUD$5.9 billion in lost productivity every year (Hilton, Scuffham, Vecchio, & Whiteford, 2010). This suggests that the societal and economic costs of mental health problems is a considerable national problem that remains unresolved.

Help-seeking

Despite the widespread prevalence of mental disorders and their impact on national economies, the availability and use of mental health services remains quite low. According to the literature, only 35-40% of people who meet the criteria for a mental disorder seek professional treatment (Bebbington et al., 2000; Burgess et al., 2009; Wang et al., 2005). Moreover, young people are the age group least likely to seek professional help, with only approximately 23% of those in need accessing a mental health service each year (Burgess et

al., 2009; Tanielian et al., 2009). Furthermore, it is during the ages of 16-24 that the disparity between men and women seeking help is also at its greatest, with 31% of young women seeking professional help, compared with 13% of young men (Burgess et al., 2009). This means that many young people, and particularly young men, are not seeking mental health care during the peak period of incidence for mental health problems.

Gulliver, Griffiths, and Christensen (2010) conducted a systematic review identifying major barriers and facilitators of help-seeking in young people. According to the review, the greatest barriers to help-seeking include: perceived stigma and embarrassment; problems recognising symptoms (poor mental health literacy); and a preference for self-reliance. Stigma and embarrassment about seeking help centres around concerns about what others, including the source of help themselves, may think of the young person for seeking help. Associated with this are concerns around confidentiality, and what may happen if a breach in confidentiality results in friends and family finding out that a young person had sought help. Problems recognising symptoms may also act as a barrier to help-seeking, as young people may justify increased levels of distress as "normal" considering their circumstances. Lastly, the research found that young people prefer to rely on themselves rather than seek help, leading to a preference for self-help as a method of treatment. The systematic review suggests that in order to facilitate help-seeking, evidence-based self-help material should be made readily available, and material should be aimed at improving mental health literacy. Furthermore, it is recommended that interventions should be provided that can minimise or eliminate the stigma relating to help-seeking.

Along with identifying barriers to help-seeking, Gulliver et al. (2010) also explored factors facilitating help-seeking. While the research in this area was noted as being limited, one factor was repeatedly mentioned: positive past experiences. Young people who have previously sought help, found the experience to be generally positive, and received support

and encouragement from others, were more likely to engage in future help-seeking. This may be partly because the experience acts to improve mental health literacy, and also may show that initial fears related to seeking help are unfounded. As such, it is important to provide services to young people experiencing mental health problems in forms that are acceptable to them, overcome some of the barriers to help-seeking, and deliver a positive experience that facilitates future help-seeking if needed (Burgess et al., 2009; Gulliver et al., 2010).

Entering the e-spectrum

With widespread prevalence of mental health problems, but low levels of help-seeking, the Australian Government has determined that the implementation of an e-mental health strategy developing online services, particularly for youth, may aid in bridging this gap (DoHA, 2012). Different methods of distance communication for psychotherapy have been in use since the 1950s, such as letters, telephone calls and closed-circuit television links (Perle et al., 2011). However, with 76% of 9-16 year-olds accessing the internet on an almost daily basis (Green, Brady, Olafsson, Hartley, & Lumby, 2011) there is a significant opportunity to create new systems of e-mental health care (Barak, Hen, Boniel-Nissim, & Shapira, 2008; Blanchard, Hosie, & Burns, 2013).

There is now a plethora of mental health information websites, online mental health screening tools, online support groups, self-help programs, and psychologists providing online group and individual counselling (Abbott et al., 2008; Ybarra & Eaton, 2005). Furthermore, young people are increasingly turning to the internet in order to seek mental health information and help. In a cross-sectional survey of 2,000 Australian young people aged 12–25 years, 30.8% of young people with a mental health problem reported searching online for mental health information (Burns, Davenport, Durkin, Luscombe, & Hickie, 2010). The growth of online interventions and interest in seeking help online has seen the development of an entire e-spectrum of interventions (Rickwood, 2012). Figure 2.2,

proposed by Rickwood (2012) presents the spectrum of mental health interventions and some of the options available online.
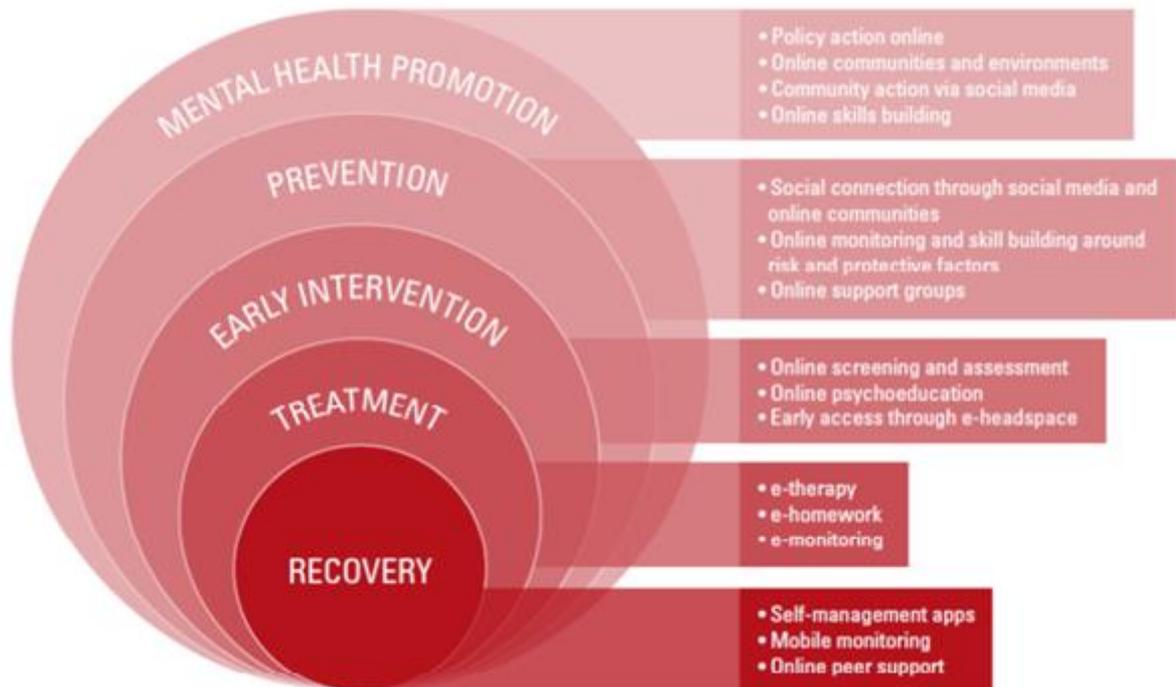
Figure 2.2. The 'e-spectrum' of interventions for youth mental health. Adapted from "Entering the e-spectrum: An examination of new interventions for youth mental health," by D. Rickwood, 2012, Youth Studies Australia, 31, p. 21.

Mental health promotion includes actions designed to improve the mental health and wellbeing of the general population by developing public policy, supportive environments, community action, and personal skills (Rickwood, 2012). Considering that many young people are going online to seek mental health information, promoting mental health information online may improve people's involvement in and knowledge about mental health issues. As such, more work needs to be done regarding mental health promotion online, as a large proportion of the population remains unaware of the number of services available (Neal, Campbell, Williams, Liu, & Nussbaumer, 2011). A number of organisations are already trying to achieve this. For example, Beyondblue (http://www.beyondblue.org.au) is a project

that aims to raise community awareness regarding depression and anxiety in order to reduce the stigma associated with these disorders and improve help-seeking.

Prevention refers to interventions that are designed to prevent the development of mental disorders by aiding in the identification of mental health risk factors and protective factors. There are three types of prevention including universal, selective, and indicated interventions (DoHAC, 2000). Universal interventions are aimed at groups with no specific risk, while selective interventions are directed at groups with higher risk than the general population, and indicated interventions provided to groups at very high or imminent risk. Interventions can focus on specific mental health risk factors (e.g., bullying and substance use), or building protective factors (e.g., resilience and social support). By moving online, prevention interventions are able to more easily reach a wider audience, create social networks, and provide self-help programs or apps. Anxiety Online (http://www.anxietyonline.org.au), for example, is a website that includes information about anxiety disorders and provides access to self-administered assessment and diagnostic tools.

Early intervention refers to interventions specifically intended to treat the early symptoms of mental health problems before they develop into psychopathology and require more extensive treatment. Recent years have seen the emergence of online interventions aimed at treating people before full episodes begin, and often include online counselling via text or video, and self-guided websites and programs. Organisations such as Kids Helpline (http://www.kidshelpine.com.au/teens/), for example, offer online synchronous chat for young people aimed at treating broadly based personal stressors (rather than specific mental health disorders). Websites such as e-couch (https://ecouch.anu.edu.au/welcome) provide web based self-help interactive programs aimed at emerging depression, anxiety, and related disorders.

Online counselling and therapy are often aimed at early intervention but, as the interventions become more sophisticated and the research base improves, they are increasingly being applied as standard treatments (Barak & Grohol, 2011; D. Kessler et al., 2009). Online interventions are becoming accepted as legitimate options for standard treatment, despite involving some controversial issues for practitioners, such as managing privacy and confidentiality (Glasheen, Campbell, & Shochet, 2013). There are an increasing number of clinician assisted CBT web-based programs available, such as This Way Up (https://thiswayup.org.au), that have reported positive results in treating anxiety (Titov et al., 2009). Furthermore, services such as eheadspace (https://www.eheadspace.org.au/) are offering free online chat sessions to young people, including multiple treatment sessions.

For continuing care, relapse prevention and recovery, online applications provide a range of options. Applications can be used to monitor progress, as a self-management option used by young people themselves, or as periodic reports that can go directly to a therapist or case manager. A number of mood monitoring applications have been developed that help identify triggers and early warning signs of declining emotional health. One example is MoodChart (https://www.moodchart.org/), a program designed to allow individuals with bipolar to track their moods and daily activities. Mood and activities over time are presented in the form of charts and reports, providing ongoing feedback that helps the client build an understanding of what helps and what may trigger problems for their ongoing wellbeing.

The development of online interventions can potentially bridge the gap between young people and mental health services, by being congruent with the way young people now live their technology-integrated lives (Blanchard et al., 2013). Developing online services also offers a method of overcoming help-seeking barriers such as perceived stigma (by offering anonymous services), poor mental health literacy (by disseminating mental health knowledge), and self-reliance (by offering self-help programs). The internet can also increase

reach and improve access, particularly to those underserviced and isolated by distance, illness or other barriers (Perle et al., 2011). Overall, the growth and increasingly sophisticated use of the internet has enabled mental health services to apply interventions to a broader range of mental health issues and has created an entirely new spectrum of e-mental health care.

Types and definitions of online mental health interventions

Despite the proliferation of online interventions, there is currently no agreed nomenclature to define and describe the different psychological services provided over the internet. Some common terms include, but are not limited to: online counselling (or therapy), internet counselling (or therapy), cybertherapy, e-therapy (or e-counselling), computer-mediated interventions, and web-based interventions. Some researchers have used broad definitions to describe psychological interventions provided over the internet, such as "any type of professional therapeutic interaction that makes use of the internet to connect qualified mental health professionals and their clients" (Rochlen, Zack, & Speyer, 2004, p. 270), or "any delivery of mental or behavioural health services, including but not limited to therapy, consultation, and psychoeducation, by a licensed clinician to a client in a non-face-to-face setting through distance communication technologies such as telephone, asynchronous email, synchronous chat, and videoconference" (Mallen & Vogel, 2005, p. 764). However, these definitions are ambiguous and, most importantly, do not aid in differentiating between different types of online interventions which can cause confusion amongst researchers and practitioners.

Several researchers have attempted to provide a unifying terminology that can label, define, and categorise the different psychological services provided online (Abbott et al., 2008; Barak, Klein, & Proudfoot, 2009; Rochlen et al., 2004); however, a broad consensus is yet to be realised. The most comprehensive taxonomy is offered by Barak et al. (2009), who posit four categories: online counselling and therapy; web-based interventions; internet-

operated therapeutic software; and personal publications, online support groups, and online assessments.

Online counselling and therapy. Online counselling and therapy refers to the provision of psychological interventions delivered over the internet, either synchronously or asynchronously, and in either an individual or group setting (Barak et al., 2009). Asynchronous forms of communication can be identified by the lag in time between contacts, whereas synchronous communication occurs in real-time (Perle et al., 2011). As such, methods of communication which do not regularly provide instantaneous responses, such as emails and forums, would be considered to be asynchronous, whereas communication modalities that allow for real-time communication, such as chat (e.g., MSN) or video (e.g., Skype), would be considered to be synchronous. There are now a number of services offering both synchronous and asynchronous online counselling, including LivePerson (Finn & Bruce, 2008), Kids Helpline (King, Bambling, Reid, & Thomas, 2006) and eheadspace (headspace, 2014).

Web-based interventions. Barak et al. (2009) define a web-based intervention as a primarily self-guided mental health related intervention that is operated by a prescriptive online program. The program itself is designed to create positive change and/or improve knowledge, awareness, and understanding by the provision of quality health-related information through the use of interactive web-based components. Thus, web-based programs can include education interventions (e.g., programs which provide information regarding the associated features of a mental disorder, explanation of symptoms, possible causes, its effects, and treatment options), self-help therapeutic interventions (e.g., treatment or prevention self-guided online programs designed to promote positive cognitive, behavioural, and emotional change), and therapist supported interventions (e.g., similar to self-help interventions, but with a mental health professional to provide support, guidance, and

feedback). An example of a self-help therapeutic intervention would be MoodGym (https://moodgym.anu.edu.au/welcome), while This Way Up (https://thiswayup.org.au) is a therapist supported intervention.

Internet-operated therapeutic software. Internet-operated therapeutic software is differentiated from web-based interventions by its use of advanced computer programming, such as artificial intelligence and language recognition software (Barak et al., 2009). Included within this category are computer simulations of therapeutic conversations. These programs operate by analysing the client's input of text for key terms and themes, and then, using algorithms based on scripts of therapeutic conversations, provide a suitable reply. ELIZA was one of the first computer programs designed to simulate a non-directive therapy conversation based on the client-centred principles of Rogerian psychotherapy (Rogers, 1957), and can be accessed online at http://www.cyberpsych.org/eliza. Manage Your Life Online (MYLO) is another automated computer-based self-help program which simulates a conversation between a client and therapist (Gaffney, Mansell, Edwards, & Wright, 2013), but is based upon the principles of Method of Levels (MOL) therapy (Carey, 2006), and can be found at http://manageyourlifeonline.org.

Other online activities. The fourth, and somewhat amorphous "other" category, includes online support groups and online mental health assessments (Barak et al., 2009). Online support groups provide a means by which people with mental health issues can communicate with each other either synchronously or asynchronously (e.g., by email, forums, or chat rooms); with or without the limited presence of a mental health professional (Castelnuovo, Gaggioli, Mantovani, & Riva, 2003). Websites that provide mental health screening and assessment tools allow people to complete questionnaires in order to obtain an indication of their physical or mental health status (Ybarra & Eaton, 2005).

Effectiveness of Online Interventions

Using Barak et al.'s (2009) taxonomy allows researchers to differentiate between online interventions, and thus compare similar services and modalities through systematic reviews and meta-analyses. Several researchers have already done so, particularly with regard to web-based interventions (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Barak et al., 2008; Gainsbury & Blaszczynski, 2011; Griffiths & Christensen, 2006; Griffiths, Farrer, & Christensen, 2010; Hanley & Reynolds, 2009; Kaltenthaler, Parry, & Beverley, 2004; Manzoni, Pagnini, Corti, Molinari, & Castelnuovo, 2011; Newman, Szkodny, Llera, & Przeworski, 2011; Postel , de Haan, & De Jong, 2008; Sethi, Campbell, & Ellis, 2010). Griffiths and Christensen (2006) reviewed 15 randomised control trials of self-help web-based interventions and found that the majority of online interventions programs were reported to be effective in reducing risk factors or improving symptoms, particularly in regards to depression and anxiety. However, the majority of studies reviewed exhibited significant methodological issues such as small sample sizes and short follow-up periods. More recently, Newman et al. (2011) compared self-help and therapist supported web-based therapeutic interventions in the treatment of anxiety and depression. Their findings suggested that while self-help web-based therapeutic interventions are effective in treating anxiety and mood disorders, therapist-supported interventions offered the best outcomes, particularly for the treatment of clinical levels of depression.

There is increasing evidence to suggest that some psychological services provided online are as effective, or almost as effective as, similar services provided face-to-face (Barak et al., 2008; Gainsbury & Blaszczynski, 2011; Griffiths et al., 2010; Kaltenthaler et al., 2004; Newman et al., 2011). In a comprehensive meta-analysis of 92 studies examining internet-based therapeutic interventions, Barak et al. (2008) reported the overall medium treatment effect size to be 0.53, which they argued is comparable with the effect sizes of traditional

face-to-face interventions. However, there are substantial differences between the findings of meta-analyses of face-to-face psychotherapy outcomes (Lambert & Ogles, 2004). One large meta-analysis of 156 meta-analytic studies reported an average treatment effect size of 0.47 (Lipsey & Wilson, 1993), while another meta-analysis of 475 studies found an average effect size of 0.85 (Smith, Glass, & Miller, 1980). However, the Smith et al. (1980) effect size was later moderated by calculating weighted effect sizes (to account for differences in sample sizes), reducing the average effect size to 0.60 (Shadish et al., 1997). It is evident from the large number of meta-analyses that, after being subjected to intense scrutiny for over 60 years, many well-established face-to-face therapies have been shown to be effective, whereas online counselling is only in the early stages of its development and the evidence for its effectiveness is preliminary.

The lack of effectiveness studies related to online interventions is particularly notable in regards to online chat. Barak et al.'s (2008) review investigated the effectiveness of different online counselling modalities. They compared chat, forum, email, audio, and webcam modalities, finding that chat and email were more effective than forum and webcams. However, the authors noted that their analysis should be interpreted within the context of the small number of studies in each modality. Of particular concern were the studies examining online chat. Of the nine articles reviewed, seven were group interventions using chat rooms (Gollings & Paxton, 2006; Harvey-Berino et al., 2002; Harvey-Berino, Pintauro, Buzzell, & Gold, 2004; Hopps, Pepin, & Boisvert, 2003; Lieberman et al., 2005; Woodruff, Edwards, Conway, & Elliott, 2001; Zabinski, Wilfley, Calfas, Winzelberg, & Taylor, 2004). Of the remaining two studies, one was a combination of chat support and a self-help website (Hasson, Anderberg, Theorell, & Arnetz, 2005), leaving only one examining the effectiveness of individual synchronous online counselling (Cohen & Kerr, 1998). Since Barak et al.'s (2008) review, only five additional studies examining the

effectiveness of individual synchronous online chat were identified, suggesting that, despite the growth of online chat services there is still a significant gap in the evidence regarding the effectiveness and efficacy of individual synchronous online counselling (Dowling & Rickwood, 2014).

Development and acceptance of individual synchronous online chat counselling

As access to and use of the internet has increased, so too has the acceptance and development of online counselling. Initially, online counselling was an adjunct to traditional psychotherapy, primarily through the use of email, and accounting for approximately 20% of counselling practice (Castelnuovo et al., 2003), it is more recently gaining acceptance as a treatment modality in its own right (Finn & Barak, 2010). There are now several service models delivering online counselling, including for example, websites for paid private clinicians (Finn & Bruce, 2008; Murphy et al., 2009), free online youth counselling services (Fukkink & Hermanns, 2009a; King, Bambling, Reid, et al., 2006), and more recently, the development of online platforms specifically for school counselling (Glasheen et al., 2013).

The increase in online chat services appears to be in response to client demands for more technologically modern services; giving rise to a greater use of emails, and service providers developing options to provide access to synchronous online chat (Bambling, King, Reid, & Wegner, 2008; Finn & Barak, 2010). However, online counselling is not preferred by all potential users. As Harun, Sainudin, and Hamzah (2001, August) found in their study, only just over 50 per cent of students from a private Malaysian college were willing to participate in online counselling sessions. Furthermore, only 16% of an Australian nonclinical sample of adolescents stated a preference for seeking help online (Bradford & Rickwood, 2012a). Notably though, within this young adolescent sample the most favoured help-seeking preference was to not seek help at all.

Despite the increasing acceptance of online counselling amongst service users and clinicians, there remain a number of issues that require further investigation. Essentially, clinicians require evidence that online chat is an effective treatment modality and information about how therapeutic practices can be adapted to meet this need (Glasheen et al., 2013). Simply providing online services is not sufficient to encourage service users and clinicians to move online—there needs to be a widespread understanding of its role within the broader aspects of service provision in support of community mental health.

The efficacy and effectiveness of online chat

To date, there are six studies examining the efficacy and effectiveness of online chat as a treatment modality. Of these studies, three have compared online counselling with telephone, two with face-to-face, and one with a randomly assigned control group.

Online versus telephone. Three studies have compared online chat with telephone counselling, although two of the studies are based on the same counselling service. Two include immediate post-tests (Fukkink & Hermanns, 2009b; King, Bambling, Reid, et al., 2006), while one includes a follow-up of one month (Fukkink & Hermanns, 2009a). All of the studies were assessing online youth counselling services providing free single sessions. Furthermore, in each study over three quarters of the participants were female and presented with similar problems, including relationships, home situations, violence/coercion, and emotional problems (e.g., loneliness, self-harm, depression).

Fukkink and Hermanns' (2009b) initial study randomly selected 53 online (84% female) and 42 telephone (77% female) client records from the Dutch Kindertelefoon database, with ages ranged between 9 and 17 years. Kindertelefoon is a one-on-one child helpline providing both telephone and online chat services. Data were collected prior to the intervention and immediately after. The study reported a moderate increase in wellbeing for both online ($ES = 0.45$) and telephone ($ES = 0.40$) clients. Furthermore, there were small

decreases in perceived burdens for both online (*ES* = 0.36) and telephone (*ES* = 0.26) clients. No significant differences between the groups were reported, demonstrating that online chat achieved similar outcomes to telephone counselling.

Fukkink and Hermanns' (2009a) second study was a naturalistic comparison of online and telephone counselling services at Dutch Kindertelefoon. This study included 339 online and 563 telephone participants, with a mean age of 13.8 years. Similar to the previous study, wellbeing increased immediately after the intervention for both online (*ES* = 0.62, medium) and telephone participants (*ES* = 0.34, small). Furthermore, the perceived burden of the presenting problem also decreased for both online (*ES* = 0.44, medium) and telephone groups (*ES* = 0.12, small). Of the initial participants, 25% (*n* = 223) were available for the follow-up phase. After one month the changes in wellbeing and perceived burden were maintained and remained stable for both online and telephone conditions. The results suggest that the online medium has a greater effect than telephone counselling for both well-being (*ES* = .11) and perceived burden (*ES* = .17).

King, Bambling, Reid et al.'s (2006) study was a naturalistic comparison of online chat and telephone counselling services at Kids Helpline in Australia. Kids Helpline is a 24 hour counselling service for kids and young people aged 5-25 years, providing telephone, chat, and email services. There were 86 online chat and 100 telephone participants. The online counselling group included more females (95% compared with 67%), was older (15.4 years compared with 13.1 years) and reported higher pre-counselling distress on the General Health Questionnaire (39.0 compared with 32.9) than the telephone counselling group. Immediately after the intervention participant distress was significantly reduced for both online and telephone treatment groups (partial eta squared = 0.50). However, there was a significant difference in outcomes between modalities, indicating that telephone counselling had a more substantial effect than online counselling (partial eta squared = 0.15).

Furthermore, while the effect size comparing the two modalities was presented in this study (demonstrating that the telephone medium achieved better outcomes than online) the individual effect sizes for online counselling and telephone counselling were not reported, limiting interpretation.

Overall, all three studies suggest that single sessions of online counselling have small to moderate effects on young people's wellbeing, perceived burden and mental health. However, the evidence is inconclusive as to whether these effects are greater than, equal to, or less than those found in telephone services. As such, there may be several factors at play that warrant further research, such as clinician training and effectiveness, or client factors, such as willingness to engage online or type of presenting problem.

Online versus face-to-face. Two studies have been identified that compared online chat with face-to-face counselling. One study was a randomised control study of undergraduate students exploring the effect of the different mediums of counselling on anxiety (Cohen & Kerr, 1998), while the other was a naturalistic comparison between adults who had received online chat or face-to-face counselling for stressors such as work related issues, separation and divorce, anxiety, depression, and parenting (Murphy et al., 2009).

Cohen and Kerr's (1998) intervention included a single counselling session led by counselling psychology graduate students. The participants were 24 undergraduates reporting symptoms of anxiety. The study reported significant reductions in anxiety for both the online and face-to-face conditions, but no significant differences were found between the two conditions. No effect sizes were reported, limiting the potential to make comparisons between studies.

Murphy et al.'s (2009) study was a naturalistic comparison of online and face-to-face counselling services at Therapy Online and Interlock in Canada. There were 26 online chat participants ($M = 42$ years) who were given a Global Assessment of Functioning (GAF) score

(1-100). For comparison, 101 face-to-face GAF scores were retrieved from their database. The specific interventions and number of sessions were not specified. Counselling sessions were provided by a mixture of trained counsellors and social workers. The online intervention group's mean GAF score significantly increased from 70.3 (*SE* = 1.5) to 77.8 (*SE* = 1.6). However, no effect size was provided. The face-to-face comparison group GAF scores also increased from 67.6 (*SE* = 0.8) to 73.7 (*SE* = 0.8). No significant interaction between time and treatment method was reported.

Overall, these findings support the effectiveness of online counselling, but have several limitations. Firstly, the sample sizes are small which limits the statistical power and generaliseability. Secondly, the Murphy et al.'s study applies the GAF, which is scored by the counsellor rather than the client. While the article does go to great length to justify the validity of the GAF, it would be preferable to be able to compare it with some measures based upon client responses. Furthermore, neither study provided effect sizes, making comparisons difficult.

Online versus control. D. Kessler et al.'s (2009) examination of online chat services appears to be the only study that applied a randomly assigned control group. The study compared 113 intervention participants treated via online chat with a control group of 97. The participants were adults (mean age 35.6 years) from the United Kingdom, 68% of whom were female. The study focused on the treatment of clients with depression, more than 75% of whom were within the severe range as assessed by the Beck Depression Inventory (BDI), ranging from 0-13 (minimal), 14–19 (mild), 20–28 (moderate), and 29–63 (severe). The intervention included between five and 10 sessions of Cognitive Behavioural Therapy (CBT) conducted via online chat. By four months, 38% of the intervention group had recovered from depression, with mean BDI scores decreasing from 32.8 (*SD* = 8.3) to 14.5 (*SD* = 11.2), which was a large effect (*ES* = 0.81). Comparatively, 24% of the control group recovered,

with mean BDI decreasing from 33.5 (SD = 9.3) to 22.0 (SD = 13.5). The gains made due to treatment were maintained after eight months, where the intervention group's mean BDI score remained steady at 14.7 (SD = 11.6), which was still a large effect when compared to pre-intervention BDI scores (ES = 0.70). By eight months, the control group also remained steady; with an average BDI of 22.2 (SD = 15.2).

The D. Kessler et al. (2009) study is the most rigorous identified in the literature regarding the effectiveness of online chat. It is a randomly controlled trial with a large sample, and the participants received the same intervention for one type of psychopathology. As such, it provides credible evidence that depression can be treated by CBT through online chat services.

Satisfaction. Both online counsellors and clients appear to have generally positive attitudes towards online counselling (Finn & Barak, 2010; Leibert, Archer, Munson, & York, 2006; Murphy et al., 2009). In a study of 92 online counsellors, 74% agreed that they were satisfied with their experience of providing help online (Finn & Barak, 2010). Similarly, online clients also reported being satisfied with online counselling (Leibert et al., 2006). In a sample of 81 online clients, clients were on average 'often satisfied' (1 = never satisfied to 7 = always satisfied) with their online counselling experience (M = 5.01, SD = 1.45). However, it should be noted that online clients' levels of satisfaction were significantly lower than those of clients in a face-to-face counselling validation study (Leibert et al., 2006; McMurtry & Hudson, 2000). The evidence suggests that online chat is satisfying for both clients and counsellors, if not as satisfactory as more traditional modalities. However, research regarding client satisfaction with online chat services is limited and should be interpreted with caution.

Strengths and benefits of online chat

As has been demonstrated, there is a dearth of literature examining the effectiveness of online chat as a valid treatment modality. However, despite the limited evidence on the

efficacy of online counselling, there are a number of strengths and benefits associated with this platform of service delivery that have already been recognised. These strengths and benefits include greater access to services (Perle et al., 2011), the value of the disinhibition effect (Suler, 2004), the provision of a safe environment (Bambling et al., 2008), the benefit of writing (Pennebaker, 1997), and providing gateways to mental health support (A. Callahan & Inckle, 2012).

Greater access. One of the most notable benefits of online counselling is the increased reach of mental health service delivery and consumer access (Perle et al., 2011). Theoretically, there are no geographic boundaries to online counselling, as a clinician in one country could be engaging therapeutically with a client on the other side of the world. Given the high usage of computers and access to the internet in most countries, online counselling can be made readily available (Blanchard et al., 2013). Online counselling overcomes proximity to service issues for those who do not have access to local services, or where going online is more practical than travelling great distances to visit a psychologist (Fenichel et al., 2002). Those who suffer from a physical or mental illness that inhibits or prevents easy access to face-to-face services may also benefit (Heinlen, Welfel, Richmond, & O'Donnell, 2003). Moreover, online counselling can also be timely and direct, with King, Bambling, Reid, et al. (2006) noting that a young person can log in and chat with a counsellor almost immediately, rather than experience the characteristic delays often associated with the more traditional modalities of therapy (e.g. registration and waiting room).

There is, however, the danger of creating a "digital divide", in which some people have access (or far superior access) to the internet, while others have limited or no access (Blanchard et al., 2013). This may hamper access to underserviced populations, if they do not have the hardware or software, or the digital literacy needed to seek help online. Fortunately, the majority of young Australians today have access to the internet and use it on a regular

basis, so while the digital divide is a potential concern, it does not appear to be a major concern for young people in Australia (Blanchard et al., 2013).

Disinhibition and disclosure. The "online disinhibition effect" was first coined by Suler (2004) to account for the apparent willingness of clients to self-disclose personal information online more frequently or intensely than they would in person. Although Suler has posited a number of factors affecting disclosure rates, two appear particularly important: dissociative anonymity and invisibility.

Dissociative anonymity is the awareness that in online communication, your identity is generally kept anonymous. Suler (2004) argues that when people have the opportunity to separate their actions from their real-world identities, they tend to feel less vulnerable and are, therefore, more willing to be open. A qualitative study exploring online therapeutic relationships reported that anonymity, for both clients and clinicians, emerged as a main theme for forming trust (Fletcher-Tomenius, 2009). Clinicians stated that they generally experienced a high level of trust in therapeutic relationships online and that their clients seemed to find the initial stages of therapy easier to establish when compared with face-to-face contact.

The other important factor, invisibility, refers to the simple fact that the person with whom individuals are communicating cannot see them. "Invisibility gives people the courage to go places and do things they otherwise wouldn't" (Suler, 2004, p. 322). Furthermore, this invisibility factor goes both ways—not only can the online client not be seen by the counsellor, the counsellor cannot be seen by the client. Seeing physical reactions such as frowns, shaking heads, sighs, and looks of boredom can minimise what people are willing to express (Rickwood et al., 2014; Suler, 2004). Recent investigations of youth-specific mental health services in Australia have shown that not feeling judged is one of the most important

service aspects for young people (Rickwood, Telford, Parker, Tanti, & McGorry, 2014) and that this is a valued aspect of the online environment (Bradford & Rickwood, 2014).

However, Nguyen, Bin, and Campbell (2012) reviewed 15 studies comparing online and offline self-disclosure levels, finding that the literature did not consistently support the argument that disclosure is greater in online contexts. The authors reported that although the disclosure frequency was generally higher online, results regarding the depth of disclosure were mixed. Self-report survey studies reported perceptions of greater disclosure between friends in face-to-face situations compared with online (Chan & Cheng, 2004; Rimondi, 2002; Schiffrin, Edelman, Falkenstern, & Stewart, 2010). However, most of the experimental studies that measured actual self-disclosure reported significantly more intimate disclosure online between strangers (Coleman, Paternite, & Sherman, 1999; Joinson, 2001). Nguyen et al. (2012) concluded that self-disclosure was most likely moderated by factors such as the relationship between the communicators (e.g., friend or stranger), the specific mode of communication (e.g., synchronous or asynchronous), and the context of the interaction (e.g., social or therapeutic). As such, while there is general confidence that disinhibition and disclosure is beneficial for online counselling, further research is needed to better understand how online disclosure affects psychotherapeutic interventions.

Safe environment. The anonymous nature of online counselling helps generate a private and emotionally safe environment for both clients and clinicians (Bambling et al., 2008). Adolescent online counselling clients have reported feeling more safe and less emotionally exposed when engaged in an online counselling session compared with face-to-face or even telephone services (King, Bambling, Lloyd, et al., 2006). The authors also found that some clients felt better protected from the counsellor's negative feedback (e.g., boredom or criticism) due to the invisible nature of the text environment.

In a qualitative study of online counsellors' experiences, it was found that the main benefit of working online was the emotional safety due to reduced emotional proximity to the client (Bambling et al., 2008). The online counselling environment might be described as relatively 'cool' in emotional temperature, as compared to the relatively 'warm' telephone and face-to-face environments. The online environment was reported to reduce young people's anxiety about receiving counselling, making it easier to discuss problems and be assertive with counsellors.

Authority/power. Within the online environment, there is a distinct shift in the power dynamic between counsellor and client. The client's ability to control the length of the communication and the amount of self-disclosure is very different to face-to-face counselling (A. Callahan & Inckle, 2012). During a face-to-face therapy session, if the client doesn't trust their counsellor, it is quite unlikely that they would walk out (Fletcher-Tomenius, 2009). Online, it is easier for the client to withdraw from the relationship, as it is simple to disconnect or stop replying. The greater autonomy and control online clients appear to have are possibly afforded through the anonymous context of online therapy and facilitated through the processes of disinhibition. Perhaps online, some clients can engage in deeper discussion and disclosure because there are fewer indications of an imbalance in power and authority (A. Callahan & Inckle, 2012). A client who finds it difficult to talk in a face-to-face setting may not be as intimidated online because there is less sense of the therapist being in control. Further, greater self-reliance is a critical issue for older adolescents and young adults as they become increasingly independent.

The benefit of writing in counselling. The therapeutic benefits of writing have been previously acknowledged. Written communication allows clients to consider what they are "saying" and revise their statements without worry about what they say coming out wrong the first time (Baker & Ray, 2011). It has been argued that writing about emotional experiences

can have significant physical and mental health improvements (Pennebaker, 1997). In the case of sending and receiving counselling emails, the process of writing was found to be cathartic in translating emotional experiences into words (Sheese, Brown, & Graziano, 2004). Furthermore, Lange, van de Ven, Schrieken, Bredeweg, and Emmelkamp (2000) demonstrated that 25 undergraduate students experienced reduced symptoms of post-traumatic stress disorder (PTSD) after 20 bi-weekly writing sessions over a 10 week period. Additionally, a six-week follow-up indicated that these reductions in PTSD symptoms were stable after six weeks. Indeed, writing may be a preferred or more suitable modality of self-expression for some individuals who are less comfortable in face-to-face interactions. Roy and Gillett (2008) found that by using emails to communicate with a treatment resistant teenager they were able to build a therapeutic relationship that allowed them to explore the client's past experiences and start resolving presenting problems.

Regarding research specifically related to synchronous chat, Cook and Doyle (2002) reported that participants appreciated that they could re-read the responses received from the therapist, feeling this allowed them more time to process the content than verbal communication would have. Beattie, Shaw, Kaur, and Kessler (2009) reported that on seeing their thoughts and emotions in writing, online clients felt that this provided them with a new perspective, and helped them review and reflect upon the therapeutic exchange. Even though the research specifically related to the benefits of synchronous chat is limited, it seems clear that clients may benefit from the cathartic nature of writing and the permanency of the written therapy record for future referencing.

Gateways to mental health support. There is also a potential benefit of online chat acting as a gateway to clients accessing further mental health information or support. In a study of clients and clinicians at a children's chat helpline, it was found that generally positive views were held about information being provided online during online chat

sessions, particularly in that it was easy, immediate, and anonymous, reducing the stigma of being seen to access that information (A. Callahan & Inckle, 2012). This suggests that online chat may be a useful way of directing help-seekers towards useful mental health resources.

It has been found that for young people seeking help, face-to-face positive attitudes and past experiences of seeking help facilitate future help-seeking (Rickwood, Deane, Wilson, & Ciarrochi, 2005). While there is no current research exploring online clients' expectations or the likelihood of them seeking further help after accessing online chat, the general satisfaction with online chat would suggest that this is a possibility (Leibert et al., 2006). If young people access online chat services, have a generally positive experience, and are directed to relevant mental health information or services, it may act to reduce or remove some of the barriers to future help-seeking.

Concerns about, and barriers to online chat

While there are a number of positive aspects associated with online chat as a treatment modality, there are also several criticisms. Concerns about online chat and potential barriers for clients include the dehumanisation of the therapeutic bond, toxic disinhibition, the loss of verbal and non-verbal cues, confidentiality, technical difficulties, suitability for crisis intervention and/or serious disorders, and ethical and legal considerations.

Loss of verbal and non-verbal cues and the dehumanisation of the therapeutic bond. One of the most frequently cited criticisms of online counselling is the potential dehumanisation of the therapeutic bond (Baker & Ray, 2011; Lovejoy, Demireva, Grayson, & McNamara, 2009). This is of considerable concern, as the therapeutic alliance is well known as a powerful component to effective therapy outcomes (Lambert & Ogles, 2004). Opponents of online counselling believe that the therapeutic alliance created between client and clinician in face-to-face interactions cannot be recreated online, primarily due to the elimination of verbal and non-verbal cues (Lovejoy et al., 2009). Communicating via text

over the internet eliminates all verbal and nonverbal cues, such as volume, tone, voice inflection, facial reactions, body posture and hand signals. As a result, clinicians have fewer ways to observe and gather information from their clients, or to convey information to them, which may result in them being less able to build an effective working relationship, thus partially or completely removing the benefits of a strong therapeutic bond (Baker & Ray, 2011; Cook & Doyle, 2002).

Studies exploring the therapeutic alliance in an online chat setting have confirmed that it is indeed more difficult to establish a therapeutic relationship online (Hanley, 2009, 2011; King, Bambling, Reid, et al., 2006). However, these studies also report that it is possible to develop a working alliance online, thus mollifying some of the criticisms of online chat. In addition, it is argued that this difficulty in establishing a therapeutic relationship is offset by online clients' willingness to self-disclose.

Toxic disinhibition. As noted previously, disinhibition is generally regarded as a positive aspect of online chat, but it is not always constructive. It is generally argued that it is the anonymity and invisibility of being online that enables people to behave in ways that they ordinarily would not. For example, on the popular message board 4chan (http://www.4chan.org/), over 90% of the seven million plus users are unidentifiable, using the default username "Anonymous" (Bernstein et al., 2011, July). While this anonymity helps generate creativity and playful exchanges of images, it can also contribute to the emergence of a crass, abhorrent and generally unpleasant environment (Knuttila, 2011). Behaviour such as this suggests that disinhibition may not always be beneficial during online counselling. Toxic disinhibition may simply be a collection of negative behaviours (e.g., insults and inflammatory remarks), resulting in no personal growth (Suler, 2004).

While researchers are aware of toxic disinhibition, few studies have examined the factors affecting the negative aspects of disinhibition online. One experimental study has

examined the effects of anonymity, invisibility, and lack of eye-contact on toxic disinhibition by presenting random pairs of participants with a topic for discussion using online chat (Lapidot-Lefler & Barak, 2012). This study found that lack of eye-contact was the most significant contributor to the negative effects of online disinhibition, such as self-reported flaming (e.g., a hostile and insulting online interaction) incidents and threats. When eye-contact was enforced via webcam, participants reported fewer occurrences of flaming and fewer threats than when there was no eye-contact. By comparison, anonymity was related to an increase in threats, and invisibility was related to creating a negative atmosphere. This suggests that online disinhibition may not have purely beneficial effects on online counselling.

Time. Time and technical difficulties are significant challenges to session management in the online environment. Online counsellors have reported frequent time lags between text responses following questions or interventions (Bambling et al., 2008). These delays in text responses were perceived as being disruptive to the flow of the session, making it difficult for the counsellors to remain engaged with the client. Repeated delays could result in very little being achieved during a single session, producing feelings that only a portion of the client's problems were being addressed. Online counsellors have noted that the slow pace of online chat can result in significantly less being achieved over the space of one hour than could be achieved via telephone or face-to-face (Bambling et al., 2008; Haberstroh, Parr, Bradley, Morgan-Fleming, & Gee, 2008). The slow pace of online chat can even cause financial difficulties for the clinicians themselves, as online counselling may end up as being less cost-effective than face-to-face as clinicians spend more time attempting to complete the same level of content (Hollinghurst et al., 2010).

Similarly, time is also a concern for online clients. In a qualitative study of online clients, a particular concern was being forced to end their session prematurely due to session

time limits (King, Bambling, Lloyd, et al., 2006). Some clients reported that they did not feel that their issue had been resolved satisfactorily, and had been advised to seek alternative sources of help. In another study of online clients' experiences, it was reported that the slow speed of typing could result in sessions losing coherency, with additional questions being asked while a client is still formulating their response to a previous question (Haberstroh, Duffey, Evans, Gee, & Trepal, 2007).

Technical difficulties. Considering the nature of the online environment, there is always the potential for there to be technical difficulties. For example, being unable to connect to the internet, or having the connection drop out, can seriously disrupt the therapeutic process (Haberstroh et al., 2007). Furthermore, online counsellors may have to help clients trouble-shoot software or hardware problems if a client is having difficulties connecting or has low levels of computer literacy (Haberstroh et al., 2008). As such, it is recommended that online counsellors maintain alternative options for communication in case of technical failures.

Suitability for crisis intervention and/or serious disorders. The suitability of online chat counselling for treating various mental health issues has been brought into question. Finn and Barak's (2010) survey 93 online counsellors found that 95% thought that online chat was appropriate for interpersonal or social issues; however, there was much less agreement regarding issues that presented higher risks to client safety. Slightly less than 50% of the online counsellors thought that online chat was appropriate for domestic violence, rape and sexual assault issues, while only 20% thought that it was appropriate for substance abuse or child abuse. Finally, only 27% thought that online chat was appropriate for discussing suicidal thoughts, while 56% thought that it was inappropriate.

Moreover, qualitative studies have identified various counsellor concerns. A study of trainee online counsellor attitudes identified concerns about working online with major

mental disorders, such as bipolar or major depression (Haberstroh et al., 2008). In particular, they expressed concerns about not being able to reach a client if they discussed suicidal thoughts and then logged out of the session. Furthermore, another qualitative study reported that counsellors providing single-sessions of online counselling to adolescents commented that it was more difficult to accurately assess the degree of young people's problems and emotional issues within the online environment (Bambling et al., 2008).

Considering the importance of gathering accurate information to the provision of appropriate interventions, Mallen, Jenkins, Vogel, and Day (2011) attempted to determine if trainee counsellors were able to identify an online client's presenting issue. To do this, they used confederates presenting with either anxiety, depression, or mixed anxiety and depression. The trainee counsellors were then asked to provide a preliminary Axis I diagnosis using the DSM-IV-TR. The study found that while 86-90% of the participants could accurately diagnose either anxiety or depression individually, only 37% were able to accurately identify mixed anxiety and depression. This difficulty in identifying complex cases online may result in a lack of confidence in treating more complex cases.

The general lack of confidence by online clinicians in being able to assess or treat various mental health issues via online chat is most likely due to the lack of evidence supporting such interventions. As noted previously, there is only one study that aimed to treat a specific disorder (depression), while the remaining studies generally focused on more general interpersonal issues. No studies have examined the efficacy of online chat therapy for serious or complex mental disorders. If online chat is to be perceived as an effective treatment modality, more will have to be done to assure clinicians that working online is safe and effective across the range of presenting issues (Glasheen et al., 2013).

Ethical considerations. There are also a myriad of ethical issues to consider when engaging in online counselling. The Australian Psychological Society (APS) responded quite

early in the emergence of this modality, addressing developing issues of concern to psychologists by releasing a set of guidelines for providing psychological services over the internet (APS, 2011). The ethical issues most relevant to online chat include informed consent, confidentiality, competence, and record keeping.

The guidelines state that clients who choose or receive psychological services over the internet are entitled to know their psychologist's name, qualifications, registration number, and links to verify registration. Furthermore, clients are to be informed of the limits of confidentiality, such as the circumstances under which the psychologist will disclose information necessary to avert risk. Psychologists should also inform clients about the potential benefits of providing psychological services online, but should also inform clients about the potential limitations. In a review of 44 online counselling websites, 82% of practitioners claimed to be registered, but only 55% included verification links (Heinlen et al., 2003). Furthermore, while 85% noted the potential benefits of online counselling, only 27% listed the potential risks. Lastly, only 27% discussed the use of passwords and encrypted communications, and only 21% discussed disclosure of information to avert risk.

Potential lack of client confidentiality is another ethical concern cited as an issue for online counselling, with approximately 52% of clients expressing concerns about privacy online (Young, 2005). Privacy concerns were related to electronic transcripts being kept and the possibility of them being intercepted or accessed by anyone with access to the database, and fears of being interrupted by someone during an online session. Furthermore, in a study of school counsellors' perceptions of online chat, only 13% believed it was possible to ensure privacy (Glasheen et al., 2013). To minimize breaches in confidentiality, counsellors are encouraged to make use of passwords and utilise encryption techniques (Midkiff & Wyatt, 2008).

Competence in providing treatment online is another ethical concern. While it may be assumed that being competent in providing treatment face-to-face or over the telephone implies competence in treating clients via text, the difficulties of lacking any verbal or non-verbal cues and the slow speed of textual communications leaves this assumption open to question (Rummell & Joyce, 2010). The APS (2011) guidelines recommend that clinicians take steps to develop and maintain their competence for working online, and there are already programs designed to teach counsellors how to work online, using specific techniques such as '*emotional bracketing*' (Murphy, MacFadden, & Mitchell, 2008). Emotional bracketing is used to express nonverbal thoughts and feelings by adding those thoughts or feelings in brackets at the end of a sentence (e.g., [feeling concerned]). Furthermore, the APS (2011) guidelines recommend regularly monitoring the progress of clients in order to make decisions about whether or not treatment online is beneficial to the client. If clients are not making adequate progress, then it may be decided to refer them to more intensive services.

Online counselling is different to other modalities, in that emails and session transcripts are recorded in their entirety. While this means that psychologists do not need to write up session notes describing what was discussed (although it may be beneficial to write a summary), there is also the challenge of storing those records. As such, the APS (2011) guidelines recommend storing records in a secure manner, such as on an external hard drive, and making use of passwords and encryption software.

Factors affecting online chat treatment outcomes

In order to address concerns about the effectiveness of online chat as an intervention modality, researchers have started by examining factors that are known to affect face-to-face treatment outcomes. In a review of over four decades of empirical research, ranging from naturalistic observations to randomised control trials, Lambert (1992) identified four factors as being consistently important to the outcome of face-to-face therapy. These factors were

conceptualised as common factors that crossed therapeutic schools and included: client variables; the therapeutic relationship; placebo, hope and expectations; and techniques. Client variables, or extra-therapeutic changes unrelated to the intervention being used, were estimated to account for 40% of the outcome variance. The therapeutic relationship (e.g., empathy, unconditional positive regard, and encouragement) was the largest factor that could be attributed to the clinician and counted towards 30% of outcome variance. Furthermore, placebo (i.e., the hope or expectation that treatment will be efficacious) accounted for a further 15% of the outcome variance. Most notably, however, techniques (e.g., specific interventions and processes) were found to account for only 15% of the outcome variance— equivalent to the placebo effect.

Lambert's (1992) findings regarding face-to-face treatment outcomes have provided a starting point for the examination of factors affecting the effectiveness of online counselling. Due to the concerns about establishing an effective online therapeutic relationship, the majority of the limited research into common factors has been directed towards examining whether or not an effective therapeutic relationship could be established online (Cook & Doyle, 2002; Hanley, 2009; King, Bambling, Reid, et al., 2006). A relatively small amount of research has been done regarding client variables or techniques, while the placebo effects of hope and expectations have not yet been investigated at all.

Client variables. The client variables that have the potential to affect the process and outcomes of psychotherapy are virtually limitless (Lambert & Ogles, 2004). Client variables can be quite extensive, including characteristics that are internal to the individual (e.g., intelligence), or external (e.g., social support). Everything from demographic variables and environmental conditions to personality traits, presenting problems, and motivation can feasibly affect treatment outcomes. So far, examining client variables online has been

relatively limited, but what research there is has tended to focus on client attitudes towards seeking help online and presenting problems.

Client attitudes towards seeking help online have been shown to be somewhat mixed. For example, research has found that those who regularly use online chat to socialise find it psychologically beneficial, but also felt that regular internet users were lonely and that accessing the internet was addictive (Campbell, Cumming, & Hughes, 2006). Furthermore, it has been found that seeking help online may not be preferred to seeking help face-to-face (Bradford & Rickwood, 2012a; Tsan & Day, 2007) and research findings vary as to whether clients' preferred method of seeking help online is via chat or email (DuBois, 2004; Tsan & Day, 2007). However, two client variables have been found that may affect attitudes towards online chat: gender and introversion. Research has found that males generally hold equal or more positive attitudes towards online chat than females (Bradford & Rickwood, 2012a; Tsan & Day, 2007), even though males are still less likely to actually seek help online than they would be face-to-face (A. Callahan & Inckle, 2012; Fukkink & Hermanns, 2009a; King, Bambling, Reid, et al., 2006; Leibert et al., 2006). Introversion has also been found to positively relate to favourable attitudes towards online chat (Tsan & Day, 2007), but it is unknown if this positive attitude translates into increased rates of seeking help online.

Client presenting problems online appear to be primarily relationship and emotional issues (A. Callahan & Inckle, 2012; DuBois, 2004; Fukkink & Hermanns, 2009a). A. Callahan and Inckle (2012) reported that telephone clients were more likely to discuss everyday life issues, while Murphy, Mitchell, and Hallett (2011) reported that online clients were virtually identical to face-to-face clients in terms of reasons for presentation. Generally though, it can be assumed that online counsellors will be faced with a wide range of problems, from relationship and emotional issues to abuse/violence and highly distressed clients (Bambling et al., 2008; A. Callahan & Inckle, 2012; Fukkink & Hermanns, 2009a).

This diversity may be a significant factor affecting treatment outcomes, particularly if online chat is not suitable for high risk issues (Finn & Barak, 2010).

      Therapeutic relationship. The therapeutic, or working, relationship can be broadly defined as the collaboration between client and clinician to facilitate psychological change (Leibert, 2011). While there are numerous conceptualisations of the therapeutic relationship, Bordin (1979, 1994) developed a pantheoretical model that is appropriate to any therapeutic approach. This conceptualisation includes three components, including: bond (i.e., the development of reciprocal positive feelings between client and clinician); task (i.e., agreement on therapeutic intervention); and goals (i.e., agreement on the intervention's objectives). The perceived difficulty of establishing a therapeutic relationship online has been one of the most frequently cited criticisms of online counselling (Fenichel et al., 2002), although there are only a handful of studies that have examined this.

      In a study comparing online chat with face-to-face counselling, it was found that a working alliance could be established just as well online as it could be done face-to-face (Cook & Doyle, 2002). Furthermore, this study reported that the online group were more likely to develop therapeutic goals, suggesting that online counselling may be a particularly effective modality for establishing and developing goals. However, the results of this study should be interpreted with caution, as the sample size was small ($N = 40$) and self-selected. In another relatively small study of young people accessing an online counselling service ($N = 49$), it was reported that quality of the online working alliance was generally good (Hanley, 2009). While close to a quarter of the clients reported the working alliance to be low (23.9%), a majority (58.7%) of clients scored it as medium, and 17.4% reported it as high. Finally, in a larger naturalistic study of a youth online counselling service ($N = 186$), the therapeutic relationship was shown to be of a good quality in single session counselling (King, Bambling,

Reid, et al., 2006), but no significant relationship was found between therapeutic relationship scores and treatment outcomes.

Overall, these studies suggest that the therapeutic relationship, while perhaps more difficult to establish online, can still be developed satisfactorily. However, it is less clear how the online therapeutic relationship affects treatment outcomes. It may be, as Hanley (2011) suggests, that establishing a therapeutic relationship is greatly influenced by working online and needs appropriate training.

Placebo, hope and expectancy factors. Placebo refers to interrelated constructs reflecting the clinician or client's beliefs that treatment will be efficacious (Lambert & Ogles, 2004). In an attempt to measure and harness the placebo effect, researchers have examined the concepts of hope and expectations. While hope and expectations are regularly conflated, it should be noted that they are theoretically distinct, but linked, constructs (Leung, Silvius, Pimlott, Dalziel, & Drummond, 2009). So far, there has been virtually no research conducted regarding the hope and expectations of online clients.

In broad terms, hope is a way of thinking about goals. More specifically, hope refers to a wish or desire for something, accompanied by the expectation of obtaining it (Snyder, 2002). Historically, theories about hope developed out of the motivational literature, with hope conceptualised as a cognitive motivational process. Snyder's (2000) hope theory, the dominant cognitive-behavioural model, argues that hope is based upon goal-directed thinking. According to this model, hope comprises the process of thinking about and the motivation to move toward one's goals (agency thinking), and planning ways to achieve those goals (pathway thinking) (Snyder, 2002). The importance of hope during treatment is now well documented, leading many counselling researchers to conclude that "whatever the system of psychotherapy, beneficial change may be attributable, in part, to hope" (Lopez et al., 2004, p. 389). In studies of face-to-face services, people with higher levels of hope tend to

present with a greater number of goals, goals that are more challenging, have greater success at achieving those goals, and better treatment outcomes (Feldman, Rand, & Kahle-Wrobleski, 2009; Snyder, 2002). This suggests that one of the counsellor's roles is to help clients think in more hopeful ways. However, there appears to be no research exploring client hope or motivation within the current literature, and therefore should be investigated.

Expectations about treatment refer to "… anticipatory beliefs that clients bring to treatment and can encompass beliefs about procedures, outcomes, therapists, or any other facet of the intervention and its delivery" (Nock & Kazdin, 2001, p. 155). It has been suggested that expectations act as a mechanism for therapeutic change by allowing clients to believe that the intervention will be beneficial and, as such, will be more likely to engage with the intervention. Engaging with the intervention in turn helps improve well-being and hope for the future, which translates into reduced symptoms and improved life functioning (Howard, Lueger, Maling, & Martinovich, 1993).

Research has examined the effects of client expectations on important outcomes, including clinical improvements and attrition (Dew & Bickman, 2005). While the evidence is predominantly based on adult samples, and should be interpreted with caution regarding young people, it suggests significant associations between client expectations and clinical improvement; generally finding that more positive expectations are associated with improvements in mental health and well-being (Dew & Bickman, 2005; Glass, Arnkoff, & Shapiro, 2001; Thompson & Sunol, 1995). Client expectations have also been found to have a strong relationship with attrition, with lower expectations being associated with higher rates of attrition (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011). Currently, it is assumed that young online counselling clients have expectations of counselling similar to those of face-to-face clients (Richards & Viganó, 2013). However, no previous studies have

investigated if online chat clients endorse this view of counselling, nor whether positive expectations are associated with client improvement.

Techniques and processes. Techniques can refer to overall schools of therapeutic approaches (e.g., Cognitive Behavioural Therapy, Acceptance and Commitment Therapy, Motivational Interviewing) or to specific interventions and procedures (e.g., systematic desensitisation, mindfulness, goal setting) (Lambert & Ogles, 2004). Research has begun to explore the processes of online counselling, mostly centred on various supportive counselling models that seem to be most widely applied.

Mallen et al. (2011) have examined the processes of online chat, but compared online chat and face-to-face conversations using a sample of counsellors-in-training. They reported that online counsellors-in-training, similar to the peer support volunteers, most frequently used social support interventions such as approval and reassurance, open questions, and self-disclosure/immediacy. However, the counsellors-in-training were less likely than face-to-face counsellors to provide interpretations or offer direct guidance.

In a similar study, except using trained volunteers, Williams, Bambling, King, and Abbott (2009) identified two frequently used processes in online counselling: rapport building (e.g., encouragement, empathy, and paraphrasing) and task-accomplishment (e.g., information seeking questions, challenging client's thoughts/ feelings/behaviours, and discussing solutions). However, they noted that the slow pace of online chat may have potentially prevented online clinicians from applying more in depth techniques such as problem clarification, goal exploration, and action planning.

Lastly, Chardon, Bagraith, and King (2011) examined online counsellor adherence to a common counselling model. They found that only 53% of transcripts progressed through each of the five key stages of counselling: orientation; problem clarification; goal exploration; action planning; and termination. Furthermore, the depth in which each stage

was undertaken was relatively superficial. The majority of session time was spent gathering information, and very little attention was paid to goal exploration or action planning.

These studies, while generally limited to trained volunteers or students, suggest that while face-to-face counselling techniques can be transferred online, the majority of time is spent building rapport and providing emotional support. This may be due to the lack of verbal and non-verbal cues, requiring more time to be spent developing rapport; or it may be due to the natural time constraints of typing, which is significantly slower that speaking. The available literature suggests some concerns about the progress and depth of online counselling processes, but as yet there is no information clearly exploring the processes that practitioners mostly use and their fidelity to established counselling procedures, nor how the level of adherence to different counselling processes may affect online treatment outcomes.

Chapter summary and rationale for current research

In summary, there is a high prevalence of mental health problems within the Australian population, particularly for young people (Slade et al., 2009). Furthermore, young people are relatively unlikely to seek help for their mental health problems (Burgess et al., 2009). However, it is thought that many of the barriers to help-seeking may be overcome through the provision of online mental health services (Perle et al., 2011), and the Australian Government has developed an e-mental health strategy to develop these online services (DoHA, 2012). With government support and the expectation that online services will play an increasingly significant role in the future of mental health care through the development of an e-spectrum of interventions, it is becoming increasingly important that online interventions are efficacious and effective. The research regarding online counselling is particularly sparse, with limited evidence regarding its effectiveness or the factors that affect its effective implementation. In particular, there is a lack of research exploring how online counselling is implemented, specifically regarding practitioner fidelity to counselling processes and how

these relate to treatment outcomes. One online service that has recently been developed in line with the e-mental health strategy is eheadspace, a youth specific online counselling service. As such, eheadspace provides an ideal environment to explore how online counselling is being implemented to meet the needs of young people.

      eheadspace. Launched as a national service in June 2011, eheadspace is a clinical, youth-friendly, confidential, and free mental health support service for young people aged 12 to 25 years, and their families, friends and other supports (https://www.eheadspace.org.au/). The specific purposes of eheadspace are to: increase the accessibility of confidential and youth-friendly telephone and web based early intervention services for young people aged 12-25; complement and increase referral pathways to headspace centres and other local mental health, physical health, substance abuse, and vocational services; improve the help-seeking behaviours of young Australians; and improve mental health outcomes for young people who access the service. eheadspace mainly assists young people with mental health issues; however, it also offers support with psychosocial, vocational and educational issues (headspace, 2014).

      Support is provided by fully qualified mental health professionals including psychologists, mental health nurses, occupational therapists, and social workers. All staff are registered with the Australian Health Practitioner Regulation Agency (AHPRA), except for social workers who are members of (or eligible for membership with) the Australian Association of Social Workers.

      The approach of eheadspace is to initially respond to young people's presenting needs by using general/supportive counselling, problem solving therapy or cognitive behavioural therapy for the first three sessions. If a client reaches the end of three sessions and wishes to continue, a thorough assessment is conducted, and a plan formulated for future care as needed. When clients log onto the eheadspace website, they are transferred to the eheadspace

waiting room, which includes a chat function though which clients may communicate with the online clinicians, and also provides mental health information through youth friendly videos. It is through the waiting room that clients are directed to clinicians, informed about any waiting times, or asked to schedule an appointment if the service is unable to meet their needs in an appropriate time frame.

Aims

The aim of the proposed research is to explore the processes and effectiveness of providing synchronous individual online counselling and therapy to young people within the environment of eheadspace. There are five specific objectives for this research:

1. Identify previous studies regarding the effectiveness of online counselling by a systematic review of the literature.

2. Develop hypotheses regarding processes and effectiveness by exploring the experiences of online clinicians.

3. Identify the characteristics of young people who seek help from eheadspace, and their hopes and expectations regarding online treatment.

4. Examine the effectiveness of online counselling/therapy for young people according to post-intervention changes in outcome measures.

5. Determine the psychotherapy activities and processes used in online counselling/therapy for young people and how these relate to client outcomes.

Chapter 3: Methodological Overview

Chapter introduction

This chapter outlines the rationale behind the overall research design, considers the ethical issues, and briefly summarises the methods used within each study.

Research design

Given that research into the processes and effectiveness of online counselling is an emerging field, the current research was primarily exploratory in nature. This research comprised five major studies, each using different methodologies to achieve methodological triangulation (Denzin, 2006). A sequential exploratory mixed methods design was used, starting with a qualitative phase, followed by a quantitative phase, a combined qualitative/quantitative phase, and finishing with an overall integration of the findings (Creswell, 2008). There were five distinct studies, including a systematic review of the literature, a qualitative analysis of online clinician experiences, a cross sectional study of online youth clients, a six-week pre- and post-test of client treatment outcomes, and a mixed qualitative/quantitative analysis of session transcripts and the relationship of counselling processes with treatment outcomes. As outlined in Figure 3.1, the sequential exploratory nature of the research allowed findings from the initial systematic review (Study 1) and qualitative investigation (Study 2) to provide a context for and inform the development of a quantitative questionnaire (Studies 3 and 4) and help determine how the session transcripts should be analysed (Study 5).
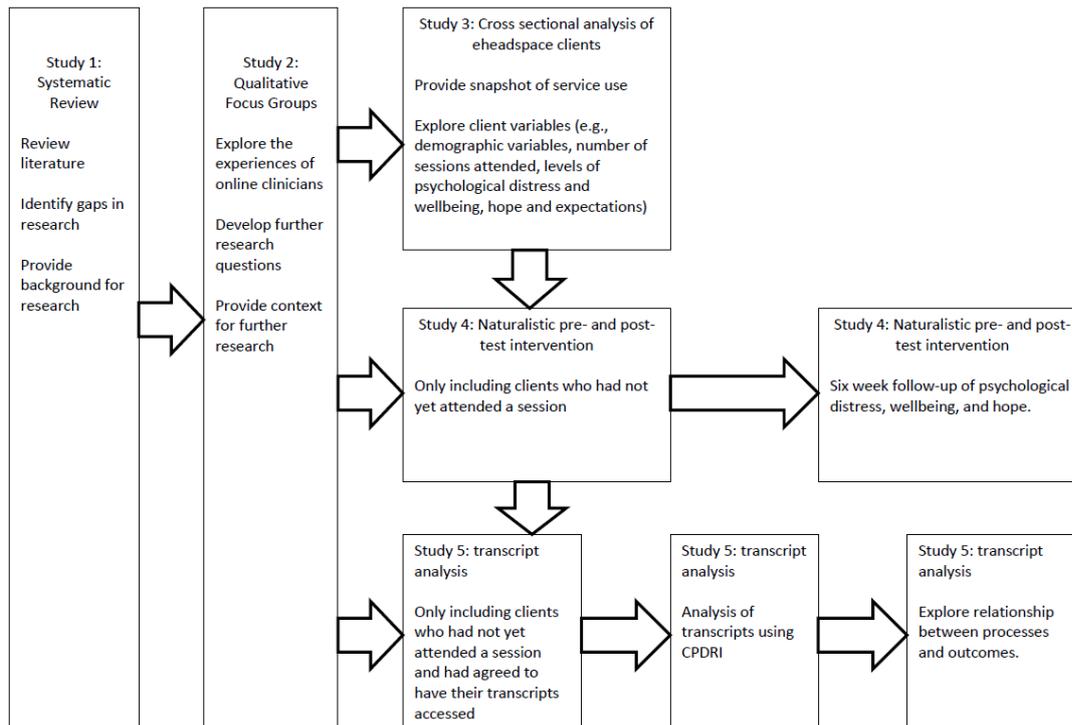
Figure 3.1. Sequential exploratory mixed methods design.

Ethics

Ethical approvals were obtained in accordance with the ethical review processes of

the University of Canberra's Human Research Ethics Committee and the guidelines of the

National Statement on Ethical Conduct in Human Research (NHMRC, 2007). Approval to

proceed with the research was granted 03/09/2012 under project number 12-143 (see

Appendix A). An amendment to conduct a focus group study with online clinicians was

submitted 11/09/2012 and was subsequently approved. Due to the slow pace of responses to

the six-week follow-up, two extensions were requested and approved. Furthermore, approval

to proceed was received from the eheadspace manager and headspace National Office.

Originally, it was proposed to include eheadspace clients across the entire age range of

those who can access the service, which is those between 12 and 25 years. Due to the self-

referral nature of the service, and almost impossibility of obtaining parental consent, it was

proposed to waive parental consent. However, the University of Canberra Human Research

Ethics Committee determined that parental consent would be required for any participants

under the age of 16. Consequently, considering the online nature of the research and the difficulty in obtaining or verifying parental consent within an online environment, it was decided to only include participants aged 16 years or over. In all other regards, the ethics application was approved, and a Contact Complaints form was provided for distribution (see Appendix B).

Study 1. Online counselling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat

The first study was a systematic review of the literature relating to online counselling, specifically focusing on effectiveness studies. The aim of this study was to identify all the published work relating to the effectiveness of online chat as a treatment method. Furthermore, a systematic review of the literature would provide context for further research and help develop relevant hypotheses. The review period took place between February and April 2012. A total of 1,872 articles were located by using the search terms "online therapy" OR "online counsel(l)ing" OR "Internet therapy" OR "Internet counsel(l)ing" OR "Internet psychotherapy" OR "cybertherapy" OR "e-therapy" OR "chat support" within the EBSCO database. A further 29 articles were located by reviewing reference lists. The process for removing articles is summarised in Figure 3.2 and the inclusion and exclusion criterion are presented in Table 3.1. The selection process left six relevant studies which were reviewed in detail. Since this systematic review was conducted, no new articles meeting the inclusion criteria have been published.

Study 1 is presented in Chapter 4, and has been published as:

Dowling, M., & Rickwood, D. (2013). Online counselling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. *Journal of Technology in Human Services, 31*(1), 1-21. doi: 10.1080/15228835.2012.728508
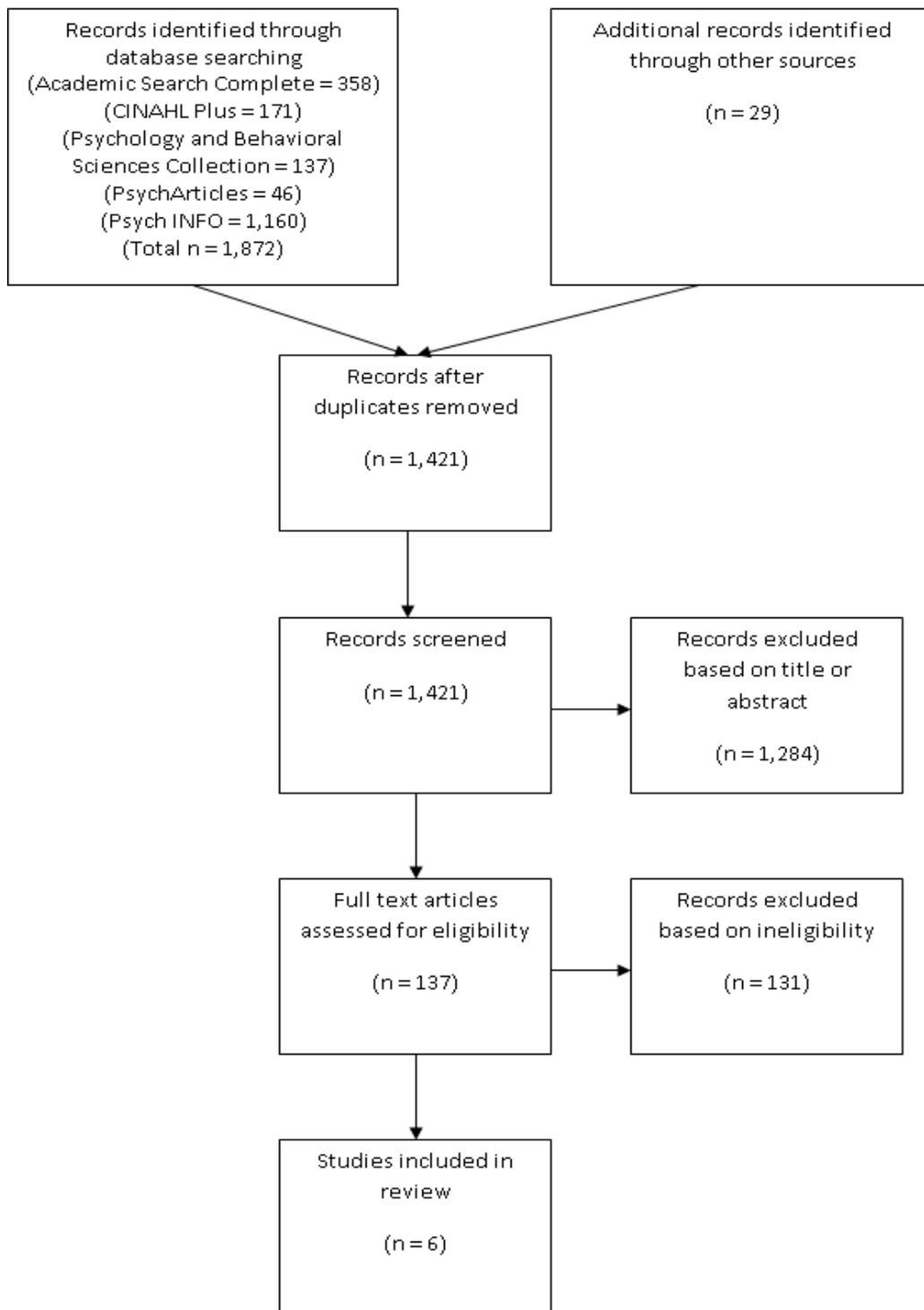
Figure 3.2. PRISMA diagram for systematic review.

Table 3.1

Systematic Review Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Participants engaged with a therapist online in real time via instant messaging or online chat.	The participants engaged with a therapist using audio or video-chat.
No web-based program was used in conjunction with counselling sessions.	Counselling was assisted by a web-based program.
There were more than five participants	There were fewer than five participants
The intervention was one-on-one	The intervention was group based.
The effectiveness of treatment was based on outcome measures of psychological symptoms, interpersonal and social functioning, and/or quality of life.	Dissertations and published poster abstracts.
Randomised control trials (RCT), quasi-experimental trials, and naturalistic comparisons included.	Articles not written in English.

Study 2. Experiences of counsellors providing online chat counselling to young people

The aim of the second study was to learn about the experiences of the online mental health clinicians, with particular reference to their experience of providing treatment online to young people. Participation was open to all the clinicians employed by eheadspace to provide online counselling. Participants were recruited during a staff training day at eheadspace in August 2012. The research took place over four 30-45 minute groups over one day with 19 clinicians who voluntarily participated. The participants were provided with participant information sheets and consent forms (see Appendix C). Most of the available clinicians participated.

Using focus groups, clinicians were asked a series of structured questions. The goal of using focus groups was to develop free-flowing discussion in which participants talked freely and interacted with one another, building on each other's comments (Patton, 2002). A comparative advantage of focus groups over individual interviews is the ability to enable

researchers to quickly identify the full range of perspectives held by the participants. While individual interviews could have potentially provided a greater depth of individuals' views/experiences, the interactional nature of the focus groups allowed participants to clarify or expand upon their contributions to the discussion in light of points raised by other participants, thus expanding the contributions that may have be left underdeveloped in an in-depth interview.

Based upon findings from the systematic review, the focus groups were asked:

1. In your experience, what types of problems are young people presenting with online?

2. What do you see as being your role during an online chat session?

3. During an online chat session, do you find yourself using any particular model or theory of counselling?

4. Are there any specific therapeutic techniques that you use during an online chat session?

5. How does online chat differ from the work you would do face-to-face?

The focus group sessions were recorded and then transcribed. Focus group data were entered into NVivo 10 qualitative data analysis software (Bazeley, 2007). A thematic analysis approach was used to identify patterns or themes within the data. Procedurally, thematic analysis includes: 1) becoming familiar with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; and 6) reporting the final thematic concepts (Braun & Clarke, 2006). The transcripts were coded line by line in NVivo by two independent researchers in order to assess interrater reliability, producing a Kappa coefficient of .76, which can be considered as 'strong' agreement (Robson, 2002). The themes and sub-themes were then reviewed in relation to the coded extracts, and ensuring that the analysis was reasoned, logical, and valid.

Study 2 is presented in Chapter 5, and has been published as:

Dowling, M., & Rickwood, D. (2014). Experiences of counsellors providing online chat counselling to young people. *Australian Journal of Guidance and Counselling, 24*(2), 183-196. doi: 10.1017/jgc.2013.28

Study 3. Exploring hope and expectations in the youth mental health online counselling environment

The aim of the third study was to determine the characteristics of the young people seeking help from eheadspace (e.g., age, gender, and psychological distress), their hopes and expectations regarding online treatment, and how many sessions they had attended. The study aimed to confirm some of the impressions from the focus group, such as the majority of clients being young highly distressed females. Specifically, it was hypothesised that hope and expectations would be associated with each other such that higher levels of hope would be related to more positive expectations of therapy. Nevertheless, some clients were expected to experience dissonance between hope and expectations, and those who were low on both hope and expectations or with incongruent scores were expected to have higher psychological distress and lower life satisfaction than those who had both high levels of hope and positive expectations. Finally, the relationship between amounts of online counselling received and differences in hope, expectations and level of psychological distress were explored.

Participants were recruited through an advertisement within the eheadspace "waiting room" posted from October 2012 to September 2013. The advertisement asked "Are you aged 16-25 and would like to participate in a survey about your experiences with eheadspace? Follow this link http://canberrahealth.qualtrics.com/SE/?SID=SV__dgPA3qmB3Ei9yqp". This stage of the research was open to all clients aged 16 years or above, regardless of the number of sessions attended. The participants were directed to an online questionnaire hosted by Qualtrics and were provided with information regarding the research and asked to

complete a consent form within the online questionnaire format before progressing to the questions (see Appendix D).

The questionnaire asked participants for their email address, gender (male or female), age (16-25), location (urban, rural, or remote), number of sessions attended (0-10), and were also asked to complete four measures. The online questionnaire is provided in Appendix D.

Psychological distress was measured by the brief Kessler Psychological Distress Scale (K10) (R. Kessler et al., 2002). The scale comprises 10 items that assess psychological distress based on anxiety and depressive symptoms over the last 30 days. Items include "During the last 30 days, about how often did you feel tired out for no good reason" and "During the last 30 days, about how often did you feel nervous". Items are responded to on a 5-point Likert-type scale from "none of the time" to "all of the time". A total score is obtained by summing all the items. This yields a scale score from 10 to 50, with higher scores indicating a higher level of psychological distress.

The K-10 has been widely used in Australian youth and adult populations, where it has been included in the Australian National Survey of Mental Health and Wellbeing (Sawyer et al., 2007). Furthermore, the K-10 is routinely used by headsapce and eheadspace (headspace, 2014; Rickwood et al., 2014). Considering the brief nature of the K-10 and its widespread use, it was decided that the K-10 would be an appropriate measure of psychological distress for the current research. A high level of internal consistency was attained in the current sample with a Cronbach alpha coefficient of .90.

Life satisfaction was assessed using the Brief Multidimensional Students' Life Satisfaction Scale (Athay, 2012). The scale comprises 6 items that measure perceived quality of life. Items include "How satisfied are you with your family life" and "How Satisfied are you with your friendships". Items are responded to on a 5-point Likert-type scale from "very dissatisfied" to "very satisfied". An average score is obtained by summing all items together

and dividing the result by 6. This yields an average score ranging from 1 to 5, with higher scores indicating greater perceived satisfaction with life.

The Brief Multidimensional Students' Life Satisfaction Scale has previously demonstrated sound psychometric qualities for young people aged 11-18 years (Athay, 2012), but has not previously been reportedly used with young adults (19-25). However, no measure of life satisfaction was found that covered the 16-25 year aged range of the current research, and considering that the majority of participants were expected to be under the age of 19, it was determined that the Brief Multidimensional Students' Life Satisfaction Scale would be the most appropriate measure to use. A good level of internal consistency was attained in the current sample with a Cronbach's alpha coefficient of .74.

Hope was measured by the Children's Hope Scale (Dew-Reeves, Athay, & Kelley, 2012). This scale comprises 4 items that assess perceived ability to generate paths toward goals and persevere toward those goals. Items include "When I have a problem I can come up with lots of ways to solve it" and "Even when others want to quit, I know that I can find ways to solve the problem". Items are responded to on a 6-point Likert-type scale from "none of the time" to "all of the time". An average score is obtained by summing all items together and dividing the result by 4. This yields an average score ranging from 1 to 6, with higher scores representing higher levels of hope.

The psychometric properties of the Children's Hope Scale are well reported (Dew-Reeves et al., 2012). While there was the option to use an adult version of the hope scale, considering the majority of participants would be under the age of 18, it was decided to use the Children's version. A good level of internal consistency was attained in the current sample with a Cronbach alpha coefficient of .83.

Expectations were measured by the Treatment Outcome Expectations Scale (Dew-Reeves & Athay, 2012). This scale comprises 8 items that assess expectations about the

outcomes of treatment. Items include "Counselling will help improve my relationship with my caregiver(s)" and "Counselling will help me learn how to deal with thoughts that are bothering me". Items are responded to on a 3-point Likert-type scale ranging from "I do not expect this" to "I do expect this". An average score is obtained by summing all items together and dividing the result by 8. This yields an average score ranging from 1 to 3, with higher scores reflecting higher expectations of treatment outcomes.

The Treatment Outcome Expectations Scale has been reported to have sound psychometric properties (Dew-Reeves & Athay, 2012). While other measures such as the Expectations About Counselling Brief Form (EAC-B) (Tinsley, Workman, & Kass, 1980) more comprehensively cover client treatment expectations, including 17 scales which measure four domains, the form was thought to be overly long for the current online study with 66 items. As such, the Treatment Outcome Expectations Scale was deemed to be a good compromise between length and providing meaningful data. A good level of internal consistency was attained in the current sample with a Cronbach alpha coefficient of .81.

The intention of the study was to recruit a cross-section of eheadspace service users at various stages of treatment. The study recruited 1,033 participants, of whom 513 (49.7%) had not yet attended a session, 246 (23.8%) had attended between one and three sessions, and 274 (26.5%) had attended between four and 10 sessions of eheadspace counselling.

This study is presented in Chapter 6, and has been submitted for publication in the journal Computers in Human Behavior as "Exploring hope and expectations in the youth mental health online counselling environment".

Study 4. A naturalistic study of the effects of synchronous online chat counselling on young people's psychological distress, life satisfaction, and hope

The aim of the fourth study was to evaluate the outcome of online counselling using repeated standardised measures. Three areas that had been identified as major gaps in

understanding the effects of online counselling were investigated. Firstly, this study examined online counselling within a naturalistic setting to determine the longer-term effects, at six weeks, of being able to utilise multiple counselling sessions. Secondly, the study explored whether clients who were also accessing telephone or face-to-face counselling had better outcomes. Third, the study investigated the effect of the common factors of hope and expectations within the online counselling environment, predicting that high and congruent hope and expectations would produce the best outcomes for online clients. The outcome measures included psychological distress, life satisfaction, and hope (agency and pathway thinking).

The 506 participants who had stated that they had not yet received a counselling session from Study 3 and consented being contacted were emailed six-weeks later asking them to complete a follow-up questionnaire. The email stated "Hi there! It has been six weeks since you completed the first part of our survey 'Online Counselling and Therapy for Young People' and we would now like to ask you to complete the second half of the survey. This should take no more than 5-10 minutes and you can then register to win one of 5 iTunes gift vouchers valued at $50 each.

Follow this link to the Survey: Take the Survey or copy and paste the URL below into your internet browser: http://canberrahealth.qualtrics.com/SE/?SID=SV_74jysbLO7Cu8fdz. Thank you for your time and co-operation!" The link directed the participants to the questionnaire hosted on the Qualtrics website and asked them to complete a consent form (see Appendix E). A total of 152 participants (31%) consented and completed the follow-up self-report questionnaire.

The questionnaire asked for the participants' email addresses (so that data sets could be linked together), how many sessions they had attended in the past six weeks, and whether they had sought additional help (e.g., face-to-face or telephone). The questionnaire included

repeated measures of the brief Kessler Psychological Distress Scale (R. Kessler et al., 2002), Brief Multidimensional Students' Life Satisfaction Scale (Athay, 2012), and Children's Hope Scale (Dew-Reeves et al., 2012). At the end of the survey, participants were asked if they would like to enter the draw to win a $50 gift voucher and provided with space to enter their postal details. The complete questionnaire is included in Appendix E.

This study is presented in Chapter 7, and has been submitted for publication in the journal Psychotherapy and Counselling as "A naturalistic study of the effects of synchronous online chat counselling on young people's psychological distress, life satisfaction, and hope".

Study 5. Investigating individual online synchronous chat counselling processes and treatment outcomes for young people

The aim of the fifth study was to determine the psychotherapy activities and processes utilised in online counselling/therapy for young people and investigate how these related to client outcomes. At the end of the initial questionnaire participants were asked if they would like to participate in an additional study. It was explained that consenting would enable their transcripts to be accessed and linked to their pre- and post-test data obtained during Study 3 and Study 4 (see Appendix D).

The participants were those young people identified in Study 3 as not yet having attended a session, had consented to have their transcripts accessed, and who had completed the follow-up questionnaire for Study 4. Of the 152 participants who had completed the follow-up, 101 also consented to having their transcripts accessed. However, almost half of these participants did not progress past requesting a counselling session due to lack of available counsellors, resulting in 49 transcripts that could be analysed.

The 49 transcripts were requested from eheadspace and were then de-identified, removing any mention of names or places, except for the email address used to link participant data. The transcripts were then entered into NVivo and analysed using the

Counselling Progress and Depth Rating Instrument (CPDRI). The conditions used to assess progress and depth are presented in Appendix F. The CPDRI was developed to evaluate counsellor adherence in the use of Egan's skilled helper model in online counselling and has been found to have sound internal consistency, good interrater reliability, and good face and convergent validity (Bagraith, Chardon, & King, 2010). The transcripts were coded by the lead researcher using the categories provided by the CPDRI. Half of the transcripts were coded by a second researcher and coding correlation was assessed by using the Kappa coefficient. In total, the CPDRI includes 11 steps of counselling. Progress is assessed by either its presence (1) or absence (0), providing an overall score ranging from 0 to 11 across all 11 steps. If progress through a step is deemed to have occurred, it may then be assessed for depth. Depth is scored using a 3-point scale, ranging from 1 (superficial or minimal depth), to 3 (elaborate or great depth). The CPDRI provides a total depth score between 0 and 33.

This study is presented in Chapter 8, and has been accepted for publication in the journal Advances in Mental Health as "Investigating individual online synchronous chat counselling processes and treatment outcomes for young people".

Chapter Summary

This chapter summarised the overall research rationale and design. The research comprised five studies that sequentially built an understanding of how online counselling is being delivered to young people through eheadspace and the factors affecting the effectiveness of the approach. The studies included a systematic review of the literature, a qualitative analysis of online clinician experiences, a cross sectional study of eheadspace client characteristics, a six-week follow-up of client treatment outcomes, and a mixed qualitative/quantitative analysis of session transcripts and the relationship of counselling processes with treatment outcomes. The ethical issue of obtaining parental consent online

was also discussed, and the subsequent need to restrict participation to those aged 16 and over.

Chapter 4: Online Counselling and Therapy for Mental Health Problems: A Systematic Review of Individual Synchronous Interventions Using Chat

Study 1. Chapter introduction

Chapter 4 presents the first research study, a systematic review titled 'Online Counselling and Therapy for Mental Health Problems: A Systematic Review of Individual Synchronous Interventions Using Chat'. This study aimed to identify previous studies regarding the effectiveness of online counselling by a systematic review of the literature. This paper has been peer-reviewed and was accepted for publication in the *Journal of Technology in Human Services* in September 2012.

Declaration for thesis chapter

Declaration by candidate.

In the case of Chapter 4, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Design and undertaking of systematic review, analysis of results, and writing of chapter.	95%

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%)	Contributor is also a student at UC Y/N
Debra Rickwood	General supervision, guidance, and editing of chapter	5%	N

Candidate's Signature		**Date: 12/12/14**

Declaration by co-authors.

The undersigned hereby certify that:

1. The above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

2. They meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

3. They take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

4. There are no other authors of the publication according to these criteria;

5. Potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and

6. The original data are stored at the University of Canberra and will be held for at least five years from 17/12/2014.

Debra Rickwood | | **Date: 12/12/14**

Chapter 4

This chapter has been removed due to copyright restrictions.

This chapter is available as:

Dowling, M. and Rickwood, D. (2013) Online counselling and therapy for mental health problems: systematic review of individual synchronous interventions using chat. *Journal of Technology in Human Services*. 31(1): 1–21.

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DOI	10.1080/15228835.2012.728508

Abstract

Online interventions are increasingly seen as having the potential to meet the growing demand for mental health services. However, with the burgeoning of services provided online by psychologists, counselors, and social workers, it is becoming critical to ensure that the interventions provided are supported by research evidence. This article reviews evidence for the effectiveness of individual synchronous online chat counseling and therapy (referred to as "online chat"). Despite using inclusive review criteria, only six relevant studies were found. They showed that although there is emerging evidence supporting the use of online chat, the overall quality of the studies is poor, including few randomized control trials (RCTs). There is an urgent need for further research to support the widespread implementation of this form of mental health service delivery.

Chapter 5: Experiences of Counsellors Providing Online Chat Counselling to Young People

Study 2. Chapter introduction

The fifth chapter presents the second research study titled 'Experiences of Counsellors Providing Online Chat Counselling to Young People'. This study aimed to explore the experiences of online clinicians and develop hypotheses regarding processes and effectiveness. Study 2 two presents the main themes that emerged from three focus groups with 19 eheadspace online clinicians. This study has been peer reviewed and was accepted for publication in the *Australian Journal of Guidance and Counselling* in October 2013.

Declaration for thesis chapter
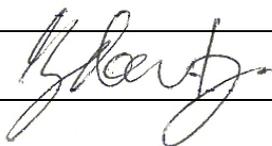
Declaration by candidate.

In the case of Chapter 5, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Design and undertaking of focus groups, analysis of results, and writing of chapter.	95%

The following co-authors contributed to the work:

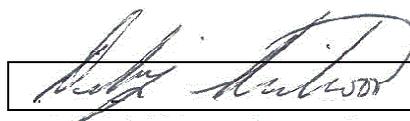| Name	Nature of contribution	Extent of contribution (%)	Contributor is also a student at UC Y/N
Debra Rickwood	General supervision, guidance, and editing of chapter	5%	N

Candidate's Signature		**Date: 12/12/14**

Declaration by co-authors.

The undersigned hereby certify that:

1. The above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

2. They meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

3. They take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

4. There are no other authors of the publication according to these criteria;

5. Potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and

6. The original data are stored at the University of Canberra and will be held for at least five years from 17/12/2014.

Debra Rickwood		Date: 12/12/14

Chapter 5

This chapter has been removed due to copyright restrictions.

This chapter is available as:

Dowling, M. and Rickwood, D. (2014) Experiences of counsellors providing online chat counselling to young people. *Australian Journal of Guidance and Counselling*. 24(2): 183–169.

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Print	http://webpac.canberra.edu.au/record=b1871885~S4
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DOI	10.1017/jgc.2013.28

Abstract

Online counselling is a rapidly growing field and, while there is emerging evidence of its comparative effectiveness, there has been little research into what techniques are being applied in practice and which clients will most likely benefit from this medium. Using a focus group methodology, this study examines the experiences of 19 online clinicians employed by a youth mental health service, investigating their perception of online clients, views on their counsellor roles, the approaches and techniques they employ, and the unique aspects of counselling in an online environment. Overall, online clinicians perceived their clients as presenting with highly complex problems and a high level of psychological distress. They noted online clients would most often use the service once or twice, and that some would use online chat as an adjunct to face-to-face counselling. The online clinicians described various roles, including: assessments, gatekeeping, providing emotional support, and therapeutic interventions. According to the online clinicians, they used a variety of techniques online, but favoured person-centred techniques, as these helped keep the clients engaged with the service. Areas of further research and implications for practice are discussed.

Chapter 6: Exploring Hope and Expectations in the Youth Mental Health Online Counselling Environment

Study 3. Chapter introduction

Chapter 6 presents the third study titled 'Exploring Hope and Expectations in the Youth Mental Health Online Counselling Environment'. Study 3 aimed to identify the characteristics of young people who seek help from eheadspace, and their hopes and expectations regarding online treatment. This study reports on the findings from 1,033 participants. Study 3 was submitted for peer-review with the journal *Computers in Human Behavior* in March 2014.

Declaration for thesis chapter
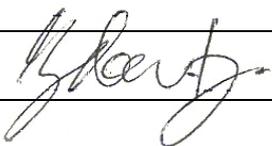
Declaration by candidate.

In the case of Chapter 6, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Design and undertaking of cross-sectional study, analysis of results, and writing of chapter.	95%

The following co-authors contributed to the work:

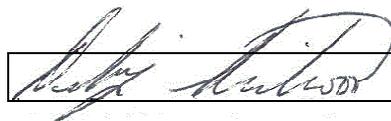| Name	Nature of contribution	Extent of contribution (%)	Contributor is also a student at UC Y/N
Debra Rickwood	General supervision, guidance, and editing of chapter	5%	N

Candidate's Signature		**Date: 12/12/14**

Declaration by co-authors.

The undersigned hereby certify that:

1. The above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

2. They meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

3. They take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

4. There are no other authors of the publication according to these criteria;

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6. The original data are stored at the University of Canberra and will be held for at least five years from 17/12/2014.

Debra Rickwood		**Date: 12/12/14**

Abstract

This paper explored the hope and expectations of young people accessing an online chat counselling service, as these common therapeutic factors have not yet been investigated in the online environment. Participants included 1033 young people aged 16-25 years, mostly young women, who completed an online questionnaire available through the online mental health service's homepage. Findings showed that online clients had low levels of hope, high treatment outcome expectations, high levels of psychological distress, and low levels of life satisfaction. Hope and expectations were barely associated and about two-thirds of respondents reported low hope but high expectations. Only hope, however, was found to be related to psychological distress and life satisfaction, with higher hope being protective. Expectations, discordance between hope and expectations, and amount of online services received were not associated with psychological distress or life satisfaction. The low levels of hope and high levels of psychological distress, but high expectations, of young people accessing online counselling reveal challenges for this approach.

Keywords: Internet; Online Counselling; Young People; Mental Health; Hope; Expectations.

Background

Adolescence and young adulthood are peak periods for the onset of mental health problems, with approximately three-quarter of all lifetime mental health disorders developing by age 24 (Kessler et al., 2005). However, only a small proportion of young people actually access mental health services. According to a national Australian survey, fewer than one-third of the young women and only 13% of young men aged 16-24 years who were experiencing clinically significant symptoms had sought professional help (Slade et al., 2009). There are many barriers to young people seeking mental health help, including lack of access to appropriate services, fear of stigma and negative attitudes to face-to-face mental health care (Rickwood, Deane, & Wilson, 2007).

It has been argued that online chat counselling, characterised by synchronous text-based communication carried out over the Internet with a counsellor or therapist, may be able to overcome some of these barriers to help-seeking (Barak, Klein, & Proudfoot, 2009; King, Bambling, Lloyd, et al., 2006). Online chat counselling provides an anonymous and potentially emotionally safer environment in which young people may feel freer to disclose their mental health problems (King, Bambling, Lloyd, et al., 2006). It also has the capability to reach a much wider audience, including those who feel uncomfortable seeking face-to-face help, who may not have access to face-to-face services (such as living in a rural or remote community), or can only access help outside of usual office hours (Perle, Langsam, & Nierenberg, 2011).

A small but developing body of research has started to investigate the effectiveness of online counselling via chat (Dowling & Rickwood, 2013) and factors affecting its outcomes, including the therapeutic relationship (Hanley, 2011; King, Bambling, Reid, & Thomas, 2006; Liebert, Archer, & Munson, 2006) and therapeutic techniques (Mallen, Jenkins, Vogel, & Day, 2011; Williams, Bambling, King, & Abbott, 2009). To date, however, the important common factors of hope and expectations have not been explored in an online chat setting. Hope and expectations are widely thought to affect positive psychological change, accounting for approximately 15% of the variance in treatment outcomes (Grencavage & Norcross, 1990; Lambert, 1992; Leibert, 2011; Norcross & Lambert, 2011). While hope and expectations were initially neglected in favour of examining therapeutic techniques and the therapeutic alliance, research has started to explore how hope and expectations can be influenced to improve client outcomes (Feldman & Dreher, 2012; Irving et al., 2004; Snyder, Ilardi, Michael, & Cheavens, 2000; Swift & Derthick, 2013).

The terms 'hope' and 'expectations' are frequently used interchangeably in the literature and, while they may be linked, it has been argued that they should be viewed as

distinct factors (Leung, Silvius, Pimlott, Dalziel, & Drummond, 2009). Hope is defined as "the perceived capability to derive pathways to desired goals, and motivate oneself via agency thinking to use those pathways" (Snyder, 2002, p. 249), whereas expectations refers to a client's probability-driven assessment of the likelihood that certain outcomes will result from counselling (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011). Hope is based on perceived personal agency, while expectations are based on perceived probable outcome.

According to Snyder (2002), the crucial aspects of hope are the process of thinking about and the motivation to move towards one's goals (agency thinking) and planning ways to achieve those goals (pathway thinking). It has been well established that a higher level of pre-treatment hope is correlated with fewer symptoms and greater wellbeing at baseline and throughout treatment (Irving et al., 2004; Waynor, Gao, Dolce, Haytas, & Reilly, 2012), goal attainment (Feldman, Rand, & Kahle-Wrobleski, 2009), and treatment outcomes (Irving et al., 2004; Snyder, 2002). A longitudinal study of 162 university students demonstrated that higher levels of hope, particularly in regards to agency thinking, were related to higher levels of self-reported goal attainment (Feldman et al., 2009). Furthermore, research exploring hope throughout a therapy intervention reported that agency thinking was associated with positive changes in well-being during the initial stages, while pre-treatment pathway thinking predicted post-treatment well-being (Irving et al., 2004). This suggests that helping clients to develop specific attainable goals may facilitate agency thinking during the initial stages of therapy that may in turn assist pathway thinking, and thus produce more positive treatment outcomes (Feldman & Dreher, 2012; Irving et al., 2004). Given the relationship between hope, goal attainment, and treatment outcomes, it is important to explore its role in the emerging context of therapeutic counselling using the medium of online chat.

Similar to hope, expectations have long been recognised as an influential therapeutic factor, affecting treatment outcomes and early termination. A comprehensive meta-analysis

of 8,016 participants between 46 independent samples reported a small yet significant positive relationship between outcome expectations and treatment outcomes (Constantino et al., 2011). Furthermore, client expectations have been found to be strong predictors of drop-out rates, accounting for 11-14% of the variance in premature termination (Aubuchon-Endsley & Callahan, 2009). Currently, there is no research exploring the treatment expectations of young online chat clients, although it is generally assumed that they would have expectations of counselling similar to those of face-to-face clients (Richards & Viganó, 2013). Given that the links between expectations, treatment outcomes, and early termination have been established within a face-to-face environment, it is timely that expectations be examined within an online setting, as results from face-to-face research may not apply online.

Leung et al. (2009) have argued that hope and expectations may be difficult to differentiate (e.g., 'I hope and expect to be in good health') in the absence of a specific stressor. However, when a stressor threatens wellbeing, a reappraisal of potential outcomes may ensue. This is likely to be based upon prior knowledge, desirability and probability and causes the person to re-evaluate the probability of counselling helping them to feel better. This may create a divergence between a client's preferred outcome (e.g., 'I hope to feel better') and their subjective probable outcome ('I do not expect counselling to help me'). Incongruent hope and expectations can, therefore, create cognitive dissonance, a feeling of excessive mental stress and discomfort resulting from holding conflicting beliefs. However, this could also act as a motivator to reduce the inconsistency. Research indicates that cognitive dissonance may produce psychological discomfort and addressing these inconsistencies may reduce it (Galinsky, 2000).

While previous research has reported a weak correlation between hope and expectations with a clinical face-to-face sample (Dew-Reeves, Athay, & Kelley, 2012), this relationship has not been explored within an online chat counselling environment. Leung et

al.'s model suggests that hope is the factor most malleable and important to maximise within the therapeutic environment, being moderated by and interacting with variables including goal setting, affect, agency and pathway thinking. There is currently no research addressing the effect of divergent or congruent hope and expectations upon online clients' levels of psychological distress and life satisfaction.

The current study aimed to explore hope and expectations as common factors potentially affecting treatment outcomes, which have not been considered by previous research with online counselling clients. Hope and expectations were hypothesised to be associated with each other such that higher levels of hope would be related to more positive expectations of therapy. Nevertheless, some clients were expected to experience dissonance between hope and expectations, and those who were low on both hope and expectations or with incongruent scores were expected to have higher psychological distress and lower life satisfaction than those who had both high levels of hope and positive expectations. Finally, the relationship between amounts of online counselling received and differences in hope, expectations and level of psychological distress were explored.

Method

Participants. Participants were 1,033 young people aged between 16 and 25 years who accessed an online youth web-counselling service from February to November, 2013. Participant recruitment was conducted via the service's homepage, with a written advertisement asking "Are you aged 16-25 and would like to participate in a survey about your experiences?" Upon clicking on the link, participants read and agreed to the consent form, and then completed the online survey. All participation was voluntary and self-selecting, although an incentive was included through the opportunity to win a $50 gift voucher.

Initially, 1,407 young people accessed the online questionnaire, but 374 of these did not complete the survey, resulting in a response rate of 73.4%. It is not known how many young people accessed the service during this time period. There were 893 (86.4%) females and 140 (13.6%) males, which is generally consistent with the demographics of other online services showing that about 80% of clients are female (Fukkink & Hermanns, 2009; King, Bambling, Reid, et al., 2006). Ages ranged from 16 to 25 years (M = 18.05, SD = 2.44), with a large positive skew. The participants came from urban (66.2%), rural (28.0%), and remote (5.8%) locations across Australia.

Procedure. Prior to the study commencing, ethical approval was obtained from the University of Canberra Committee for Ethics in Human Research. Due to concerns regarding obtaining parental consent, only young people aged 16 years or over were asked to participate. A link to the online survey was placed on the service's homepage which redirected participants to the Qualtrics website, an Internet survey software company. The participants were informed that they would be asked questions about how they felt regarding different aspects of their lives and their expectations of online chat counselling, and that the survey would take about 10-15 minutes to complete. Duplicate surveys were screened for by examining email and Internet Protocol (IP) addresses, but none were found.

Measures. A self-report questionnaire comprising 32 items was developed to collect data relating to demographics, hope for and expectations of counselling, psychological distress, and life satisfaction.

Demographic questions. These questions gathered background information on participants' gender, age, location, and number of online sessions previously attended.

Hope. The Children's Hope Scale (CHS-PTPB) is a measure of hopefulness that asks young people to report on their ability to generate paths toward goals and persevere toward those goals (Dew-Reeves et al., 2012). The CHS-PTPB has previously been used with young

people aged 11-18 years, and was deemed more suitable for this sample than the adult version that has only been used with those aged 18 years and over (Snyder, 2002). It measures goal-oriented thinking using four items, including questions such as "When I have a problem I can come up with lots of ways to solve it". Respondents are asked to answer each item on a 6-point scale ("None of the time" to "All of the time"), and answers are averaged to create a score ranging from 1 to 6. The CHS-PTPB has demonstrated sound psychometric properties, with satisfactory of internal consistency ($\alpha = .87$) and convergent validity (Dew-Reeves et al., 2012). The CHS-PTPB's internal consistency estimate for this study was $\alpha = .81$.

Expectations. The Treatment Outcome Expectations Scale (TOES) is a measure of client expectations about mental health treatment (Dew-Reeves & Athay, 2012). It consists of eight items assessing expectations about the anticipated outcomes of treatment. An example question is "Counselling will help me learn how to deal with my painful feelings". Respondents are asked to answer each item on a 3-point scale ("I do not expect this" to "I do expect this"), and answers are averaged to create a score ranging from 1 to 3. The TOES displays excellent psychometric properties, including an internal consistency coefficient of 0.91 for the youth version (Dew-Reeves and Athay, 2012). The TOES's internal consistency estimate for this study was lower but still acceptable, $\alpha = .83$.

Psychological distress. The Kessler Psychological Distress Scale (K-10) is a 10-item questionnaire widely used internationally to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent four week period (Kessler et al., 2002). Respondents are asked to answer each item on a 5-point scale ("None of the time" to "All of the time"), and answers are summed to create a score ranging from 10 to 50. Considering the brief nature of the K-10, its widespread use, and sound psychometric properties, it was decided that the K-10 would be an appropriate measure

of psychological distress for the current research (Andrews & Slade, 2001). The K-10's internal consistency estimate for this study was α = .90.

Life satisfaction. The Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS-PTPB) is a 6-item measure of perceived quality of life, which assesses global life satisfaction and satisfaction in the areas of family, friends, school, self, and living environment (Athay, 2012). Respondents are asked to answer each item on a 5-point scale ("Very dissatisfied" to "Very satisfied"), and answers are averaged to create a score of 1 to 5. The BMSLSS-PTPB has demonstrated sound psychometric qualities (Athay, 2012). The internal consistency estimate for this study was α = .74.

Results

Preliminary analysis. Means and standard deviations for each of the variables are presented in Table 1. Two age groups were created, those under the age of 18 years and thus more likely to still be involved in institutions such as school, and those aged 18 years and over, who are legally adults. Participants identifying themselves as being from rural or remote locations were combined due to the small number of participants from remote locations.

Initially, four factorial between groups analysis of variance (ANOVA) tests were used to compare the average hope, expectations, psychological distress, and life satisfaction of online chat clients according to gender (2), age group (2), and location (2). The only significant effect found with an effect size of more than one percent was a main effect for gender on psychological distress, $F(1, 985) = 12.82$, $p < .001$, partial $\eta^2 = .013$. This indicated that females reported slightly higher levels of psychological distress, but this was a small effect.

Hope scores were shown to be low, being below the midpoint of the scale ranging from 1-6. In contrast, expectation scores were high, as the average score was above the

midpoint of the scale that ranged from 1-3. While the expectation scores were similar to those reported by Bickman et al. (2010) (also shown in Table 1) for a clinical sample of adolescents accessing face-to-face (F2F) services, the hope scores were more than a standard deviation lower than those reported by the face-to-face clients.

Psychological distress scores were very high, with the average score being above the cut-off of 30 indicating severe psychological distress (Andrews & Slade, 2001). In concert, life satisfaction scores were low, with the average being below the midpoint of the scale ranging from 1-5. Furthermore, more than half of the current sample was over one standard deviation below the mean reported by Bickman et al. (2010) for a clinical face-to-face sample.

Table 1

Mean Scores (Standard Deviation) for Measures by Gender, Age, and Location

	Hope	Expectations	Distress	Life Satisfaction
F2F clinical youth sample (Bickman et al., 2010)	3.98 (1.25)[a]	2.44 (0.57)[b]	N/A	3.81 (0.85)[c]
Online chat sample				
Total (*N* = 1033)	2.32 (0.89)	2.34 (0.46)	35.11 (8.23)	2.50 (0.76)
Gender				
Male (*n* = 140)	2.53 (1.04)	2.23 (0.50)	32.07 (8.30)	2.56 (0.85)
Female (*n* = 893)	2.29 (0.87)	2.36 (0.46)	35.57 (7.91)	2.48 (0.73)
Age				
16-17 (*n* = 588)	2.31 (0.91)	2.32 (0.46)	35.51 (8.08)	2.52 (0.75)
18-25 (*n* = 445)	2.33 (0.91)	2.36 (0.47)	34.55 (7.98)	2.45 (0.75)
Location				
Urban (*n* = 684)	2.34 (0.92)	2.33 (0.46)	35.12 (8.01)	2.50 (0.77)
Rural/Remote (*n* = 349)	2.28 (0.85)	2.36 (0.47)	35.05 (8.13)	2.48 (0.70)

[a]*n* = 521; [b]*n* = 291; [c]*n* = 694

Correlational analysis. To assess the size and direction of the linear relationships between hope, expectations, psychological distress, and life satisfaction, bivariate Pearson's product-movement coefficients (r) were calculated and are presented in Table 2. According to Cohen (1988), an r of .1 can be considered small, an r of .3 can be considered medium, and an r of .5 can be considered large. The correlation analysis indicated that hope had a very small positive correlation with expectations, a moderate to large negative correlation with psychological distress, and a strong positive correlation with life satisfaction. Furthermore, expectations had a small positive correlation with life satisfaction, and life satisfaction had a strong negative correlation with psychological distress.

Table 2

Intercorrelations for Scores of Hope, Expectations, Psychological Distress, and Life Satisfaction

Measure	1	2	3	4
1. Hope	---	.07*	-.47**	.54**
2. Expectations		---	-.02	.15**
3. Psychological Distress			---	-.49**
4. Life Satisfaction				---

* $p < .05$, ** $p < .01$, *** $p < .001$.

Congruent and incongruent hope and expectations. Unexpectedly, hope and expectations were only weakly correlated. To examine their dissonance, high and low groups were created using the cut-off scores recommended by Bickman et al. (2010). The high hope group were those with scores equal to or above 3 (moderate to high hope), and the low hope group had scores less than 3 (low hope). The high expectations group were those with scores of 2 or more on the scale (moderate to high expectations), whereas the low expectations group scored less than 2 (low expectations). A cross-tabulation of these groups showed that 19.3% of the sample had both high hope and expectations; a substantial 64.6% had high

expectations but low hope; only 4.0% had high hope and low expectations; and there were

12.2% who were low on both.

Two factorial ANOVAs were used to compare the effects of level of hope and

expectations on psychological distress and life satisfaction. For psychological distress there

was a statistically significant but small main effect of level of hope, $F(1, 1029) = 80.33$, $p <$

.001, partial $\eta^2 = .072$, with those with lower levels of hope displaying higher levels of

psychological distress. The main effect of expectation level and the interaction were not

significant. For life satisfaction, the ANOVA test reported a statistically significant main

effect for hope, $F(1, 1029) = 141.95$, $p < .001$, partial $\eta^2 = .121$, with higher hope associated

with greater life satisfaction. The main effect of expectation and the interaction were not

significant.

Hope and expectations and online sessions attended. To determine whether hope

and expectations varied depending on the amount of online counselling that had been

received, two one-way analysis of covariance (ANCOVA) tests were used to compare hope

and expectation scores of online chat clients according to the number of sessions attended.

Because psychological distress and life satisfaction were quite strongly related to hope, these

factors were controlled for as covariates. The number of sessions attended ranged between

none (young people who answered the questionnaire during their initial log on and prior to

receiving any online counselling), up to more than 10 sessions, with a large positive skew.

Consequently, the sample was divided into three groups—those who had attended zero

sessions (49.7%), those who had attended between one and three sessions (23.8%), and those

who had attended four or more sessions (26.5%).

With hope as the dependent variable, results indicated that after controlling for the

effects of psychological distress ($F(1, 1028) = 80.44$, $p < .001$, partial $\eta^2 = .073$) and life

satisfaction ($F(1, 1028) = 204.54$, $p < .001$, partial $\eta^2 = .166$), hope did not differ significantly

according to the number of sessions attended. Similarly, for expectations, after controlling for life satisfaction ($F(1, 1027) = 25.85$, $p < .001$, partial $\eta^2 = .025$), there was no difference in expectations by the number of sessions attended.

Discussion

This study aimed to explore the hope and expectations of online counselling clients, as these are common factors affecting treatment outcomes that have not been studied in the online counselling environment. Results showed that online clients presented with low levels of hope, far lower than those reported in a clinical face-to-face youth sample, although they reported high expectations of treatment outcomes, in line with those of face-to-face clients (Bickman et al., 2010). While hope was strongly related to both psychological distress and life satisfaction, expectations only had a small correlation with life satisfaction. Unexpectedly, hope and expectations were barely correlated, and the relationship between them was extremely weak. However, no differences in psychological distress or life satisfaction were found due to incongruent hopes and expectations. Finally, it was found that after controlling for the effects of psychological distress and life satisfaction, the number of sessions attended had no impact upon client hope or expectations.

This research suggests that online clients have very low levels of hope, meaning that they may not believe that they can develop pathways to achieve their goals or have the agency and motivation to pursue those pathways to the completion of their goals (Dew-Reeves et al., 2012; Snyder, 2002). The results support previous findings that low levels of hope are strongly related to higher levels of psychological distress and lower levels of wellbeing (Irving et al., 2004; Valle, Huebner, & Suldo, 2006; Waynor et al., 2012). Considering the relationships between hope, goal attainment and treatment outcomes, these findings should be of considerable concern to online clinicians (Feldman et al., 2009; Irving et al., 2004; Valle et al., 2006). In order for online clinicians to help their clients achieve their

goals, it will be important to focus on collaboratively setting achievable goals, as this may help improve their agency thinking (Feldman & Dreher, 2012). Furthermore, once online clients have demonstrated that they can achieve a goal, this may improve their pathway thinking, helping them set and achieve their own goals (Irving et al., 2004).

In contrast to hope, online chat clients have quite high expectations, suggesting that they expect online counselling to provide positive outcomes (Dew-Reeves & Athay, 2012). This is an encouraging indicator, as positive expectations have been linked to improved clinical outcomes (Constantino et al., 2011). However, online clinicians should be aware that high expectations are associated with their own risks. Research indicates that clients who have negative experiences counter to their outcome expectations have poorer clinical outcomes (Watsford & Rickwood, 2013). Considering the high levels of distress and low levels of hope reported by online clients, their expectations of treatment outcomes may be unrealistic. This is crucial to realise, considering that approximately 30% of clients drop-out after the first session (Garfield, 1994; Hansen, Lambert, & Forman, 2002), and single sessions of online chat counselling only report moderate effect sizes (Fukkink & Hermanns, 2009; King, Bambling, Reid, et al., 2006). This reinforces the need for online clinicians to manage client expectations by presenting a convincing treatment rationale, provide outcome education, and compare client progress with expectations (Swift & Derthick, 2013).

Hope and expectations have been conceptualised as distinct, but linked, constructs (Leung et al., 2009), and previous research has reported at a small relationship ($r = .22$) between these two factors (Dew-Reeves et al., 2012). The current research supports the argument that they are distinct constructs, as only a very weak association between the two was found, accounting for less than one percent of the shared variance. This may be an effect of the online environment, however, as this is an emerging modality client hope and expectations may not yet be accurately shaped by prior beliefs, knowledge, or cultural norms,

and may not be realistic (Leung et al., 2009). Expectations were similar to those reported by face-to-face clients, but hope was very low. Online clients may be expecting equivalent outcomes of therapy but, perhaps due to the ease of access, anonymity and no-cost aspects of the online environment, they may not be highly committed to implementing cognitive and behavioural change. Consequently, it may be even more important for online clinicians to manage client expectations and build hope, particularly in the form of agency and motivation, as this may help reduce the divergence between hope and expectations (Leung et al., 2009; Swift & Derthick, 2013).

It was anticipated that high client expectations coupled with low levels of hope would signify incongruent cognitions, generating further psychological discomfort within online clients (Festinger, 1942; Gawronski, 2012; Leung et al., 2009). While two thirds of the sample was found to have incongruent hopes and expectations, their levels of psychological distress were similar to those who held congruent hopes and expectations. This may suggest that online clients do not find these beliefs to be in conflict and are not distressed by the apparent incongruence. Rather, they may view online chat counselling as a way of solving problems that they feel unable to solve by themselves. This may be a particularly challenging set of cognitions for online clinicians to manage, as the slow speed of online chat could limit their ability to complete interventions (Bambling, King, Reid, & Wegner, 2008). Research already suggests that online clinicians may focus on developing rapport rather than accomplishing tasks with young people (Williams et al., 2009), and if this does not meet the expectations of online clients, they may drop-out of the service (Watsford & Rickwood, 2013). In particular, the very high levels of psychological distress evident for young people accessing counselling online indicates that immediate distress reduction is likely to be an important outcome for young people, and something that they do not feel competent to achieve themselves. They, therefore, have high expectations that the online service will help

them achieve something that they cannot do on their own. It may be crucial that online clinicians attempt to reduce incongruent client hope and expectations by helping young people reduce immediate distress; this may increase their agency, facilitate further engagement, and produce the best outcomes for clients (Leung et al., 2009).

The results did not show a difference in hope or expectation according to amount of online counselling received, nor a difference in level of psychological distress related to different amounts of service provision. The cross-sectional nature of the current research, however, means that it is not possible to determine the effects of more or less online counselling, as this requires a longitudinal study of change over time. In the current study, it is possible that those who had attended more sessions may have had more serious problems, and this may have lowered their hopes or expectations. This may be evident in the fact that level of psychological distress was equivalent regardless of amount of service access.

Implications for online clinicians.

The current research suggest that young people seeking help online may be challenging for clinicians to treat, as they are lacking confidence to produce strategies and pursue them, yet expect clinicians to solve their problems. As such, during the initial session it may be important for online clinicians to build hope in clients by presenting a convincing treatment rationale, increasing faith in the clinician and the client, and provide realistic outcome education (Swift & Derthick, 2013). Clients who are confident in themselves, their clinician, and that the techniques will work will be more likely to be motivated to engage with treatment. Moreover it is important for young people seeking help to understand that significant psychological improvement is unlikely to be immediate but that it will happen over time, as this will help reduce the risk of not meeting the high expectations of clients (Watsford & Rickwood, 2013). As such it is crucial that online clinicians manage their clients

expectations and provide a positive experience of seeking help, which may increase the number of sessions clients attend and improve future help-seeking behaviour.

Limitations and directions for further research.

Several limitations must be kept in mind when interpreting these results. While this research has provided some insights into the hopes and expectations of online clients, due to the cross-sectional nature of the study design, causal inferences cannot be made to explain with any certainty the lack of change in clients' hopes and expectations according to the number of sessions they attended. Furthermore, being a naturalistic study, we were unable to control for subject factors, such as personality or preference for seeking help online, which may have affected the results. The voluntary nature of the participants may have introduced some level of bias to the findings, particularly the high proportion of young women (although this reflected the service's patterns of use according to gender). Similarly, being unable to include participants under the age of 16 restricted the ability of the results to match the client profiles of the service. However, one of the benefits of conducting the research online was that this allowed us to recruit a larger number of participants than can generally be achieved face-to-face. This research also relied on self-report methods, which and may be inaccurate due to issues being exaggerated or minimised. However, self-report methods are still the best method of collecting data regarding feelings and emotions that are inherently subjective, and online participants are generally just as honest as traditional paper-and-pencil participants (Gosling, Vazire, Srivastava, & John, 2004).

This research has presented a number of avenues for further research. Firstly, it would be recommended that research explore the effects of collaboratively developing client goals online and managing client expectations. In particular, it will be important to discover if managing online clients' expectations will address the divergence with hope. While client hope and expectations are known to affect face-to-face treatment outcomes, it is important to

establish if this also occurs in an online setting. Considering the generally incongruent levels of hope and expectations reported by online clients, future research should explore if this incongruence affects online counselling outcomes. Finally, future research should investigate if and how client hopes and expectations change over time, and if these changes are correlated with client outcomes

Conclusion

The current study has explored the hopes and expectations of young online chat clients, common factors affecting treatment that have not yet been explored in an online environment. This study found that online chat clients are highly distressed, with very low levels of hope, but relatively high treatment outcome expectations. Online clinicians will need to manage these divergent cognitions when tailoring an intervention strategy. It will be of key importance to address immediate distress, present a convincing treatment rationale, collaboratively develop achievable goals, provide outcome education, compare progress with expectations, and ensure that clients have a positive experience of seeking help online.

References

Andrews, G., & Slade, T. (2001). Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health, 25*(6), 494-497. doi: 10.1111/j.1467-842X.2001.tb00310.x

Athay, M. M. (2012). Satisfaction with Life Scale (SWLS) in caregivers of clinically-referred youth: Psychometric properties and mediation analysis. *Administration and Policy in Mental Health, 39*(1-2), 41-50. doi: 10.1007/s10488-011-0390-8

Aubuchon-Endsley, Nicki L., & Callahan, Jennifer L. (2009). The hour of departure: Predicting attrition in the training clinic from role expectancies. *Training and Education in Professional Psychology, 3*(2), 120-126. doi: 10.1037/a0014455

Bambling, M., King, R., Reid, W., & Wegner, K. (2008). Online counselling: The experience of counsellors providing synchronous single-session counselling to young people. *Counselling and Psychotherapy Research, 8*(2), 110-116.

Barak, A., Klein, B., & Proudfoot, J. (2009). Defining internet-supported therapeutic interventions. *Annals of Behavioral Medicine, 38*, 4-17. doi: 10.1007/s12160-009-9130-7

Bickman, L., Athay, M. M., Riemer, M., Lambert, E. W., Kelley, S. D., Breda, C., . . . Vides de Andrade, A. R. (2010). *Manual of the Peabody Treatment Progress Battery* Retrieved from http://peabody.vanderbilt.edu/ptpb\

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2 ed.). Hillsdale, NJ: Erlbaum.

Constantino, M. J., Arnkoff, D. B., Glass, C. R., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. *Journal of Clinical Psychology, 67*(2), 184-192. doi: 10.1002/jclp.20754

Dew-Reeves, S. E., & Athay, M. M. (2012). Validation and use of the youth and caregiver Treatment Outcome Expectations Scale (TOES) to assess the relationships between expectations, pretreatment characteristics, and outcomes. *Administration and Policy in Mental Health, 39*(1-2), 90-103. doi: 10.1007/s10488-012-0406-z

Dew-Reeves, S. E., Athay, M. M., & Kelley, S. D. (2012). Validation and use of the Children's Hope Scale-revised PTPB edition (CHS-PTPB): High initial youth hope and elevated baseline symptomatology predict poor treatment outcomes. *Administration and Policy in Mental Health, 39*(1-2), 60-70. doi: 10.1007/s10488-012-0411-2

Dowling, M., & Rickwood, D. (2013). Online counseling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. *Journal of Technology in Human Sciences, 31*(1), 1-21. doi: 10.1080/15228835.2012.728508

Feldman, D. B., & Dreher, D. E. (2012). Can hope be changed in 90 minutes? Testing the efficacy of a single-session goal-pursuit intervention for college students. *Journal of Happiness Studies, 13*(4), 745-759. doi: 10.1007/s10902-011-9292-4

Feldman, D. B., Rand, K. L., & Kahle-Wrobleski, K. (2009). Hope and goal attainment: Testing a basic prediction of hope theory. *Journal of Social and Clinical Psychology, 28*(4), 479-497. doi: 10.1521/jscp.2009.28.4.479

Festinger, L. (1942). A theoretical interpretation of shifts in level of aspiration. *Psychological Review, 49*(3), 235-250. doi: 10.1037/h0055434

Fukkink, R., & Hermanns, J. (2009). Children's experiences with chat support and telephone support. *Journal of Child Psychology & Psychiatry, 50*(6), 759-766.

Galinsky, Adam D. Stone JeffCooper Joel. (2000). The reinstatement of dissonance and psychological discomfort following failed affirmations. *European Journal of Social Psychology, 30*(1), 123-147.

Gawronski, B. (2012). Back to the future of dissonance theory: Cognitive consistency as a core motive. *Social Cognition, 30*(6), 652-668. doi: 10.1521/soco.2012.30.6.652

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? Professional Psychology: *Research and Practice, 21*(5), 372-378. doi: 10.1037/0735-7028.21.5.372

Hanley, T. (2011). Understanding the online therapeutic alliance through the eyes of adolescent service users. *Counselling and Psychotherapy Research, 12*(1), 35-43. doi: 10.1080/14733145.2011.560273

Irving, L. M., Snyder, C. R., Cheavens, J., Gravel, L., Hanke, J., Hilberg, P., & Nelson, N. (2004). The relationships between hope and outcomes at the pretreatment, beginning, and later phases of psychotherapy. *Journal of Psychotherapy Integration, 14*(4), 419-443. doi: 10.1037/1053-0479.14.4.419

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L., . . . Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959-976. doi: 10.1017/S0033291702006074

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602.

King, R., Bambling, M., Lloyd, C., Gomurra, R., Smith, S., Reid, W., & Wegner, K. . (2006). Online counselling: The motives and experiences of young people who choose the

Internet instead of face to face or telephone counselling. *Counselling and Psychotherapy Research, 6*(3), 169-174. doi: 10.1080/14733140600848179

King, R., Bambling, M., Reid, W., & Thomas, I. . (2006). Telephone and online counselling for young people: A naturalistic comparison of session outcome, session impact and therapeutic alliance. *Counselling and Psychotherapy Research, 6*, 175-181. doi: 10.1080/14733140600874084

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. Norcross & C. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.

Leibert, T. W. (2011). The dimensions of common factors in counseling. International *Journal for the Advancement of Counselling, 33*(2), 127-138. doi: 10.1007/s10447-011-9115-7

Leung, K. K., Silvius, J. L. , Pimlott, N., Dalziel, W., & Drummond, N. (2009). Why health expectations and hopes are different: The development of a conceptual model. *Health Expectations, 12*, 347-360. doi: 10.1111/j.1369-7625.2009.00570.x

Liebert, T., Archer, J., & Munson, J. (2006). An exploratory study of client perceptions of internet counselling and the therapeutic alliance. *Journal of Mental Health Counselling*, 28, 69-84.

Mallen, M., Jenkins, I., Vogel, D., & Day, S. (2011). Online counselling: An initial examination of the process in a synchronous chat environment. *Counselling and Psychotherapy Research, 11*(3), 220-227. doi: 10.1080/14733145.2010.486865

Norcross, J., & Lambert, M. (2011). Evidence-based therapy relationships. In J. Norcross (Ed.), *Psychotherapy relationships that work* (2 ed., pp. 3-21). New York: Oxford University Press.

Perle, J., Langsam, L., & Nierenberg, B. (2011). Controversy clarified: An updated review of clinical psychology and tele-health. *Clinical Psychology Review, 31*, 1247–1258. doi: 10.1080/15228835.2012.760332

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems. *The Medical Journal of Australia, 187*(7), 35-39.

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). *The mental health of Australians 2: Report on the 2007 national survey of mental health and wellbeing*. Canberra: Department of Health and Ageing.

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry, 13*(4), 249-275. doi: 10.1207/S15327965PLI1304_01

Snyder, C. R., Ilardi, Stephen, Michael, Scott T., & Cheavens, Jen. (2000). Hope theory: Updating a common process for psychological change. In C. R. Snyder & R. Egram (Eds.), *Handbook of psychological change: Psychotherapy processes & practices for the 21st century* (pp. 128-153). Hoboken, NJ: John Wiley & Sons.

Swift, J., & Derthick, A. (2013). Increasing hope by addressing clients' outcome expectations. *Psychotherapy, 50*(3), 284-287. doi: 10.1037/a0031941

Valle, M. F., Huebner, E. S., & Suldo, S. M. (2006). An analysis of hope as a psychological strength. *Journal of School Psychology, 44*(5), 393-406. doi: 10.1016/j.jsp.2006.03.005

Watsford, C., & Rickwood, D. (2013). Disconfirmed expectations of therapy and young people's clinical outcome, help-seeking intentions, and mental health service use. *Advances in Mental Health, 12*(1), 69-80. doi: 10.5172/jamh.2013.12.1.75.

Waynor, W. R., Gao, N., Dolce, J. N., Haytas, L. A., & Reilly, A. (2012). The relationship between hope and symptoms. *Psychiatric Rehabilitation Journal, 35*(4), 345-349. doi: 10.2975/35.4.2012.345.348

Williams, R., Bambling, M., King, R., & Abbott, Q. (2009). In-session processes in online counselling with young people: An exploratory approach. *Counselling and Psychotherapy Research, 9*(2), 93-100. doi: 10.1080/14733140802490606

Chapter 7: A Naturalistic Study of the Effects of Synchronous Online Chat Counselling on Young People's Psychological Distress, Life Satisfaction, and Hope

Study 4. Chapter introduction

The fourth study titled 'A Naturalistic Study of the Effects of Synchronous Online Chat Counselling on Young People's Psychological Distress, Life Satisfaction, and Hope' is presented in Chapter 7. This quantitative research paper examined the effectiveness of online counselling for young people according to post-intervention changes in outcome measures. This paper was submitted for peer-review with the journal *Counselling and Psychotherapy Research* in July 2014 and was re-submitted with changes in October 2014.

Declaration for thesis chapter

Declaration by candidate.

In the case of Chapter 7, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Design and undertaking of follow-up study, analysis of results, and writing of chapter.	95%

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%)	Contributor is also a student at UC Y/N
Debra Rickwood	General supervision, guidance, and editing of chapter	5%	N

Candidate's Signature		Date: 12/12/14

Declaration by co-authors.

The undersigned hereby certify that:

1. The above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

2. They meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

3. They take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

4. There are no other authors of the publication according to these criteria;

5. Potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and

6. The original data are stored at the University of Canberra and will be held for at least five years from 17/12/2014.

| Debra Rickwood | | Date: 12/12/14 |

Abstract

Background: Online individual chat counselling is an emerging treatment modality that appears to be an effective method of providing single sessions of counselling to young people. Aims: The current study aimed to investigate the effects of online counselling over a six week period and if this was affected by the number of sessions attended or having sought additional help. Furthermore, this study aimed to explore the effects of congruent and incongruent client hopes and expectations upon treatment outcomes. Method: This study used a naturalistic prospective design, measuring online clients' levels of psychological distress, life satisfaction, hopes, expectations, and tracking the number of sessions they attended or if they sought additional help during the six week period. Complete data was collected for 152 young people aged between 16 and 25 years. Results: After six weeks, participant levels of psychological distress and life satisfaction were not significantly affected by the amount of online counselling received or by having sought additional treatment. However, participants who attended one or more online sessions reported significantly higher levels of hope six weeks later than those with no online counselling. Furthermore, participants with low hope but high expectations at the commencement of counselling reported significantly increased hope after six weeks. Conclusions: The implications of these findings are discussed.

Keywords: Online counselling; adolescence; mental health; hope; outcome

Background

There are widespread mental health problems among young people (Slade et al., 2009), and young people are increasingly turning to the internet in order to seek mental health information and help (Perle, Langsam, & Nierenberg, 2011). In a large, 2000-participant, cross-sectional survey, 30.8% of Australian young people with a mental health problem reported searching online for mental health information (Burns et al., 2013). In order to take advantage of young people's increasingly frequent use of the internet, online counselling has emerged as a medium for the provision of mental health services, allowing clients a convenient method of communicating with a counsellor over any distance (Perle et al., 2011).

Communicating online for therapeutic purposes can occur via e-mail, video conferencing, internet phone, and online chat (Barak, Klein, & Proudfoot, 2009). In particular, online chat as a treatment modality appears to have been driven by demand from young people, with mental health services moving to meet that demand (Finn & Barak, 2010). While face-to-face service provision has been shown to remain the preferred source of help, approximately 16% of young people state a preference for seeking help online (Bradford & Rickwood, 2012).

There has been a proliferation of online chat services aimed at providing treatment to young people, but the research regarding effectiveness has been relatively scarce (Dowling & Rickwood, 2013). Of the research investigating the effectiveness of online chat with young people, all of the studies have focused on single sessions of supportive counselling. The first such study was a small study of 24 American undergraduates who were randomly assigned to receive either a single session of either online chat or face-to-face supportive counselling for anxiety (Cohen & Kerr, 1998). There were large pre- and post-effects for both the online chat ($ES = .83$) and face-to-face ($ES = .94$) treatment modalities. However, no significant differences were found between treatment modalities, indicating that there was no difference in receiving counselling either online or face-to-face. More recently, a large naturalistic comparison of 902 Dutch young people ($M_{age} = 13.8$, $SD = 2.0$) provided with either a single session of online chat or telephone counselling (Fukkink & Hermanns, 2009a). The study reported that client wellbeing increased for participants who received online chat ($ES = 0.62$, medium) or telephone ($ES = 0.34$, small) support. Furthermore, the perceived burden of the presenting problem fell for both online ($ES = 0.44$, medium) and telephone ($ES = 0.12$, small) groups. These improvements were maintained after one month. A smaller sample ($N = 95$), drawn randomly from the same service's database found online chat to be roughly equivalent to that of telephone counselling immediately after the intervention. By comparison, another naturalistic study providing single sessions of supportive counselling to 186 Australian young

people (M_{age} = 15.4, SD = 1.9) reported that participant distress was reduced for both online and telephone treatment groups (partial eta squared = 0.50), but that online chat was less effective than a telephone delivered service (King, Bambling, Reid et al., 2006). Together, these findings suggest that young people generally benefit from receiving a single session of online chat counselling.

While these results are encouraging, further exploration of the online chat medium is needed, particularly regarding the common factors that are thought to affect treatment outcomes. Lambert (1992) identified four factors that crossed therapeutic schools, including: client variables; the therapeutic relationship; placebo (hope and expectations); and techniques. Client variables, or extra-therapeutic changes unrelated to the intervention being used, were estimated to account for 40% of the outcome variance. The therapeutic relationship (e.g. empathy, unconditional positive regard and encouragement) was found to be the largest factor that could be attributed to the clinician, counting towards 30% of outcome variance. Finally, techniques (e.g. specific interventions and processes) and placebo (i.e. the hope or expectation that treatment will be efficacious) and were estimated to account for 15% of the outcome variance each. Lambert's findings regarding face-to-face treatment outcomes provide a starting point for the examination of factors affecting the effectiveness of online chat counselling.

While there is a virtually limitless number of client variables that may affect treatment outcomes, based on prior online chat research, the effects of multiple sessions and additional help-seeking appear to be important to assess. For example, previous studies with young people have only considered the effects of single online counselling sessions and no study has explored providing online clients with the naturalistic choice of access to multiple sessions. Moreover, research suggests that online clients may use online counselling alongside in-

person services (Dowling & Rickwood, 2014), but it is unknown if there is additional benefit to using a combination of service modalities.

While previous research has found that a good quality therapeutic relationship can be developed during a single session of online counselling (Cook & Doyle, 2002; Hanley, 2009), no significant relationship has yet been found between therapeutic relationship scores and treatment outcomes (King, Bambling, Reid, et al., 2006). Some research has examined the techniques and processes utilised during an online chat session (Mallen et al., 2011; Williams, Bambling, King, & Abbott, 2009; Chardon, Bagraith, & King, 2011), and although these studies suggest that face-to-face techniques can be transferred online, the findings have not yet been analysed in relation to treatment outcomes. While these common factors have received some attention by researchers, so far there has been virtually no research conducted regarding the hope and expectations of online clients.

Snyder's (2002) hope theory, the dominant cognitive-behavioural model, argues that hope is based upon goal-directed thinking. According to this model, hope comprises the process of thinking about and the motivation to move toward one's goals (agency thinking) and planning ways to achieve those goals (pathway thinking). The importance of hope during treatment is now well documented; in studies of face-to-face services, people with higher levels of hope tend to present with a greater number of goals and goals that are more challenging, and they have greater success at achieving those goals (Feldman, Rand, & Kahle-Wrobleski, 2009). Furthermore, studies have shown that hope is malleable and can be increased in the short term leading to greater levels of goal progress (Feldman & Dreher, 2012). This suggests that not only are clients' baseline levels of hope important to treatment outcomes, but that increased hope may be an important outcome itself.

Commonly associated with hope, client expectations about treatment are another important factor in establishing how treatment will proceed, and have been linked to

treatment processes (e.g. working alliance), outcomes (e.g. symptom reduction), and attrition (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011). While hope is a motivational construct, accessing what clients would prefer to happen, expectations are pragmatic assessments related to prior knowledge (Leung, Silvius, Pimlott, Dalziel, & Drummond, 2009). Currently, it is assumed that young online counselling clients have expectations of counselling similar to those of face-to-face clients (Richards & Viganó, 2013). However, to our knowledge, no previous studies have investigated expectations for online chat clients or whether positive expectations are associated with client improvement.

The current study aimed to investigate online counselling over a six-week period and determine if treatment outcomes were affected by (a) hope and expectations at baseline, (b) number of sessions attended, and (c) additional help-seeking. Specifically, it was hypothesised that:

1. Baseline hope and expectations would be positively associated and related to improvements in psychological distress and life satisfaction.

2. The number of sessions attended would moderate outcomes in terms of client levels of psychological distress, life satisfaction, and hope (i.e. agency and pathway thinking), such that more sessions would lead to better outcomes.

3. Clients who were also accessing additional (e.g. face-to-face or telephone) counselling would have better outcomes.

Method

Participants. This study utilised data from a total of 152 Australian young people aged between 16 and 25 years who were accessing an online youth mental health service. The participants self-selected by accessing a link requesting volunteers for the study on the service website. The link directed participants to a Qualtrics online questionnaire. Upon clicking on the link, participants read and agreed to the consent form, and then completed the

online survey. An incentive was included through the opportunity to win a $50 gift voucher. The initial survey was completed by 506 clients who had not yet commenced online counselling. These participants were then emailed six weeks later with a follow-up survey, of which 31% returned a completed follow-up questionnaire. The sample comprised 12.2% males and 87.8% females. The mean age of participants was 17 years (SD = 2.45), but the data were significantly skewed with 16 and 17 year olds making up almost half the sample. Approximately two thirds of the sample was from an urban location.

Intervention. The online counselling service is a youth friendly, confidential, free online mental health support service for young people aged 12 to 25 years. The approach of the service is to initially respond to young people's needs by providing general/supportive counselling, problem solving therapy, or cognitive behavioural therapy. If a client reaches three sessions and wishes to continue, a more thorough assessment is conducted and a treatment plan developed. Support is provided by fully qualified and supervised mental health clinicians, including psychologists, mental health nurses, occupational therapists, and social workers. All staff are registered with the Australian Health Practitioner Regulation Agency, or the Australian Association of Social Workers. When young people log on to the website, they are directed to a virtual 'waiting room' through which they are assigned to a clinician, informed of any waiting times, or asked to schedule a later appointment if the service is currently unable to provide access to a clinician in a timely manner. After their first session, clients can schedule an appointment with the same clinician, or return to the website at their time of choosing and chat to any available clinician.

Ethics Approval. Ethics approval was obtained from the University of Canberra's Human Research Ethics Committee. Originally, it was proposed to include clients aged between 12 and 25 years of age, consistent with the age range of the service, but the requirement of the Ethics Committee to obtain parental consent for those under 16 made this

untenable. Obtaining and verifying parental consent within the online environment is extremely challenging, and would introduce considerable bias by excluding all those who for cannot obtain parental consent.

Measures. A self-report questionnaire was developed to collect data relating to basic demographics, psychological distress, life satisfaction, and hope for and expectations of counselling. The six-week follow-up survey repeated the measures of hope, psychological distress and life satisfaction, and included measures of the number of online counselling sessions attended in the intervening period and the use of additional counselling.

Psychological distress was measured using the commonly used brief Kessler Psychological Distress Scale (K-10; Kessler et al., 2002). Respondents are asked to answer each item on a 5-point scale from 1 ('None of the time') to 5 ('All of the time'), and answers are summed to create a score ranging from 10 to 50. The K-10's internal consistency estimate (Cronbach's alpha) for this study was $\alpha = .90$.

The Brief Multidimensional Students' Life Satisfaction Scale (Athay, 2012) assessed global life satisfaction in the domains of family, friends, school, self, and living environment (Athay, 2012). Respondents are asked to answer each item on a 5-point Likert-type scale from 1 ('Very dissatisfied') to 5 ('Very satisfied'), and answers are averaged to create a score of 1 to 5. The scale's internal consistency estimate for this study was $\alpha = .74$.

The Children's Hope Scale measured ability to generate paths to and persevere toward goals (Dew-Reeves et al., 2012). The scale has previously been used with young people aged 11-18 years, and was deemed more suitable for this sample than the adult version that has only been used with those aged 18 years and over (Snyder, 2002). Respondents are asked to answer each item on a 6-point scale ('None of the time' to 'All of the time'), responding to questions such as 'When I have a problem I can come up with lots of ways to solve it'.

Answers are averaged to create a score ranging from 1 to 6. The internal consistency estimate for this study was α = .81.

The Treatment Outcome Expectations Scale determined client expectations about mental health treatment (Dew-Reeves & Athay, 2012). Respondents use a 3-point scale ranging from 1 ('I do not expect this') to 3 ('I do expect this') to respond to items such as 'Counselling will help me learn how to deal with my painful feelings'. The scale's internal consistency estimate for this study was α = .83.

Results

Descriptive analysis. Analyses were undertaken using SPSS (Version 21.0). Of the 152 young people who accessed the online chat website and responded to the follow-up, 38 (25%) did not progress to having an online counselling session, 62 (40.8%) had one session and 52 (34.2%) had 2-5 sessions (See Figure 1). Table 1 shows that just over one-third (39.5%) also sought additional mental health care (e.g. face-to-face or via telephone). Although a trend is evident whereby those who did not progress to online counselling were also less likely to use other forms of mental health care, this was not significant, $\chi^2 = 2.41$, $p = .299$.

Table 1

Number and Percentage of Participants Who Sought Adjunct Treatment by Online Sessions Attended

	No Sessions n (%)	One Session n (%)	Two or more sessions n (%)
Sought face-to-face/ telephone counselling.	11 (28.9%)	26 (41.9%)	23 (44.2%)
Did not seek other help.	27 (71.1%)	36 (58.1%)	29 (55.8%)
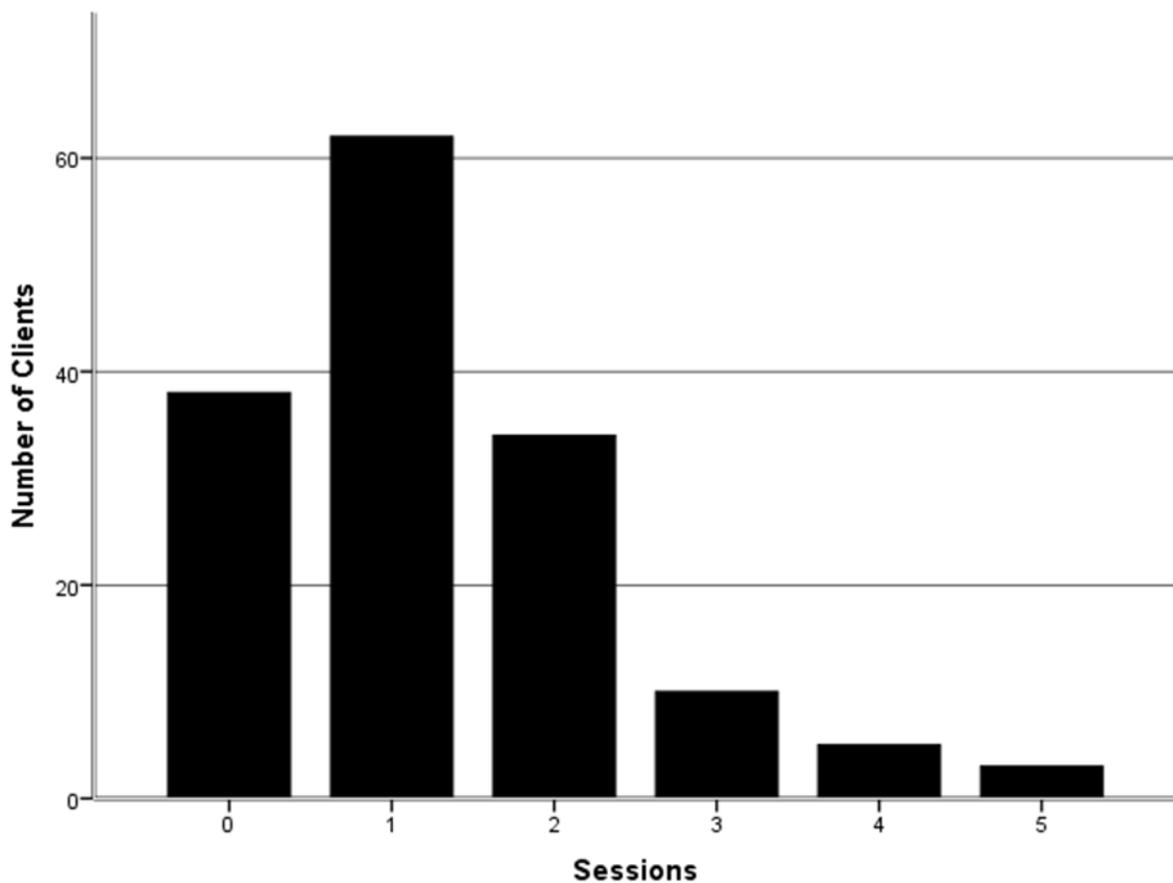
Figure 1. Distribution of number of counselling sessions.

Mean pre-, post-, and change scores for psychological distress, life satisfaction, and hope, along with pre-rated expectations, are presented in Table 2. Change scores were calculated for psychological distress by deducting post-test scores from baseline scores, while life satisfaction and hope change scores were calculated by deducting baseline scores from post-test scores. This produced measures where positive scores indicated improvements.

Pre-session psychological distress scores show that participants were very highly distressed, with 74.3% within the Very High range, 15.8% in the High range, and only 9.9% within the Low-Moderate range (Kessler et al., 2002). This was mirrored by low life satisfaction scores, with all means below the scale midpoint (Athay, 2012). Pre-session hope scores were also low, below the scale midpoint (Dew-Reeves et al., 2012). In contrast, treatment expectations were generally high, above the scale's midpoint (Dew-Reeves &

Athay, 2012). After six weeks the average psychological distress scores were significantly

lower ($t(151) = 4.72$, $p < .001$), and life satisfaction ($t(151) = 2.67$, $p = .009$) and hope ($t(151)$ $= 2.38$, $p = .018$) were significantly higher.

To determine whether the participants differed at baseline, a multivariate analysis of variance was undertaken. Any significant differences in psychological distress, life satisfaction, hope or expectations at baseline between those who attended no sessions, one session, or two or more sessions could potentially influence the treatment outcomes. However, the analysis revealed no multivariate effect (Wilks' Lambda = .96, $F(8,146) = 1.05$ $p = .400$), nor univariate effects for any of the measures of psychological distress, life satisfaction, hope or expectations at baseline. This shows that there were no differences between the participants at baseline on these measures, and as such any changes that occurred would most likely be due to the intervention, rather than the individual.

Table 2

Mean Scores and Standard Deviations by Number of Sessions

	No sessions	Single Session	Two or More Sessions
	($n = 38$)	($n = 62$)	($n = 52$)
Pre-Psychological Distress	35.50 (7.40)	33.16 (8.27)	35.90 (7.95)
Post- Psychological Distress	34.68 (8.72)	30.55 (8.81)	32.77 (8.81)
Psychological Distress Change	0.82 (6.08)	2.61 (6.11)	3.14 (6.28)
Pre-Life Satisfaction	2.59 (0.73)	2.56 (0.68)	2.47 (0.72)
Post-Life Satisfaction	2.56 (0.75)	2.78 (0.86)	2.64 (0.72)
Life Satisfaction Change	-0.03 (0.62)	0.21 (0.62)	0.17 (0.65)
Pre-Hope	2.55 (1.05)	2.57 (1.05)	2.23 (0.81)
Post-Hope	2.31 (0.90)	2.84 (1.05)	2.61 (1.06)
Hope Change	-0.24 (0.78)	0.26 (0.84)	0.38 (0.99)
Expectations	2.35 (0.42)	2.32 (0.54)	2.32 (0.43)

Hypothesis 1. Baseline hope and expectations would be highly associated and positively related to changes in psychological distress and life satisfaction. To assess the relationship between baseline hope and expectations, bivariate Pearson's product-movement coefficients (r) were calculated. According to Cohen (1988), coefficients of .1, .3 and .5 can be considered small, medium and large effects, respectively.

The correlation analysis showed that, unexpectedly, hope and expectations were not correlated. This lack of association was further evident by creating groups of those who were high or low on each measure by using the cut-off scores recommended by Bickman et al. (2010). The high hope group were those with scores equal to or above 3 (moderate to high hope), and the low hope group had scores less than 3 (low hope). The high expectations group were those with scores of 2 or more on the scale (moderate to high expectations), whereas the low expectations group scored less than 2 (low expectations). This revealed that 62.2% of the participants reported low hope but high expectations, 23.1% reported high hope and high expectations; 12.2% were low on both hope and expectations; and only 2.6% had high hope and low expectations.

To examine the association of hope and expectations with outcomes, separate correlations were undertaken for those who did and did not actually go on to access counselling, as a third of the sample did not receive any counselling. Because of the multiple tests, a Bonferroni-adjusted significance level of $p < .006$ was used to account for the increased possibility of type-I errors. As shown in Table 3, the analysis revealed that there were no significant relationships between baseline hope and expectations and positive changes in outcomes for either group. Note, however, that the sample size for the group that did not access online counselling is small and there is a lack of power to detect significant relationships.

Table 3

Intercorrelations for Scores of Pre-Hope, Expectations, Psychological Distress Change, Life Satisfaction Change and Hope Change.

		1	2	3	4
No Sessions	1. Pre-Hope	1.00	.04	.18	.20
	2. Expectations		1.00	-.17	-.16
	3. Psychological Distress Change			1.00	.42*
	4. Life Satisfaction Change				1.00
One or More Sessions	1. Pre-Hope	1.00	.11	-.22	-.15
	2. Expectations		1.00	.07	.09
	3. Psychological Distress Change			1.00	.39*
	4. Life Satisfaction Change				1.00

* p < .006

Hypothesis 2 and 3. The number of sessions attended would moderate outcomes in terms of client levels of psychological distress, life satisfaction, and hope, such that more sessions would lead to better outcomes; and clients who were also accessing additional counselling would have better outcomes. To examine the effects that online counselling and seeking additional help had upon treatment outcomes over the six-week period, three mixed repeated measures analyses of variance examined the dependent variables of psychological distress, life satisfaction, and hope. The amount of online counselling received included three groups: no counselling, one session, or two or more sessions. Participants were further divided into those who sought additional counselling and those who did not.

For psychological distress, a moderate to large effect for time was attained, $F(1,146) = 19.61$, $p < .001$, partial $\eta^2 = .118$. However, no significant effects were found for amount of online counselling received ($F(1,146) = 1.04$, $p = .356$, partial $\eta^2 = .014$), or having sought additional help ($F(1,146) = 1.97$, $p = .163$, partial $\eta^2 = .013$). The analysis revealed that the

participants who received online counselling did not improve any more than those who did not receive online counselling. Moreover, no differences were found between those participants who sought additional help and those who did not.

A similar pattern was evident for life satisfaction, with the only significant effect being a small effect of time, with an increase in life satisfaction across all groups, $F(1,146) = 7.01$, $p = .009$, partial $\eta^2 = .046$. However, no differences were found according to the amount of online counselling received ($F(1,146) = 0.86$, $p = .425$, partial $\eta^2 = .012$) or having sought additional help ($F(1,146) = 3.11$, $p = .080$, partial $\eta^2 = .021$).

For hope, no main effects were found for time ($F(1,146) = 3.49$, $p = .064$, partial $\eta^2 = .023$) nor for having sought additional help ($F(1,146) = 2.01$, $p = .158$, partial $\eta^2 = .014$). However, there was a moderately sized significant interaction effect between time and amount of online counselling received, $F(2,146) = 2.32$, $p = .003$, partial $\eta^2 = .077$. As shown in Figure 1, participants who had received one session, $t(61) = 2.41$, $p = .019$, $d = .25$, or two or more sessions, $t(51) = 2.75$, $p = .008$, $d = .36$, showed small and moderate improvements in hope scores, respectively. However, while the average hope score reported by those who did not receive any online counselling was lower after six weeks, this change was not found to be significant, $t(37) = 1.88$, $p = .068$, $d = .24$.
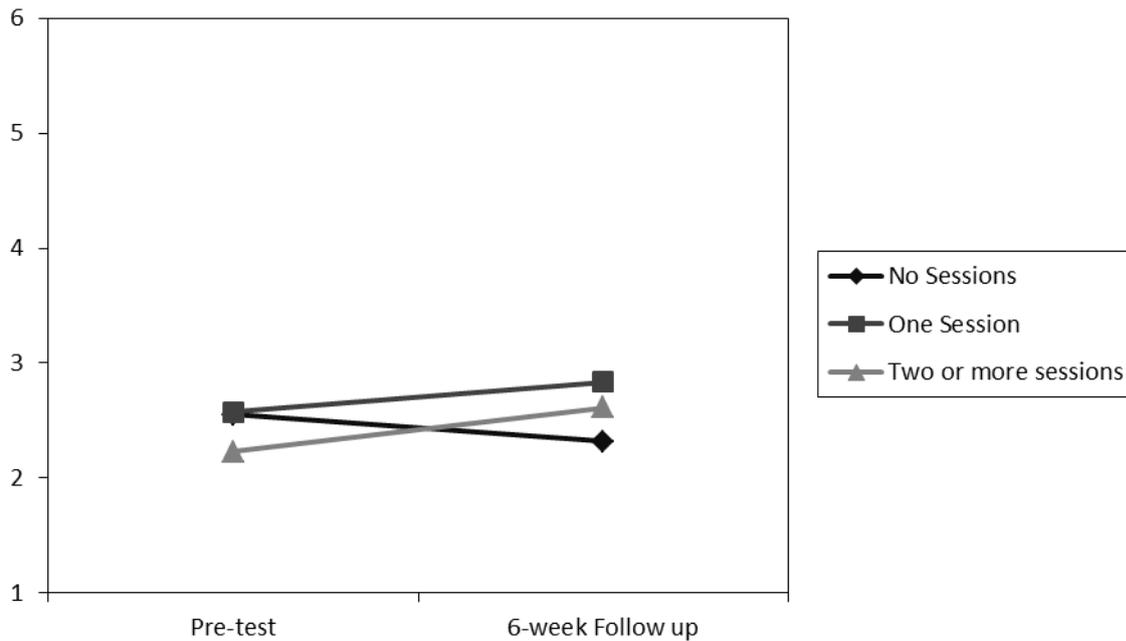
Figure 2. Hope scores over time by amount of online counselling.

Discussion

This study is the first to explore young people's hope and expectations within an online counselling context. The results revealed no relationship between hope and expectations; in fact, close to two thirds of the participants reported high expectations but low hope. Furthermore, baseline hope and expectations were generally found not to be related to changes in psychological distress or life satisfaction. The results indicated that all participants improved over time in terms of psychological distress and life satisfaction, regardless of how much counselling or additional help they received. However, results also showed that online counselling uniquely improved client levels of hope over a six week period, a change that did not occur for those who did not progress to receiving online counselling support.

It was hypothesised that higher levels of baseline hope and expectations would be related to each other and positive changes in psychological distress and life satisfaction. This study found no relationship between young people's hope and expectations. This was unexpected, and may be due to measurement issues or reflect real differences for young

people in the online environment. A weak correlation has previously been found between the Children's Hope Scale and the Treatment Outcome Expectations Scale with young face-to-face clients (Dew-Reeves et al., 2012), suggesting that hope and expectations may be distinct constructs as argued by Leung et al (2009).

Nevertheless, for a large proportion of participants, hope and expectations were incongruent, with them reporting high expectations but low levels of hope. This incongruence may explain this studies' inability to detect a relationship between hope and expectations and positive changes in psychological distress and life satisfaction as, conceptually, high and congruent hope and expectations should produce the best treatment outcomes (Leung, Silvius, Pimlott, Dalziel, & Drummond, 2009), and this pattern was evident for less than one-quarter of the young people. This has significant implications for online counsellors. For example, low levels of client hope may reflect a lack of motivation to achieve therapeutic goals (Feldman & Dreher, 2012) making it more difficult to engage young people with the therapeutic intervention. Moreover, there is a potentially detrimental effect in holding high expectations, and not having those expectations met (Watsford & Rickwood, 2013). As such, it may be important for online clinicians to manage young clients' expectations by presenting a convincing treatment rationale, express faith in their clients, provide outcome education, and compare progress with expectations (Swift & Derthick, 2013). This may help increase client hope and thus produce better treatment outcomes.

While psychological distress and life satisfaction scores generally improved over the six-week period, this was not unique to the participants who received online counselling. The general improvement, irrespective of the amount of counselling received, may reflect a lack of client engagement with the therapeutic process, or that clients are accessing as much counselling as they desire, as opposed to what clinicians would prefer. It has previously been noted that online clinicians find it difficult to keep clients engaged online, particularly if

attempting to deliver time consuming and complex interventions (Dowling & Rickwood, 2014; Glasheen, Campbell, & Shochet, 2013). As such, young people may not return for further treatment and the immediate benefit noted in previous studies may diminish (Fukkink & Hermanns, 2009a). Alternatively, according to the good enough level model of treatment, clients may be accessing as much help as they need to achieve their desired level of functioning (Stiles et al., 2008). It may be the case that seeking help online improves clients' motivation to complete their own goals.

Unique to this study, it was found that young people who had attended one or more sessions of online counselling reported moderately higher levels of hope, suggesting that they may have been more likely to develop solutions and be motivated to make behavioural changes (Snyder, 2002). The key aspects of short-term interventions are to ensure that clients leave with a pathway to solving their problem, increase their confidence that they have the skills and resources to do so, and the knowledge that they can return for further help (Campbell, 2012). The results of the current study suggest that a small number of online counselling sessions are able to achieve this important motivator of improving hope, which may be an essential antecedent to future change.

Lastly, over one-third of the participants were found to have sought additional treatment to online counselling (e.g. telephone or face-to-face), although this did not impact on the treatment outcomes measured in this study. While it was expected that seeking additional help would be beneficial, it could equally be the case that seeking help from multiple sources may be detrimental, if there is lack of coordination and integration, as this would not be ideal for clients. As such, it would be of interest to explore exactly how online counselling can be used in conjunction with additional services in order to provide the best outcomes for clients.

Implications for clinicians.

This research has highlighted several challenges for online clinicians; most notably that young clients report high levels of psychological distress, hold incongruent hope and expectations, generally attend a small number of sessions, and may be seeking additional help. These findings suggest that the young people seeking help online may be challenging to treat, as they are lacking confidence to produce strategies and pursue them, yet expect counselling to solve their problems. Combined with the severity of their psychological distress and the small number of sessions generally attended, it is unsurprising that there were only small improvements made over the six week treatment period. As such, it may be important, as Swift and Derthick (2013) suggest, for online counsellors to focus on building hope by fostering appropriate treatment expectations, including: presenting a convincing treatment rationale; increasing clients' faith in their clinician; expressing faith in clients; providing outcome education; and comparing progress with expectations.

Limitations.

Several major limitations must be kept in mind when interpreting these results. Firstly, this was a naturalistic study with no control over level of intervention; other unmeasured factors (e.g. personality or social factors) are likely to determine whether one or more treatment session were accessed. Voluntary participation invariably introduces bias to findings, particularly the preponderance of young women (although this reflected the service's patterns of use according to gender). Similarly, being unable to include participants under the age of 16 restricted the ability of the results to match the client profiles. Responsive outcome measures are also a challenge in this field and use of the K-10 and life satisfaction measures may not be the most sensitive and client-relevant measures of change. Other measures, such as session impact, may provide more useful indicators of therapeutic change.

Conclusion.

Online counselling has distinct advantages and is an increasingly popular treatment modality and it is important to find ways to improve its effectiveness. This study adds to the limited empirical data on the effectiveness of online counselling, the effects of baseline hope and expectations, access to multiple sessions, and seeking additional help. Results suggest that a small number of online counselling sessions may not uniquely improve client levels of psychological distress or life satisfaction over a six-week period, but that client hope may be improved during this time, which is an important outcome of itself. Online counselling clearly has benefits, but further research is needed to determine how this counselling modality can best achieve outcomes for young clients, and be incorporated within an integrated system of care for young people with mental health problems.

References

Athay, M. (2012). Satisfaction with Life Scale (SWLS) in caregivers of clinically-referred youth: Psychometric properties and mediation analysis. *Administration and Policy in Mental Health, 39*(1-2), 41-50. doi: 10.1007/s10488-011-0390-8

Bickman, L., Athay, M., Riemer, M., Lambert, E., Kelley, S., Breda, C., . . . Vides de Andrade, A. (2010). *Manual of the Peabody Treatment Progress Battery*   Retrieved from http://peabody.vanderbilt.edu/ptpb\

Bradford, S., & Rickwood, D. (2012). Adolescent's preferred modes of delivery for mental health services. *Child and Adolescent Mental Health, 19*(1), 39-45. doi: 10.1111/camh.12002

Burns, J., Davenport, T., Durkin, L., Luscombe, G., & Hickie, I. (2010). The internet as a setting for mental health service utilisation by young people. *Medical Journal of Australia, 192*(11), S22-S26.

Cohen, G., & Kerr, A. (1998). Computer-mediated counseling: An empirical study of a new mental health treatment. *Computers in Human Services, 15*(4), 13-27.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2 ed.). Hillsdale, NJ: Erlbaum.

Constantino, M., Arnkoff, D., Glass, C., Ametrano, R., & Smith, J. (2011). Expectations. *Journal of Clinical Psychology, 67*(2), 184-192. doi: 10.1002/jclp.20754

Dew-Reeves, S., & Athay, M. (2012). Validation and use of the youth and caregiver Treatment Outcome Expectations Scale (TOES) to assess the relationships between expectations, pretreatment characteristics, and outcomes. *Administration and Policy in Mental Health, 39*(1-2), 90-103. doi: 10.1007/s10488-012-0406-z

Dew-Reeves, S., Athay, M., & Kelley, S. D. (2012). Validation and use of the Children's Hope Scale-revised PTPB edition (CHS-PTPB): High initial youth hope and elevated

baseline symptomatology predict poor treatment outcomes. *Administration and Policy in Mental Health, 39*(1-2), 60-70. doi: 10.1007/s10488-012-0411-2

Dowling, M., & Rickwood, D. (2013). Online counseling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. *Journal of Technology in Human Services, 31*(1), 1-21. doi: 10.1080/15228835.2012.728508

Dowling, M., & Rickwood, D. (2014). Experiences of counsellors providing online chat counselling to young people. *Australian Journal of Guidance and Counselling*, *FirstView*, 1-14. doi: doi:10.1017/jgc.2013.28

Feldman, D., & Dreher, D. (2012). Can hope be changed in 90 minutes? Testing the efficacy of a single-session goal-pursuit intervention for college students. *Journal of Happiness Studies, 13*(4), 745-759. doi: 10.1007/s10902-011-9292-4

Feldman, D., Rand, K., & Kahle-Wrobleski, K. (2009). Hope and goal attainment: Testing a basic prediction of hope theory. *Journal of Social and Clinical Psychology, 28*(4), 479-497. doi: 10.1521/jscp.2009.28.4.479

Finn, J., & Barak, A. (2010). A descriptive study of e-counsellor attitudes, ethics, and practice. *Counselling and Psychotherapy Research, 10*(4), 268-277.

Fukkink, R., & Hermanns, J. (2009a). Children's experiences with chat support and telephone support. *Journal of Child Psychology & Psychiatry, 50*(6), 759-766.

Fukkink, R., & Hermanns, J. (2009b). Counseling children at a helpline: Chatting or calling? *Journal of Community Psychology, 37*(8), 939-948.

Glasheen, K., Campbell, M., & Shochet, I. (2013). Opportunities and Challenges: School Guidance Counsellors' Perceptions of Counselling Students Online. *Australian Journal of Guidance & Counselling, 23*(2), 222-235. doi: 10.1017/jgc.2013.15

Grencavage, L., & Norcross, J. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*(5), 372-378. doi: 10.1037/0735-7028.21.5.372

Kessler, R., Andrews, G., Colpe, L., Hiripi, E., Mroczek, D., Normand, S., . . . Zaslavsky, A. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959-976. doi: 10.1017/S0033291702006074

King, R., Bambling, M., Reid, W., & Thomas, I. (2006). Telephone and online counselling for young people: A naturalistic comparison of session outcome, session impact and therapeutic alliance. *Counselling and Psychotherapy Research, 6*, 175-181. doi: 10.1080/14733140600874084

Leung, K., Silvius, J., Pimlott, N., Dalziel, W., & Drummond, N. (2009). Why health expectations and hopes are different: The development of a conceptual model. *Health Expectations, 12*, 347-360. doi: 10.1111/j.1369-7625.2009.00570.x

Perle, J., Langsam, L., & Nierenberg, B. (2011). Controversy clarified: An updated review of clinical psychology and tele-health. *Clinical Psychology Review, 31*, 1247–1258. doi: 10.1080/15228835.2012.760332

Richards, D., & Viganó, N. (2013). Online counseling: A narrative and critical review of the literature. *Journal of Clinical Psychology, 69*(9), 994-1011. doi: 10.1002/jclp.21974

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). *The mental health of Australians 2: Report on the 2007 national survey of mental health and wellbeing*. Canberra: Department of Health and Ageing.

Snyder, C. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry, 13*(4), 249-275. doi: 10.1207/S15327965PLI1304_01

Stiles, W., Barkham, M., Connell, J., & Mellor-Clark, J. (2008). Responsive regulation of

    treatment duration in routine practice in United Kingdom primary care settings:

    Replication in a larger sample. *Journal of Consulting and Clinical Psychology, 76*(2),

    298-305. doi: 10.1037/0022-006x.76.2.298

Swift, J., & Derthick, A. (2013). Increasing hope by addressing clients' outcome

    expectations. *Psychotherapy, 50*(3), 284-287. doi: 10.1037/a0031941

Watsford, C., & Rickwood, D. (2013). Disconfirmed expectations of therapy and young

    people's clinical outcome, help-seeking intentions, and mental health service use.

    Advances in Mental Health, 12(1), 69-80. doi: 10.5172/jamh.2013.12.1.75.

Chapter 8: Investigating Individual Online Synchronous Chat Counselling Processes and Treatment Outcomes for Young People

Study 5. Chapter Introduction

The final research paper is presented in Chapter 8 and is titled 'Investigating Individual Online Synchronous Chat Counselling Processes and Treatment Outcomes for Young People'. This research paper examined the psychotherapeutic activities and processes used in online counselling with young people and how these related to client outcomes. Paper five has been peer-reviewed and was accepted for publication in the journal *Advances in Mental Health* in December 2014.

Declaration for thesis chapter

Declaration by candidate.

In the case of Chapter 8, the nature and extent of my contribution to the work was the following:

Nature of contribution	Extent of contribution (%)
Design and undertaking of transcript study, analysis of results, and writing of chapter.	95%

The following co-authors contributed to the work:

Name	Nature of contribution	Extent of contribution (%)	Contributor is also a student at UC Y/N
Debra Rickwood	General supervision, guidance, and editing of chapter	5%	N

Candidate's Signature		Date: 12/12/14

Declaration by co-authors.

The undersigned hereby certify that:

1. The above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

2. They meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

3. They take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

4. There are no other authors of the publication according to these criteria;

5. Potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and

6. The original data are stored at the University of Canberra and will be held for at least five years from 17/12/2014.

Debra Rickwood | | **Date: 12/12/14**

Chapter 8

This chapter has been removed due to copyright restrictions.

This chapter is available as:

Dowling, M. and Rickwood, D. (2014) Investigating individual online synchronous chat counselling processes and treatment outcomes for young people. *Advances in Mental Health*. 12(3): 216–224.

Links to this chapter:

Abstract

Objective: The aim of the current study was to explore the progress and depth of counselling processes used during online chat sessions, and their relationships to the number of sessions attended and client treatment outcomes.

Method: Transcripts from 49 online clients were analysed using the Counselling Progress and Depth Instrument. Psychological distress, life satisfaction, and hope measures were collected prior to the participant's first session and again 6 weeks later providing treatment outcomes. Results: Overall, progress and depth scores were higher for clients who attended multiple sessions and associated with greater alleviation in clients' psychological distress. Problem clarification and action planning processes were both correlated with reductions in psychological distress.

Conclusions: Findings imply that advancing through more of the stages of counselling in greater depth may help improve client outcomes from online counselling.

and efficacy of online counselling, with all six studies reporting a significant positive effect of online chat for outcomes relating to depression, anxiety, and general psychological distress and wellbeing (Dowling & Rickwood, 2013). Two studies reported that individual online synchronous chat was equivalent to face-to-face help (Cohen & Kerr, 1998; Murphy et al., 2009); one found that it was associated with better outcomes than telephone-delivered care (Fukkink & Hermanns, 2009a); one that it was equivalent to a phone delivered service (Fukkink & Hermanns, 2009b); one that it was better than a wait-list control (D. Kessler et al., 2009); and one that it was effective but less so than a phone delivered service (King, Bambling, Reid, et al., 2006).

Several areas were identified as needing further research, such as the effect of the number of sessions attended and factors affecting treatment outcomes. The findings suggested that the best treatment outcomes may be related to multiple sessions of structured therapy, rather than single sessions of supportive counselling. As such, it was determined to investigate the effects of multiple sessions of online counselling on client treatment outcomes. Furthermore, while conducting the literature review, it became apparent that little research had been conducted regarding common factors affecting treatment outcomes within the online environment, such as hope and expectations, or processes and techniques. As such, these were all deemed to be research gaps and areas of need for further research.

Study 2. Experiences of counsellors providing online chat counselling to young people. The aim of the second study was to examine the experiences of online counsellors providing mental health interventions to young people over the internet. The study explored counsellor perceptions of their online clients, client presenting problems, and if they felt online clients differed from clients they would expect to see face-to-face. The study also sought to determine online counsellors' perceptions of their own role and how they applied psychotherapeutic theory and techniques when working within the online environment.

According to the clinicians, their online clients were generally young females presenting with complex psychological and social problems, who often presented as highly distressed with a wide range of presenting problems, including clinically diagnosable problems as well as psychosocial and situational problems. Furthermore, the clinicians stated that most young clients generally only accessed the service once or twice. Of particular note was the report from clinicians that some young people were using online counselling in conjunction with face-to-face counselling.

Online clinicians were also asked about their own role and how they applied psychotherapeutic theory and techniques online. The clinicians reported fulfilling multiple roles, including acting as an assessor, gatekeeper, and counsellor. However, they reported that it was slow and difficult work conducting an assessment online, particularly as it was hard to keep the clients engaged. Moreover, these difficulties, combined with the small number of sessions clients were likely to attend, meant that clinicians reported a preference for nondirective techniques, such as empathy and validation, and referring clients to other services rather than more time consuming cognitive techniques, such as Socratic questioning.

This study provided a context for the subsequent research and helped develop further hypotheses. In particular, it became clear that there may be a need to manage clients engaging in multiple treatment interventions. Furthermore, when investigating psychotherapeutic techniques it seemed best to focus on a general counselling model, as this appeared to be what the majority of clinicians stated they were comfortable performing online. Considering this, it also seemed important to research clients' expectations of online counselling, to understand the types of therapeutic response they were anticipating, as these may differ from what the online clinicians actually do.

Study 3. Exploring hope and expectations in the youth mental health online counselling environment. The third study was a cross sectional analysis that aimed to

identify the characteristics of those who sought help from eheadspace, and their hopes and expectations regarding online treatment. It was hypothesised that clients would have high hope and expectations and that these would be associated with each other and related to better outcomes in terms of less psychological distress and better quality of life, or life satisfaction. Clients who experienced dissonance between hope and expectations, and those who were low on both hope and expectations or with incongruent scores were expected to have higher psychological distress and lower life satisfaction than those who had both high levels of hope and positive expectations. Finally, the relationship between amounts of online counselling received and differences in hope and expectations were explored.

Results showed that online clients were predominantly young females from an urban setting. Approximately half of those who participated in the online self-report questionnaire (49.7%) were waiting for their first eheadspace session and had not yet attended a session, while almost another quarter had attended between one and three sessions, and the remaining quarter had attended between four and ten sessions. Session attendance was heavily skewed, with the most frequent number of sessions attended being one or two. Online clients presented with high levels of psychological distress, low levels of life satisfaction, and low hopes regarding treatment outcomes. However, they held relatively high outcome expectations.

Regarding the hypotheses, it was found that hope and expectations were correlated, but the relationship between them was unexpectedly small ($r = .07$). Furthermore, while hope was negatively related to psychological distress ($r = -.47$) and positively related to life satisfaction ($r = .54$), expectations were related only to life satisfaction ($r = .15$). While it was expected that those who were low on both hope and expectations or with incongruent scores would report higher levels of psychological distress and lower life satisfaction, no such relationship was found. Finally, it was found that, after controlling for the effects of

psychological distress and life satisfaction, the amount of online counselling received had no impact upon client hope or expectations.

Study 4. A naturalistic study of the effects of synchronous online chat counselling on young people's psychological distress, life satisfaction, and hope. The fourth study was a six week follow-up of those participants in Study 3 who had said they had not yet attended any sessions. The study aimed to follow up with these clients after they had commenced online treatment to investigate if treatment outcomes were affected by: initial hope and expectations; number of sessions attended; and additional help-seeking. Specifically, it was hypothesised that: (1) baseline hope and expectations would be associated and positively related to changes in psychological distress and life satisfaction; (2) the number of sessions attended would moderate outcomes in terms of client levels of psychological distress, life satisfaction, and hope (i.e., agency and pathway thinking), such that more sessions would lead to better outcomes; and (3) clients who were also accessing additional (e.g., face-to-face or telephone) counselling would have better outcomes.

Of the 152 participants who responded, 25% did not progress to having an online counselling session, 40.8% had one session and 34.2% had between two and five sessions. However, more than a third of young people who accessed online counselling also sought help from telephone or face-to-face services. Regarding the first hypotheses, the results of this study indicated no relationship between hope and expectations; in fact, almost two thirds of the participants reported high expectations but low hope. Furthermore, baseline hope and expectations were generally found not to be related to changes in psychological distress or life satisfaction. In relation to the second hypothesis, the results indicated that on average participants improved over time in terms of psychological distress and life satisfaction, regardless of the number of sessions attended. However, the results of this study did suggest that online counselling may have improved clients' levels of hope over a six week period

compared with those who did not receive any counselling, with effect sizes ranging from ranging from $d = .25$ for those who attended one session to $d = .36$ for those who attended two or more. Finally, accessing additional help was not found to affect treatment outcomes.

Study 5. Investigating individual online synchronous chat counselling processes and treatment outcomes for young people. The fifth and final study examined the psychotherapy activities and processes utilised in online counselling/therapy for young people and compared these with outcomes. The progress and depth of counselling was explored and it was hypothesised that more sessions of online chat would increase the progress and depth of counselling sessions, and that higher progress and depth scores for online chat sessions would be related to better treatment outcomes.

The results of this study revealed that online counselling sessions were generally limited on progress and shallow in depth. The sessions analysed generally focused upon the problem clarification stages and action planning stages of counselling, with limited attention paid towards the goal exploration stage. However, even within the problem clarification and action planning stages, the majority of activity occurred within the story telling and strategy steps. Regarding the research hypotheses, it was found that clients who attended two sessions had higher progress ($d = 1.77$) and depth ($d = 1.76$) scores than those who attended a single session. Furthermore, higher overall progress and depth scores were related to greater changes in psychological distress, $r = .29$ and $r = .30$, respectively. However, progress and depth were not related to changes in life satisfaction. Further analysis revealed that depth in the problem clarification stage was positively related to changes in psychological distress ($r = .29$). Moreover, higher levels of progress ($r = .37$) and depth ($r = .37$) within the action planning stage were also positively related to improvements in psychological distress.

The effectiveness of online chat

A key aim of this research project was to examine the effectiveness of online counselling for young people according to post-intervention changes in outcome measures. As noted, the follow-up study found that while the participants' psychological distress and life satisfaction generally improved over six weeks, this improvement was not related to the number of sessions attended, nor by attending any sessions at all. However, what did improve by accessing one or more sessions of online chat were clients' levels of hope after six weeks. These results are of some concern, as they suggest that online chat may not be an effective means of reducing the symptoms of psychological distress or improving life satisfaction in young people in the short-term.

Previous studies have reported improvements immediately after one session of online counselling from similar online chat services (Fukkink & Hermanns, 2009a; King, Bambling, Reid, et al., 2006) and it has been noted that this improvement has been sustained over one month (Fukkink & Hermanns, 2009b). While the results of the current research also found an improvement in treatment outcomes, it could not be ascertained if this was due to the online chat intervention. Considering the lack of a clear finding regarding the overall effectiveness of online chat as a treatment intervention, it is crucial to consider variables that may have affected the treatment outcomes, including client variables, placebo (hope and expectations), techniques and processes, and the therapeutic relationship (Grencavage & Norcross, 1990; Leibert, 2011).

Factors affecting online chat treatment outcomes

In order to integrate the findings of the individual studies and better understand the results regarding treatment outcomes, the following section will discuss each of the significant findings using the common factors model as a framework, considering client variables, placebo (hope and expectations), techniques and processes, and the therapeutic

relationship (Grencavage & Norcross, 1990; Leibert, 2011). Client variables explored in this research include gender, number of sessions attended, additional help-seeking and presenting problems. The placebo factor is explored through client hope and expectations. Techniques and processes are addressed through progress and depth. The therapeutic relationship will be discussed focusing on bond task and goal.

Client Variables. The client variables potentially affecting treatment outcomes are extensive, including demographic factors and environmental conditions to personality traits, presenting problems, and motivation. The current research focussed specifically on four client variables of note: the gender disparity in clients accessing online chat; the number of sessions clients decided to attend; the decision to access additional forms of help; and the main presenting problem of the client.

Gender Disparity. The current research found a significant gender disparity, with over 85% of the online client samples being female. This is similar to what has been found in other naturalistic studies of online chat, where frequently more than 80% of clients are female (A. Callahan & Inckle, 2012; Fukkink & Hermanns, 2009a; King, Bambling, Reid, et al., 2006). However, it should be noted that females are also more likely to volunteer to participate in research, and as such the true gender disparity may be somewhat lower (Whitley, 2002). Despite this, the gender disparity online appears to be considerably higher than rates found in face-to-face sessions. In a census of 21,274 young people (aged 12-25 years) accessing a headspace centre across Australia, 63.7% of clients were female, and 35.6% male (Rickwood et al., 2014). While no gender effects on treatment outcomes were found, it is of significant concern that the proportion of young men seeking help online is relatively so low.

It has been commonly argued that online counselling is a model of service provision that would appeal to young men, who generally rate themselves as having more positive attitudes towards computers than females (Perle et al., 2011). Initial results were

encouraging; for example, one survey of 231 young Australians found that 16% reported a preference for seeking help online, and young men were 1.66 times more likely to prefer online sources over face-to-face sources than females (Bradford & Rickwood, 2012a). However, the large gender disparity in online chat service clients suggests that this positive attitude towards computers and seeking help online has not translated into higher rates of accessing online help.

While online chat may potentially reduce some of the major barriers to help-seeking for young men, such as the stigma related to seeking help for mental health problems, it may not address others, such as a lack of awareness of resources and lack of social support or encouragement from others (Gulliver et al., 2010; Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003). Despite the proliferation of online mental health services, there is a lack of overall organisation and the services are only weakly integrated with the broader mental health system (King, Bickman, Shochet, McDermott, & Bor, 2010). Essentially, this may mean that young men are unaware that seeking help from an online chat service is an option, as highlighted by research findings that young people were comfortable searching google for mental health information, but rarely found the information or resources they needed (Neal et al., 2011). As such, there may be an issue with the dissemination of information related to awareness of online interventions. Furthermore, based on the results of a cross-sectional survey of young people's attitudes towards mental health and technology, it was found that females stated that they would respond proactively to a friend who needed help online and intervene, while young men reported that they would be less likely to confront the issue directly (Ellis et al., 2012). This may reflect a lack of social support for males online, as they may not be encouraging each other to seek help for mental health problems. The researchers concluded that online interventions aimed at young men needed to be action-oriented,

informed by young men's views and everyday technology practices, and the leverage of peers in the help-seeking process.

Number of sessions attended. In Study 2 online clinicians reported that it was often difficult keeping clients engaged and that the majority of clients only attended a small number of sessions. The cross-sectional study of 1,033 online clients supported this, finding that the majority of clients completing the survey had attended only one or two sessions, although there was a small but notable proportion who stated they had attended ten or more sessions. Similarly, the six week follow-up study of commencing clients found that the majority only attended a single session of counselling, while no clients attended more than five (although this is not surprising over a six week period). It was hypothesised that more sessions would provide greater improvements over the six week period. However, the results of the current research generally did not support this hypothesis, with only hope improving in relation to the number of sessions attended. There are three potential explanatory models that may explain the general lack of change in relation to the number of sessions attended—the dose-response model, the good-enough level model, and unmet expectations.

In psychotherapy research, the dose-response model investigates the effects of differing numbers of sessions (doses) on treatment outcomes (responses) (Harnett, O'Donovan, & Lambert, 2010). The aim of dose-response focused research has been to identify how many sessions are needed for clients to reliably improve. While there is still debate regarding the methodology of dose-response studies, there is a general consensus that 13-18 sessions are needed for 50% of clients to improve to a level of functioning consistent with the general population (Hansen, Lambert, & Forman, 2002). Considering that the participants in the six week follow-up study generally attended only one or two sessions, the dose-response model would suggest that they had simply not attended enough sessions to experience clinically significant improvements in their levels of psychological distress or life

satisfaction. As such, it could be argued that online clinicians should guide their clients'

expectations regarding how many sessions they would most likely need to attend in order to

improve (Swift & Derthick, 2013) and encourage their clients to commit to and return for

further sessions, or refer to a specialist. However, attending so many sessions may require

high levels of motivation to change or positive engagement with the treatment intervention,

which does not appear to be evident in the current environment.

Another explanation for the general lack or weak relationship between the number of

sessions attended and treatment outcomes may be the good-enough level model, which

argues that individuals who attend fewer sessions do so because they respond more quickly to

treatment than those who attend more sessions (Reese, Toland, & Hopkins, 2011). In this way

treatment duration may be regulated by the client, so that clients may terminate the

intervention when a satisfactory level of improvement has been attained (Barkham et al.,

2006). This may help explain why there was generally no relationship found between the

number of sessions attended and treatment outcomes, as clients improve at different rates.

However, it is difficult to determine if the good-enough level model is applicable to the

current research, as the overall effectiveness of online chat as a treatment modality is unclear.

Generally, there is a lack of qualitative information exploring precisely what young people

hope to achieve by seeking help online. As such, it is conceivable that clients commonly only

wanted to attend a small number of sessions and were satisfied with their experience, as has

been found to be the case for single sessions of face-to-face therapy (Hymmen, Stalker, &

Cheryl-Anne, 2013). Further research would be required to explore this possibility.

Finally, the generally small number of sessions attended and small changes in

treatment outcomes may be indicative that online chat services are not meeting client

expectations. As shown in this research, the majority of clients held relatively high

expectations of online counselling, which has been identified as a problem in face-to-face

studies (Constantino et al., 2011). If a session does not meet the high expectations of a client, or if they have a negative experience, then they are far less likely to return for further sessions (Watsford & Rickwood, 2014). While there is currently no qualitative data regarding what clients expect to occur online, the high expectations of improvements in treatment outcomes may suggest that client expectations are either unrealistic or not being met.

Young people seeking help from online youth services are generally only attending one or two sessions. Evidence from face-to-face studies using the dose-response model would suggest that online clients are not attending enough sessions to experience clinically significant psychotherapeutic change. The good-enough level model would suggest that young people are terminating contact when they feel that they have achieved a satisfactory level of improvement. However, at present this does not seem evident from the measures of psychological distress and life satisfaction which remained high and low, respectively, although it is promising that the current participants did report higher levels of hope after six weeks. Lastly, clients may be only attending a small number of sessions because they are not meeting their high expectations. Future research will need to identify exactly what clients expect to occur during an online counselling session, what they hope to achieve by seeking help online and whether they are receiving what they wanted.

Additional Help-seeking. One of the unique findings of this research was that over one third of young people accessing online chat were also seeking help from telephone or face-to-face services. This was initially indicated during the focus groups with online clinicians as being a feature of working online. Consequently, online client research participants were asked during the six week follow-up if they had sought additional help (e.g., telephone or face-to-face). A total of 39% of the 152 young people who completed the follow-up reported seeking additional help. It was hypothesised, based on the dose-response model, that additional help-seeking would be related to improved treatment outcomes.

However, no evidence was found to suggest that this additional service use had any effect on psychological distress, life satisfaction, or hope. Furthermore, it was thought that seeking additional help would be related to attending one or more sessions, perhaps reflecting referrals to other services. There did appear to be a trend towards higher levels of additional help-seeking for those who had received online counselling compared with those who did not go on to receive a service. However, an analysis of the data suggested that this difference was not statistically significant.

Ideally, seeking additional treatment should improve client outcomes (Brent, Kolko, Birmaher, Baugher, & Bridge, 1999). Previous studies have found that using e-mail as an adjunct to face-to-face psychotherapy has been an effective method of providing therapy (Peterson & Beck, 2003) and mobile phones are now recognised as a useful tool for extending therapy (Boschen & Casey, 2008). However, the current results could not find any advantage of receiving additional support along with online chat counselling, suggesting that attending multiple services within a relatively brief timeframe may not be any more effective in treating mental health issues. This may be due to factors such as interference between clinicians, the type of help received (e.g., face-to-face or telephone), therapeutic model (e.g., non-directive counselling or cognitive behavioural therapy), and the circumstances under which it was received (e.g., referral versus lack of satisfaction with help received online).

The apparent absence of improvement related to seeking additional help may also reflect a lack of integration between services (King et al., 2010). The integration of mental health services has always been an issue, but there were previously fewer options available and these were generally face-to-face. Furthermore, many traditional service options generally required referral and assessment. Now, however, young people can make use of a wide range of services, both online and offline, many of which, like eheadspace, encourage self-referral, which adds to the complexity of service integration. There are now more

therapeutic options available to young people, and the current research highlights the potential for online clients to be accessing multiple services. Therefore, additional research needs to be conducted to investigate when young people seek multiple types of help and under what circumstances, what types of help are sought and in what combinations, and how this may affect their treatment outcomes.

Presenting Problems. During the focus group study, clinicians reported that they were faced with a wide variety of presenting problems, including clinically diagnosable mental disorders as well as psychosocial and environmental problems. Clinically diagnosable disorders were perceived as primarily being related to anxiety and depression, along with self-harm and suicidal ideation. However, there was debate as to whether or not most of the presenting problems would meet the diagnostic criteria to warrant a diagnosis. Psychosocial and environmental problems were most frequently reported as being related to relationship issues with family, peers, or partners. It was agreed by all focus group clinicians that online clients, like those using more traditional services, presented with complex multiple stressors and that the clinical, psychosocial, and environmental problems were interrelated.

The diversity of presentations was confirmed through a brief examination of the transcripts in Study 5; that study revealed discussions relating to problems such as anxiety, depression, relationship issues, suicidal ideation, and self-harm. Similarly, a recent evaluation report of eheadspace revealed that approximately 75% of 11,574 clients reported seeking help for emotional health issues, such as feeling sad, depressed, anxious, angry, and stressed (headspace, 2014). A further 20% of the presenting problems were situational in nature, including relationship problems and problems at school or work.

The wide variety of presenting problems reported by ehadspace clients appear to be similar to those found in a large face-to-face sample of 21,274 headspace clients (Rickwood et al., 2014). Similarly, the most frequently self-reported presenting problem was for

emotional problems (71.6%), followed by relationship problems (11.4%), physical health issues (6.6%), and school/work problems (6.0%). This would suggest that young online clients are not demonstrably dissimilar from their face-to-face counterparts in terms of presenting problems. However, due to the range of issues addressed by eheadspace clinicians and the lack of diagnostic information for the eheadspace clients, a breakdown of treatment approaches and outcomes by presenting issues was not undertaken in the current studies. The variety of presenting problems may have affected treatment outcomes, and as such, future research should investigate what psychological presentations are best treated online and how online chat services can be better integrated to produce the best treatment outcomes for specific presenting problems (King et al., 2010).

Placebo, hope and expectancy factors. Previously, the common factors of hope and expectations have not been investigated within the online chat research. This research aimed to explore online client hope and expectations, and how these factors interacted with each other and treatment outcomes.

Hope. The current studies were the first to explore hope within the online chat environment. Within the cross-sectional analysis it was found that young people accessing help online reported relatively low levels of hope when compared with young people accessing care in face-to-face settings (Dew-Reeves et al., 2012). Based on the face-to-face research, it was hypothesised that baseline hope would be related to treatment outcomes, in that higher levels of hope would correlate with greater levels of improvement (Snyder, 2002). However, the results of the six week follow-up found no relationship between baseline hope, and changes in psychological distress or life satisfaction.

While hope is generally acknowledged as an important factor in treatment outcomes (Snyder, 2002), it is not clear if there is a direct relationship between high levels of hope and better treatment outcomes; although high levels of hope are generally considered as being

beneficial, this may not always be the case. High levels of hope have even, in some research, been found to have negative effects on treatment outcomes (Dew-Reeves et al., 2012). These instances have been defined as false hopes and are thought to be generated by: (a) expectations that rest on illusions rather than reality, (b) pursuing unsuitable goals, and (c) designing poor strategies to achieve desired goals (Snyder, 2002). As such, clinicians need to foster a realistic sense of hope by moderating expectations, developing realistic goals (e.g., using a difficulty ladder approach), and developing clear pathways to goal attainment (e.g., goal mapping) (Feldman & Dreher, 2012). To achieve this, the website itself could outline what may be achieved online within the framework of a clinical staging model that would help to better match illness stage to the type of intervention received (Cross et al., 2014). For example, single sessions may be recommended for relatively minor issues or just wanting to confide or seek advice from someone, whereas five to six sessions may be for more significant problems such as social and environmental problems (Gingerich & Peterson, 2013), and 10 or more sessions for disorders such as depression and anxiety (Hansen et al., 2002; D. Kessler et al., 2009).

While hope at baseline was not related to improved treatment outcomes, it was found that hope improved for those young people who accessed online counselling but did not change for those who did not go on to access counselling. This finding suggests that online chat may help young people plan and pursue their desired goals. Building hope is generally associated with goal development and attainment (Feldman et al., 2009); however, examination of the transcripts revealed very little time was spent on goal exploration. As such, goal exploration processes may not justify the overall rise in hope. Rather, other studies exploring hope in early counselling sessions have suggested that the counselling relationship is an early source of client hope, offering a mixture of safety, acceptance, understanding, and signs of counsellor commitment (Larsen & Stege, 2012). This is consistent with the finding

that significant amounts of time are dedicated to problem clarification processes that allow clients to tell their stories while the clinician provides emotional support. Further exploration of the importance of building hope online and how best to do this is an important avenue for future research.

In particular, future research should pay attention to hope's agency component, which has been found to be related to higher levels of self-reported goal attainment (Snyder, 2002). While it is important for clients to be able to develop pathways towards goal attainment, it is perhaps imperative that online clinicians focus on building client agency, helping young people develop the motivation to begin and continue along those pathways (Feldman et al., 2009). This could be an important part of providing early interventions as hope has previously been found to act as a psychological strength, moderating global life satisfaction and internalising behaviours (e.g., anxiety/depression, somatic complaints, and withdrawal) (Valle, Huebner, & Suldo, 2006). However, further research is needed to understand the range of conditions (e.g., chronic vs. acute) under which hope may act as a psychological strength.

Expectations. Client expectations refer to the conditions a client thinks or expects will occur during the course of therapy (Constantino et al., 2011). Research has explored the effects of client expectations on treatment outcomes, premature termination of therapy, service satisfaction, and therapeutic alliance (Dew & Bickman, 2005). While the literature generally focuses on adult samples and should be interpreted with caution in regards to a younger population, it suggests that there is a significant relationship between client expectations and treatment outcomes; typically finding that more positive expectations are associated with improved mental health and wellbeing (Glass et al., 2001).

Findings of the current research revealed that participants generally held high expectations, higher than those usually found in face-to-face settings (Dew-Reeves & Athay,

2012). Congruent with previous research, it was hypothesised that expectations would be positively correlated with treatment outcomes. However, during the six week follow-up, no relationships were found between client expectations and treatment outcomes. This could indicate that, being young and having limited previous experience of seeking help, young people may not have accurate expectations of online counselling, and may in fact be over estimating the benefits of seeking help online. This would be consistent with previous research exploring expectations of young people in a face-to-face setting, which reported that initial expectations may not be as relevant to young people's engagement or outcomes because they are less well-formed, and are less important than motivation and actual experiences in therapy that facilitate motivation (Watsford & Rickwood, 2014).

Furthermore, as with false hope, there are issues associated with holding unrealistic expectations. If young people hold high expectations and have these expectations disconfirmed, there is the potential for them to disengage from the treatment process, perceiving it as ineffective or a waste of time (Constantino et al., 2011; Watsford & Rickwood, 2013a). As unrealistic and unmet expectations can lead to poorer engagement and outcomes in therapy, online youth-focused mental health services need to manage expectations by better informing young people about what to expect when accessing help online (J. Callahan et al., 2014). Further, providing a positive experience early on is very important, with the potential to improve future help-seeking and prevent relapse. However, what comprises a positive experience for young people online still needs to be determined.

Incongruent hope and expectations. Hope and expectations are two factors that are often conflated within research. However, as demonstrated previously and again in the current body of research, they are linked but distinct concepts. While hope is primarily a motivational concept based on agency and pathway thinking, expectations are based on previous experience and knowledge of the area. As such, it is possible for hope and

expectations to be congruent, and it is argued that this will lead to better treatment outcomes. However, they can easily become incongruent if an individual holds false hopes or has unrealistic expectations (Leung et al., 2009). Regarding the hypotheses of this research, it was found that hope and expectations were significantly correlated, but the relationship between them was unexpectedly small. However, perhaps due to the weak correlation and the smaller sample size, no relationship was found between hope and expectations at baseline for the six week follow-up sub-sample, suggesting that the relationship between hope and expectations is weak at best. Overall, it was found that approximately two thirds of the participants reported incongruent levels of hope and expectations; generally reporting low hope, but holding high expectations.

This incongruence holds several implications for online practitioners. Firstly the current research suggest that the young people seeking help online may be challenging to treat, as they are lacking confidence to produce strategies and pursue them, yet expect counselling to solve their problems. Combined with the severity of their psychological distress and the small number of sessions generally attended, it is perhaps unsurprising that there were only small improvements made over the six week treatment period. As such, it may be important for online counsellors to focus on building hope, helping clients develop goals, and moderate their expectations about what can be achieved during one or two sessions.

According to Swift and Derthick (2013), there are five interventions that may be used to increase hope by fostering appropriate treatment expectations, including: presenting a convincing treatment rationale; increasing clients' faith in their clinician; expressing faith in clients; providing outcome education; and comparing progress with expectations. It is generally accepted by most face-to-face therapy approaches that at some point during the initial treatment stages, the clinician should provide the client with a causal explanation of the

presenting problem and a description of how specific techniques will help overcome those problems (Horvath, 1990). As such, clients who are confident that the techniques will work will be more likely to be motivated to engage with the treatment model. As well as believing in the treatment model, clients need to believe that their clinician has the ability to act as a helping agent. In a study that included ratings from 32 clients, Goates-Jones and Hill (2008) found that perceived therapist credibility explained roughly 60% of the variance in client-rated outcomes, 25% of the variance in therapist-rated outcomes, and 22% of the variance of target problem change after a single session of therapy. In a meta-analytic review, W. Hoyt (1996) found credibility ratings to be influenced significantly by reputational (e.g., framed diploma), verbal (e.g., use of psychological jargon), and nonverbal (e.g., attentiveness, organisation, posture) cues of the therapist. Unfortunately, visual, verbal, and non-verbal cues are absent from online interactions and would need to be adjusted for, perhaps by including clinician expertise on the website, making use of psychological terms during textual interactions, and displaying attentiveness by replying quickly. In addition to building faith in the treatment model and the clinician, it is important to build faith in the client themselves. Expressions of confidence can include genuine statements recognising the client's fit with the treatment approach or client strengths that should assist in the journey of recovery, which may help develop agency thinking (Feldman & Dreher, 2012).

After building faith in the treatment model, clinician, and client, it is important to provide accurate outcome education (Swift & Derthick, 2013). Although it is generally beneficial for clients to hold optimistic expectations for treatment success, overly positive expectations, if not met, can actually lead to negative treatment outcomes (J. Callahan, Aubechon-Endsley, Borja, & Swift, 2009). Research has found that young people accessing face-to-face headspace services generally hold high expectations for treatment outcomes that tend to be unmet after two months and, consequently, it is important to provide young people

with more information regarding the processes of clinical improvement and ensure that they are aware that psychological change takes time and improvement is not likely to be immediate but will happen with perseverance (Watsford & Rickwood, 2013b).

While the majority of the elements addressed so far can take place early on in the therapeutic encounter, it may also be beneficial to reflect on client expectations after the initial session. Previous research within a face-to-face context has found positive results in monitoring client progress and discussing this with clients (Reese, Norsworthy, & Rowlands, 2009). As such, it may be beneficial to check in on how client progress is matching with client expectations. Identifying and addressing any discrepancies may help avoid early termination by the client.

Techniques and processes. Techniques and processes can refer to overall therapeutic approaches as well as specific activities. This research aimed to build on previous studies exploring the processes utilised during online chat sessions. Similar to previous research, it was found that online chat sessions tended to focus on problem clarification and rapport building processes, spending some time developing strategies, but generally neglecting goal exploration (Chardon et al., 2011). While it was recognised that simply writing about emotional issues could be beneficial, it was hypothesised that advancing through more counselling stages, including goal exploration and action planning, and in greater depth, would be related to improved treatment outcomes. Generally, it was found that higher levels of progress and depth were both related to improved treatment outcomes. Specifically, the greater depth during the problem clarification stage, and progress and depth within the action planning stage, were related to greater improvements.

Within the different stages, it was noted that problem clarification depth was associated with improved changes in psychological distress. This may reflect the clinician dedicating time to developing rapport, gathering information for an assessment, managing

any potential risks, and letting clients tell their story. The implication of these findings is that there are many processes that online clinicians are expected to perform online that are quite time consuming. It may be important to find methods of reducing the time spent gathering information, such as the inclusion of an online intake form (Bradford & Rickwood, 2014). This may allow time-constrained clinicians to quickly check what the most pressing issue is for a client and move on to what they wish to work on. This could enable clinicians to help clients focus on what they most want to discuss in greater depth, rather than covering a wider range of topics in a more shallow fashion.

Perhaps due to the amount of time spent on clarifying client problems, goal exploration generally received little attention. This is somewhat concerning as goal setting has been recognised as an effective way of achieving behavioural change in people (Feldman et al., 2009; Locke & Latham, 2002). While no correlation was found between goal exploration and client outcomes within the current research, this is most likely due to the lack of goal exploration related activities occurring in the current sample of transcripts, resulting in little variation on this measure. Considering the importance of goal setting to helping direct counselling sessions and helping clients achieve their desired outcomes, it may be important for clinicians to assign more time to goal exploration.

Of the three processes examined, action planning progress and depth were the most strongly associated with positive changes in psychological distress. This would indicate that the greater and more detailed the strategy developed, the more likely the clients are to experience improvement (Gingerich & Peterson, 2013). Collaboratively aiding clients develop solutions is generally regarded as an important aspect of many interventions (Egan, 2014), and is the primary focus of others, such as Solution-Focused Brief Therapy (Kim, 2008).

Although some highly detailed strategies were identified while exploring the session transcripts, of some concern was the frequency with which online clinicians attempted to refer their clients to other services, such as face-to-face or telephone. While encouraging young people to seek further help may be desirable, the very high levels of psychological distress that young people are presenting with needs to be dealt with immediately. Further, this distress is generally caused by a situational event related to relationship and emotional issues (A. Callahan & Inckle, 2012). Considering that clients often search online for solutions to their emotional problems (Neal et al., 2011), it would seem to be important to help them develop some more immediate workable solutions, other than referral for additional help.

Therapeutic relationship. While this research did not directly examine the therapeutic relationship within the online chat environment, it is acknowledged that this is an important therapeutic factor and there are a few points worth discussing that arise from the current findings. As noted in the introduction, Bordin (1979, 1994) developed a pantheoretical model that conceptualised the therapeutic relationship in three components: bond (i.e., the development of reciprocal positive feelings between client and clinician); task (i.e., agreement on therapeutic intervention); and goals (i.e., agreement on the intervention's objectives). The therapeutic relationship is considered to be one of the most important factors affecting treatment outcomes in face-to-face settings (Lambert, 1992), and while previous research has found that an adequate therapeutic relationship can be established online, it is also evident that this can be time consuming (Cook & Doyle, 2002; Hanley, 2009). Furthermore, research by King, Bambling, Reid, et al. (2006) found that the therapeutic relationship may not be strongly related to online treatment outcomes, particularly with regard to the bond component. The authors suggested that session impact may be a more potent variable within this form of service delivery, arguing that collaboration on counselling

goals and tasks may be of more importance to online outcomes than developing a mutual liking.

Based on the current research findings, it appears that much of the online chat sessions were devoted to rapport building processes, which roughly align with the problem clarification processes noted in other studies (Mallen et al., 2011; Williams et al., 2009). While this may address the bond component of the therapeutic relationship, the general lack of agreement or even discussion of the therapeutic intervention used or development of goals would suggest that significant aspects of the therapeutic relationship are not being addressed during online chat sessions.

Implications for online clinicians

This research has produced findings with significant implications for online clinicians. The most notable findings are that young people accessing help online are generally female, highly distressed, report low hope but high expectations, attend few sessions, and may also seek additional help. Within the sessions there is generally a focus on problem clarification processes, with some action planning and strategy suggestions. Overall, only relatively small changes in treatment outcomes were found and only improvements in hope were found to be specifically related to online chat counselling. Based on these findings and previous research, it implies that online clinicians face some significant time constraints within which they have to deliver their interventions (Bambling et al., 2008). Furthermore, while a small proportion of clients may be attending more than five sessions, the vast majority of clients only attend one or two, suggesting a high rate of attrition. The time constraints and high levels of attrition may contribute to the wide variety of roles required of online clinicians. This lack of role clarity, along with the risk of vicarious traumatisation from exposure to young people in so much situational distress (Taylor & Furlonger, 2011), may

result in higher levels of burnout and turnover amongst clinicians (Hassan, 2013), which is becoming evident in the evaluation of the eheadspace service (headspace, 2014).

Time Constraints. As noted by the online clinicians in the focus group study, time is a significant issue, with approximately one hour of online chat perceived as being the equivalent of a quarter of an hour of face-to-face work. There was a general consensus amongst the online clinicians that there was a lot of work that could be done online, but not necessarily the time to do it. This may be in part due to the perception that online clients are often multi-tasking while online, producing long and often unexplained pauses; however, it may also be related to the amount of time spent on clarifying client problems as found in Study 5. As such, it stands to reason that there is a need to either increase the length of time spent on each therapy session, or make more efficient use of the time available. Online clients have been found to support the idea of longer sessions (King, Bambling, Lloyd, et al., 2006), however, while some online clinicians are happy to extend the length of a therapy session, others reported that they would not have the emotional capacity to provide longer sessions (Bambling et al., 2008). Nevertheless, there is no guarantee that even a 100 minute long online counselling session would result in the same amount of work achieved during a traditional therapeutic hour. As such, ways for online clinicians to use time more efficiently are needed. This could include the use of online psychosocial intake and assessment forms (Bradford & Rickwood, 2012b), structured goal-directed interventions (Wright, Sudak, Turkington, & Thase, 2010), and incorporating guided self-help web-based interventions (Newman et al., 2011).

When young people present seeking help they may be experiencing a wide range of problems, and a holistic assessment may aid in the identification of specific risks, needs, and strengths that may otherwise be missed (Bradford & Rickwood, 2012b). Obtaining the information necessary for an assessment online can be time consuming (Chardon et al.,

2011), difficult to make an accurate diagnosis (Mallen et al., 2011), and may make it challenging to keep the client engaged with the session (Dowling & Rickwood, 2014). The use of online intake forms may help address all of these issues. A self-administered intake form may help reduce the amount of time spent gathering information during a session, leaving more time to focus on the most relevant and important aspects for the client (Bradford & Rickwood, 2012b). Furthermore, research has found that self-administered intake forms are generally better at gathering information than face-to-face interviews, enabling young people to disclose more by reducing fear of judgment by health professionals (Brener, Billy, & Grady, 2003; Silber & Rosenthal, 1986). Online intake forms may also actually help keep young people engaged by improving their input into deciding what matters are to be discussed (Bradford & Rickwood, 2012b, 2014; Elliott et al., 2005; Harrison, Beebe, & Park, 2001). The use of online self-administered intake and assessment forms may help reduce the amount of time spent gathering information, help identify significant risks, and keep the young person engaged with the intervention.

In addition to implementing an online intake form, online clinicians may also benefit from providing more structured, goal-directed interventions. Due to the time constraints faced by online clinicians, a more goal-oriented and solution-focused approach may help direct sessions in a time efficient manner (Gingerich & Peterson, 2013). It has been noted in a recent systematic review that single session structured interventions are becoming increasingly popular treatment options, spurring a growth of 'walk-in' psychotherapy centres in Ontario, Canada (Hymmen et al., 2013). The review concluded that the prospects of single session therapy were good, with generally positive research findings regarding problem improvement, and client perceptions of the sufficiency and satisfaction with a single session. However, they noted that in the research to date, there was a lack of control groups, limited use of standardised measures, and small sample sizes.

When discussing the provision of brief interventions, Wright et al. (2010) state that goals provide a guide for the entire session, and work best if they are specific achievable goals. They argue that without clear goals, clinicians and clients may wander aimlessly through unproductive discussions and miss opportunities to apply effective interventions. To further focus the therapy effort, they suggest using a session agenda that includes items that are linked to the overall therapy goals, are specific, can be tracked, and lead to useful homework. Once the goals are agreed upon and the agenda set, it is possible to move on to specific treatment techniques. In order to manage the inherent time constraints of working online, it may be recommended that online clinicians make a concerted effort to direct the counselling session in a manner that makes the best of the limited time available (Bloom, 2001). While it is important not to give clients the impression that they are being rushed, it is just as important that sessions don't lose focus on helping clients meet goals.

While having an online intake form and a structured goal-directed intervention may enable more to be achieved in a single online session, other web-based interventions may be particularly useful adjuncts to online chat. Web-based interventions are primarily self-guided interventions that are accessed through a website and are operated by a prescriptive program—these can include psychoeducation websites, self-help online interventions, and therapist supported interventions (Barak et al., 2009). Studies of self-help web-based interventions have found that substantial reductions in symptoms can be achieved, in some cases similar to those found in face-to-face samples (Andersson, 2009; Barak et al., 2008). Directing clients towards these resources may also be of benefit as many young people are unaware of the resources available online (Neal et al., 2011). Moreover, this would improve the overall integration between mental health services (King et al., 2010). There are, however, a large number of web-based interventions of varying quality that clinicians could direct clients towards and it is difficult for clinicians to know what to recommend. The

implementation of evidence review projects, such as the Beacon project

(https://beacon.anu.edu.au/), is an important assistance. On the Beacon website is information

that categorises, reviews and rates websites and mobile applications for mental health

problems. Online chat clinicians are well positioned to direct young people to web-based

interventions and can act as points of contact, and web-based interventions are an excellent

method of extending therapy sessions without imposing further time constraints on clinicians.

While web-based interventions may be useful therapy extenders, online clinicians

must be careful with how they are implemented. It may not be enough to simply direct young

people towards additional resources, as evidence suggests that young people do not regard

therapeutic homework highly (Watsford, Rickwood, & Vanags, 2013). Furthermore, it has

been found that self-help online interventions, while effective if completed, have high

attrition rates (Christensen, Griffiths, Groves, & Korten, 2006). It has been found that

therapist supported web-based interventions address some of these issues and this is

considered to be the optimal method of implementing web-based interventions (Andersson &

Titov, 2014; Newman et al., 2011). Consequently, it is recommended that online clinicians

have an e-toolbox of useful therapy adjuncts that can be matched to client issues and goals.

The clinician can then support, motivate and guide the client through these interventions. By

using email or SMS contact, online clinicians could provide clients with support, guidance

and feedback, which are key factors in reducing attrition for web-based interventions (Wright

et al., 2010).

As noted above, online chat sessions have inherent time constraints, including the

relatively slow pace of typing compared with speaking (Haberstroh et al., 2008), and frequent

pauses between responses (Bambling et al., 2008). This may have some effect upon online

clinicians' abilities to provide counselling online, which has been found to primarily focuses

on gathering information and building rapport, rather than engaging in task oriented activities

(Chardon et al., 2011; Mallen et al., 2011). While it may be recommended that online chat sessions be lengthened in order to address some of these issues, it is perhaps even more important that online clinicians are more efficient in their use of time online. As such, it is proposed that online clinicians introduce an online self-administered assessment form, which will not only reduce the amount of time spent gathering information during a session, but may also help young people engage more with the session (Bradford & Rickwood, 2012b). Another method of increasing the efficiency of an online chat session would be to introduce more structured, goal-directed interventions. This may help direct sessions in a more efficient manner and avoid moving on to subjects that are of less importance to clients (Bloom, 2001). Lastly, online clinicians can extend therapy sessions and integrate with other mental health initiatives by providing links to web-based interventions, whether they are educational websites or online treatment interventions. However, it is important to note that web-based interventions are most effective when supported by a clinician, which can be done either by email or with additional sessions (Newman et al., 2011).

Attrition. It has now been widely noted that mental health programs operated over the internet suffer from significant attrition rates (Eysenbach, 2005; Murray et al., 2013). In a large scale evaluation of a web-based self-help intervention for panic disorder, only 12 out of 1,161 participants completed the entire 12 week program (Farvolden, Denisoff, Selby, Bagby, & Rudy, 2005). Similarly, an evaluation of MoodGym, a web-based self-help CBT intervention for depression, reported that only 97 of the 19,607 participants completed all five modules, and fewer than 7% even completed the first two (Christensen et al., 2006). There are several points during which clients may be lost: most notably this can be before they see a clinician (e.g., wait time is too long), during the session (e.g., negative experience), and after the session (e.g., failing to return for another session). As shown in the current research, a significant proportion of clients do not progress onto receiving a session after accessing the

eheadspace website, and the clinicians reported that young people could simply log off during a session. Clearly, the online environment provides clients more power in determining when and how they engage with mental health services (Fletcher-Tomenius, 2009).

Previously, it has been found that young people can wait up to three hours to chat with an online clinician, which can make them feel neglected (King, Bambling, Lloyd, et al., 2006). As the current research found, 25% of clients who sought help via eheadspace were unable to get through to actual contact with a clinician, presumably due to all the available clinicians being occupied with other clients. Young people are likely to drop out while waiting, particularly if there is a long wait and they do not know how long it will be before they receive help (King, Bambling, Lloyd, et al., 2006). Having to wait, especially if after expecting an immediate response, may constitute a negative experience whereby the young person feels rejected, and thereby dissuaded from seeking help again in the future (Rickwood et al., 2005). Furthermore, the ability for young people to simply seek help from another website if they do not receive immediate service, suggests there is a danger of them seeking support from less professional sources, such as un-moderated peer support sites (Anderson, 2011). While some un-moderated peer support sites may be helpful, others are actually dangerous, such as pro-anorexia websites (Bardone-Cone & Cass, 2007).

In order to reduce attrition rates while young people are waiting for service, it may be beneficial to include a self-report intake form that young people can complete while they are waiting. Furthermore, a counter on the webpage indicating the number of people waiting and the clients' place in the queue could be helpful in reducing attrition. A queuing algorithm can be used, either as a simple method of informing clients of their place in line, or a more complex algorithm that determines if it is better to turn a client away if it is likely that they have to wait so long that they will abandon the service (Koçağa & Ward, 2010). A risk of such approach is the potential to not attend to or turn away a high risk client, and there would

need to be processes for identifying and managing these cases by either prioritising them or directing them to crisis support services (e.g., Lifeline).

From the focus groups with eheadspace clinicians, it was noted that it could be quite difficult to keep young people engaged online, particular if the clinician was attempting to gather information for an assessment (Dowling & Rickwood, 2014). It was noted that young people would log off and leave the session if they were inclined to do so. This differs significantly from face-to-face sessions, where clients cannot easily terminate the conversation. There are three potential strategies that may aid in engaging clients and reduce attrition rates: managing expectations, online intake forms, and collaborative goal setting. As highlighted previously, building faith in the clinician, client, and treatment rationale, while also providing outcome education and comparing progress with expectations may help manage client expectations (Swift & Derthick, 2013). Implementing these strategies may in turn help reduce client attrition (Watsford & Rickwood, 2014). The introduction of an online intake form may also aid in reducing client attrition by reducing the amount of time spent gathering information for an assessment (Bradford & Rickwood, 2012b). Lastly, collaborative goal setting has been recognised as being an important part of the therapeutic relationship that may help keep clients engaged with therapy (DeFife & Hilsenroth, 2011). Utilising these strategies may aid in the reduction of client attrition during the counselling session.

While clients may suddenly log off during a session if they do not feel engaged, it is also highly likely that they may decide not to attend additional sessions. As noted previously, in face-to-face studies treatment outcomes generally improve with the number of sessions attended (Hansen et al., 2002) and the best outcomes using online chat as a treatment modality included 10 sessions (D. Kessler et al., 2009). However, online chat clients are generally only attending one or two sessions. As such, online clinicians need to determine if

it is preferable to accept that online clients are only going to attend a small number of sessions online and adapt to this, or attempt to increase the number of sessions attended.

As discussed earlier, there is the option to provide single session structured interventions (Hymmen et al., 2013). Interest in single session therapy developed when Talmon (1990) found that the modal number of appointments attended by clients of an outpatient clinic was one. Further research found that at three to 12-month follow-ups, 58.6% of clients reported a single session had been sufficient and led to improvement in the presenting problem (M. Hoyt, Rosenbaum, & Talmon, 1992). Importantly, a single session intervention approach does not need to preclude multiple sessions—it is simply argued that each session should be self-contained (Bloom, 2001).

If online clinicians do feel the need to try and increase the number of sessions attended by their clients, there are two notable techniques that may be employed, including providing young people with a positive experience of seeking help (Watsford & Rickwood, 2014), and patient led appointment scheduling (Carey, Tai, & Stiles, 2013). Providing a positive experience of therapy is an important factor in reducing client attrition rates and the use of single session therapy style interventions may actually help improve clients' initial experience seeking help, as focusing on immediate problems may be more congruent with client expectations (Watsford & Rickwood, 2013b). Secondly, patient led appointment scheduling, in which clients schedule their own therapy appointments within the constraints of available resources, has been found to produce similar outcomes over fewer sessions and result in very low levels of missed and cancelled appointments (Carey et al., 2013). By providing a positive experience for clients and encouraging them to schedule their own follow-up appointments, client attrition rates may be reduced.

Role clarity. During the focus group study, the online clinicians reported fulfilling multiple roles, including assessor, gatekeeper, and counsellor. The wide ranging nature of the

roles reported by online clinicians suggests that there may be some risks regarding a lack of role clarity. Roles are essentially a set of activities or behaviours that are expected to be performed by the person holding a particular position within an organisation (Graen, 1976; Katz & Kahn, 1978). Role clarity has been found to be positively associated with higher levels of staff satisfaction, performance, and lower turnover rates (Hassan, 2013; Lyons, 1971). As such, it is important for online clinicians to have a clearer understanding of what their role entails, and specifically what sort of interventions they should be providing online.

Currently, clinicians need to take into account numerous factors when providing an online intervention, including the wide variety of clients accessing the service, the demand to conduct assessments, keep clients engaged, manage risk, and also acknowledge that the majority of clients will only attend one or two sessions. The wide array of issues may be in some part contributing to the generally low levels of improvements in treatment outcomes noted within this research, particularly in contrast to the outcomes reported from research with other online services (Fukkink & Hermanns, 2009a; King, Bambling, Reid, et al., 2006). As such, a clear set of guidelines would benefit online clinicians and provide a framework for the effective delivery of services.

Developing role clarity for online clinicians also needs to take into account factors that are unique to providing 'walk-in' online youth counselling services. Most notably, young people are presenting as highly distressed and with a wide range of issues, but frequently report seeking help for relationship and emotional problems (Bambling et al., 2008; A. Callahan & Inckle, 2012; DuBois, 2004; Fukkink & Hermanns, 2009a). Furthermore, young people are likely to access online services to clarify their problems, seek advice, or take an opportunity to think through a current difficulty. However, as shown in the current research and supported by the findings of the eheadspace evaluation, the majority of young people are only attending one or two online counselling sessions (headspace, 2014).

Taking these factors into account, it is evident that within this setting, the role of online clinicians is to provide brief interventions that focus on helping clients develop solutions to immediate presenting issues. Due to the wide variety of presenting problems, the intervention would need to follow a flexible, transdiagnostic approach to treatment interventions, rather than diagnosis specific treatment interventions (King et al., 2010). While it is clear that more traditional diagnosis specific treatments are effective using online chat (D. Kessler et al., 2009), the evidence suggests that it may be inefficient to use such a model within the context of a free youth-oriented online mental health chat service. Considering the time constraints, rates of attrition, and variety of presenting problems, it may be a better option for clinicians to focus on the provision of single sessions of goal directed therapy addressing the main presenting issues causing clients distress (Bloom, 2001). More broadly, a distinct role would help define the purpose of online clinicians and encourage them to integrate with other specialised services to help meet needs outside of their scope.

Brief online chat counselling intervention

The current research found a concerning lack of change in treatment outcomes related to receiving online chat counselling, with only hope specifically found to improve in relation to the number of sessions attended. Given the time constraints inherent in online work, the likelihood of young people only accessing one or two sessions, and the difficulty of predicting which clients will attend more sessions, it is reasonable to propose that online clinicians adopt a brief intervention framework (Hymmen et al., 2013). While it is clear that online chat can be used to good effect over 10 or more sessions (D. Kessler et al., 2009), it is equally evident that clients accessing services such as eheadspace are unlikely to attend more than one or two sessions. If these findings are accepted, then online clinicians should be encouraged to provide brief structured interventions designed to make the most out of the first session with a client (Perkins & Scarlett, 2008) and may provide better treatment

outcomes than those currently reported. This is not to discourage clients who would want ongoing therapy online, due to either a preference to work online or inability to attend traditional face-to-face services, as additional sessions can always be provided and a long term strategy developed as necessary. However, rather than attempt to apply a multiple session model to a large percentage of clients that will not adhere to it, a focus on single session interventions may provide the best outcomes to the most clients.

In a review of single-session psychotherapy, Bloom (2001) identified three principles. First, the clinician plans each session as self-contained and aimed at providing rapid help. Secondly, the clinician takes a much more active role in establishing goals and determining interventions. Thirdly, clients are encouraged to engage in therapeutic homework following the session. While there is a lack of methodologically rigorous effectiveness studies, a review of single-session therapy studies found that the majority of clients reported the interventions to be sufficient and helpful (Hymmen et al., 2013). Furthermore, research with young people accessing face-to-face headspace services reported initial expectations related to clinical outcomes were much more optimistic than their actual experience of their therapeutic outcomes, suggesting that clinicians may need to focus on alleviating psychological distress earlier in therapy with brief interventions, rather than concentrating on assessment (Watsford & Rickwood, 2013b). Such a focus may help young people feel better sooner and may help meet their positive expectancies around treatment outcomes. In one promising study of single session therapy with young people, it was found that statistically and clinically significant improvements were achieved after one month relative to the control group (Perkins, 2006). Furthermore, 95% of the sample reported being satisfied with the intervention.

Proposed brief online chat counselling model. Considering these principles for brief interventions and the findings of the current and previous research, the following section proposes the development of guidelines for conducting online chat counselling based around

Chapter 9: Discussion

Chapter introduction

This final chapter reviews the aims of the research, outlines the main contributions of each of the five studies and draws together the key findings of the thesis. The chapter establishes the significance of the current research and discusses the clinical implications. The strengths and limitations of the research are identified and directions for future research are offered. Finally, the chapter provides concluding comments from the research.

Summary of findings

The primary goal of this research was to investigate the processes and effectiveness of a youth-targeted online counselling service. This investigation is important as there is a high prevalence of mental health problems among young Australians, and online counselling is a modality that can provide easier access to mental health services. This thesis comprised five studies aimed at exploring different aspects of online counselling, in order to determine the processes used compared with traditional counselling techniques and its overall effectiveness. Although each study had a distinct aim and different methodology, the research was designed to be progressive and sequential in nature, starting with a qualitative phase, followed by a quantitative phase, and subsequently a combined qualitative/quantitative phase.

Study 1. Online counselling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. The first study undertaken was a systematic review of the literature. Specifically, it aimed to identify the previous literature relating to the effectiveness of online chat as a treatment modality. However, it also had the secondary aim of providing context and developing hypotheses for the following studies.

The systematic review revealed a dearth of information regarding the effectiveness of online chat. Overall, the findings of the few studies in the field supported the effectiveness

the five stages of counselling outlined in Study 5. The proposed steps for a brief online chat

counselling model are presented in Table 9.1.

Table 9.1

Summarised Steps of the Brief Online Chat Counselling Model

Stage	Step	Summary of step
Online orientation	Introduction	Introduction to service, treatment model, and clinician role.
	Self-report intake form	Client completes self-report online intake form.
	Self-report rating scales	Client completes rating scale (e.g., impact and outcome measures).
Problem clarification	Introduction to clinician	Clinician introduces themselves, clarifies any queries based on orientation, intake form, and rating scales.
	Story telling	Clinician invites client to expand on issues of importance as indicated by intake form.
	Build faith in treatment model, clinician, and client.	Clinician increases client hope by managing expectations, while also promoting strengths of clinician and client.
Goal exploration	Develop treatment goals	Clinician aids client in developing explicit attainable goals.
	Develop session agenda/leverage	Client and clinician choose issues to work on.
Action planning	Strategies	Clinician provides direction to psychoeducation, self-help, and mutual help strategies.
	Best-fit	Client and clinician choose strategies that best fit the client's resources and situation.
	Plan and set homework	Client and clinician review plan. Homework, if appropriate, is assigned.
Termination	Review and wrap-up	Clinician summarises session, checks for understanding, asks for feedback, and discusses future contact.

Orientation. Overall, it is proposed that the entirety of the orientation stage is moved out of the session itself and into the online 'waiting room'. The orientation stage would start with an introductory preface to the service that explains the limitations to the service (e.g., confidentiality, legal), treatment model, and clinician role. In order to manage risk, clinicians could also encourage young people to agree to a safety plan whereby they provide their real name, address, and telephone number, or the name and number of a trusted relative (Campbell & Robards, 2013). This would need to be balanced against potentially losing the perceived benefits of online anonymity and self-disclosure (Suler, 2004). Nevertheless, the inclusion of a preface should help manage client expectations about what will occur, build hope in the intervention (Swift & Derthick, 2013), and save time during the upcoming counselling session.

After the introduction, it is proposed that the clients complete a self-administered intake form. The intake form could be based upon the 'HEEADSSS' assessment, which stands for Home, Education/employment, Eating, Activities and peer relations, Drugs and Alcohol, Sexuality, Suicide/depression, and Safety. This is a common assessment tool designed to cover a broad range of topics while causing minimal stress to young people (Goldenring & Rosen, 2004), and is an expected part of routine care for young people in the headspace initiative (Parker, Hetrick, & Purcell, 2010). Research has found that electronic psychosocial assessment in clinical settings supports disclosure and enables stronger input and direct engagement of young clients in the face-to-face treatment process (Bradford & Rickwood, 2012b). As such, online intake forms could improve online chat sessions by: reducing the amount of time spent during sessions gathering information; engaging clients; and being potentially therapeutic in and of itself (Pennebaker, 1997). In particular, the use of an online self-administered intake form may help identify high risk clients and either prioritise their access to counselling or direct them to crisis counselling specific services.

Once the online intake form is completed, clients would be able to complete some self-report rating scales. These need only be brief, but it has been found that routine measurement and feedback can be used to reduce deterioration and improve treatment outcomes (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Lambert et al., 2003). It is proposed that this is achieved by assessing actual client change, enhancing the therapeutic alliance, and fostering richer discussions of potential change (Hatfield & Ogles, 2006). Due to the very brief nature of the proposed model, it would be also be beneficial for clients to include self-report rating scales post session so they can determine if they feel the session has been of value and met their needs. It has previously been noted that there is little in the way of continuous feedback amongst online services that can be used to improve service provision (King et al., 2010). However, the online environment is well-suited to continuous service evaluation through client feedback, and the regular measurement of treatment impact and outcomes.

Problem clarification. The problem clarification stage, which has typically been found to take up the most time during an online chat session (Chardon et al., 2011), should be significantly shorter with the introduction of an online intake form. As such, in a relatively brief amount of time, online clinicians should be able to introduce themselves and clarify any client queries regarding the service. The clinician can then invite the client to expand on any issues of particular importance, and identify any potential risk factors, while aiming to build faith in the treatment model, clinician and client (Swift & Derthick, 2013). Online clinicians may feel that this does not give them enough time to build a rapport with the clients. However, establishing a therapeutic relationship includes more than building rapport, and also includes establishing agreements on treatment interventions and therapeutic goals (Bordin, 1994). Overall, clinicians need to be mindful that time is limited, and that this time

may be used more efficiently by quickly establishing specific goals based on the concerns highlighted by young people in their online intake form.

Goal exploration. Goal exploration is notably the most underutilised of all the treatment processes (Chardon et al., 2011). This is somewhat surprising as it is widely recognised that goal setting is an effective way of achieving behavioural change in people (Feldman et al., 2009; Locke & Latham, 2002). The aim of goal exploration should be to collaboratively develop specific client centred goals that are achievable (Gingerich & Peterson, 2013). While this may be quite difficult, aiding clients to develop goals is a crucial part of helping them develop their pathway and agency thinking abilities, which are key aspects of hope (Feldman & Dreher, 2012). Furthermore, clients are more likely to achieve their goals if they have clearly established them beforehand.

If a client has stated that they have multiple goals, it would then be prudent to set a session agenda, ranking the goals in order of importance and allowing the agenda to guide the remainder of the session. A session agenda may further focus the therapy effort, and should include items that are linked to the overall therapy goals, are specific, can be tracked, and lead to useful homework (Wright et al., 2010). Once the goals have been established, and the agenda set, the online clinician may start to develop potential strategies.

Action planning. While the action planning stages are utilised more frequently than goal exploration, they are generally applied superficially (Chardon et al., 2011). However, this need not be the case, as working online provides easy access to numerous additional interventions (Campbell & Robards, 2013). Considering the brief nature of the proposed model, sessions may be extended by directing clients to appropriate psychoeducation interventions, self-help therapeutic interventions, internet-operated therapeutic software, online support groups, mental health apps, and therapist supported interventions (Barak et al., 2009). Online clinicians should develop a familiarity with online interventions in order that

they can suggest appropriate strategies to clients. In particular, it is recommended that initially, clinicians should prioritise psychoeducation, self-help, and mutual help interventions as these are generally the types of interventions people are seeking when going online (Chang, 2005). As previously noted, the Beacon web-site is a good source for clinicians to determine evidence based online interventions.

Once a selection of interventions has been proposed, it would be possible to discuss the different types of interventions available and what would best suit the needs of the client. A strategy on realising goal accomplishment can be agreed, and the plan reviewed and homework assigned as appropriate. Essentially, the aim is to develop tasks and strategies that increase the self-efficacy of clients, giving them a sense of hopefulness and confidence in their ability to manage their problems (Perkins, 2006). It would be important for clinicians to develop processes for guiding clients through self-help interventions, such as by providing support and feedback via email, SMS or similar brief communication tools.

Termination. Once a plan has been developed, it is time for the session to be terminated. The clinician should summarise the session and check for client understanding. Furthermore, it is good practice for the clinician to ask clients for feedback, and complete treatment impact and outcome measurement, which may help improve future clinician performance through practice-based evidence (Barkham et al., 2001). This may be done in session, but it may also be done as an online form, similar to the intake and rating scale forms, which could store the information and link it with previous results for the clinician and client to view.

Lastly, the possibility of future sessions can be discussed. While the overall approach is that each session should be self-contained, at the end of the session client and clinician can collaboratively decide if further sessions are needed or different types of interventions are required (Perkins, 2006). In particular, rather than suggest a time for clients, it may be

worthwhile to introduce a patient-led appointment model, in which clients are able to book in for future sessions online. Patient-led appointment scheduling has the benefit of being effective (in terms of treatment outcomes) and efficient (in terms of reducing the number of missed or cancelled appointments) (Carey et al., 2013). This, in addition to queuing algorithms, is promising for mental health services that have limited resources.

Social Policy Implications

An online chat service specialising in single session therapy interventions would fulfil a unique niche within the myriad of online mental health services available. While there would be flexibility for eheadspace to provide crisis support or ongoing treatment services, a focus on brief interventions would conceptually situate the service within the early intervention range of the e-spectrum (Rickwood, 2012). Early interventions emphasise the provision of help for first presentations of mental health problems for people experiencing mild to moderate symptoms of mental illness, and in particular those who are experiencing stress, anxiety or depression (Blanchard et al., 2013). Thus, an online service that provided brief interventions may be the optimal way of meeting these needs and, ideally, is expected to improve the low take-up rate of mental health services by young people, and provide a valuable contribution to the Australian Government's e-mental health strategy (DoHA, 2012).

Based on the current research, online chat could be part of a 'stepped care' approach, by which clients commence with a low-intensity, low-cost treatment (van Straten, Seekles, Veer-Tazelaar, Beekman, & Cuijpers, 2010). Clients would be provided with a single session of structured therapy, providing them with a positive experience of seeking help and some possible solutions to their problems. Clients would be allowed to return for additional sessions as desired. Young people who present with more complex or severe problems may be monitored and provided with higher intensity and higher cost treatments when necessary. This could include referral to face-to-face services or the provision of structured evidence

based treatments using online chat when face-to-face services are unavailable, particularly for young people in rural or remote areas. Online chat services could serve a vital role in providing and directing young clients to cost effective treatments, and systematically keeping track of client progress, making recommendations to seek brief or long-term face-to-face psychotherapy as necessary.

There is an absence of evidence relating to the cost-effectiveness of using online chat as a treatment modality. While it has been found that CBT delivered by a therapist via online chat was likely to be cost-effective compared with face-to-face CBT (Hollinghurst et al., 2010), this may not necessarily be the case for the current youth online chat model. Given that young people are only attending a small number of sessions and that improvements, if any, are generally small, there are serious concerns that the current model for providing online chat services may not be cost-effective. Future research needs to determine the most effective uses of the online chat modality in the provision of mental health care for young people, including future consideration of the cost-effectiveness of youth targeted online chat interventions.

Strengths and limitations

The current research has many strengths, but also has some notable limitations. The research benefits from a mixed methods approach, and by examination at different points of the online intervention process, including clinician views and characteristics and outcomes for clients at different levels of engagement (i.e., number of sessions attended). However, the results were limited in particular by the high rate of participant attrition for the follow-up, the self-selecting nature of the voluntary participants, the sensitivity of outcome measures, lack of identification of presenting issues, and the absence of a dedicated control or comparison group.

A major strength of this research was the very nature of the research approach; the integration of qualitative and quantitative methods, which facilitated the exploratory and developmental nature of the research. The aims of the thesis were achieved by adopting a qualitative methodology in Study 2, which allowed for an in-depth exploration of the perceptions of online clinicians providing mental health support to young people. This qualitative research informed the development of the quantitative questionnaires used during studies 3 and 4, and highlighted areas for analysis during Study 5. The use of quantitative methods in studies 3 and 4 enabled pre- and post-test analyses to be conducted, which enhanced understanding of the effect of online chat as a treatment modality. Finally, Study 5 applied a mixed method of analysis, quantifying the progress and depth of online chat transcripts and comparing them against treatment outcomes. As demonstrated throughout this chapter, the results of each complementary phase of research were compared and contrasted in order to make stronger inferences relating to the effectiveness and processes of online chat counselling and its ability to provide help to young people.

Another strength of the current studies was the analysis of several stages of the treatment intervention. Data were collected prior to the intervention, and again six weeks later to provide outcome data. Furthermore, transcripts of the sessions were analysed to provide an insight into what was occurring during the intervention. Unique to this research of online chat counselling, the data were then compared to gain an insight into what processes were associated with changes in client outcomes. This is an area of research that has not previously been undertaken and significantly contributes to our understanding of what occurs during an online chat session and how this may affect young people seeking help online.

While the initial sample was large, with over a thousand participants completing the first stage, the attrition rate was also high. Of the approximately 500 participants eligible for follow-up by virtue of being first time service users, only one third completed the follow-up

questionnaire. Furthermore, of those who completed the follow-up, only a third agreed to have their transcripts accessed as well. The issue of attrition has potential implications for the internal validity of the research, as those participants who continued to participate in the study may have differed from those who withdrew. However, although there appears to be no demonstrated solution to the problem of participant attrition, an analysis of the data found no differences on any demographic characteristics, or baseline measure, between clients who withdrew and those who remained. This would suggest that there were strong similarities between the groups (Shadish, Cook, & Campbell, 2002).

A similar issue affecting the internal validity of the results is selection bias due to the self-selecting nature of the participants. In general, people who volunteer for psychological studies tend to be female, more altruistic, more self-disclosing, more maladjusted, and higher in need for social approval (Whitley, 2002). These factors are likely to affect the current sample, which was, for example, even more likely to comprise females than the service data reveal (headspace, 2014). Specifically related to this research, is the possibility that there was a selection bias towards those clients who had to wait longer to see a counsellor, and thus had time to complete the initial survey. A longer wait could have potentially affected participant perceptions, particularly regarding hope and expectations, which are influenced by personal experience. Replication studies may help address concerns about the impact of selection bias, but only a randomised control trial can control for selection bias.

This research also relied on self-report methods, which gives rise to some inherent limitations. Self-report measures are dependent on participants' self-perceptions and may be inaccurate due to issues being exaggerated or minimised. Self-report studies are fundamentally affected by the participants' feelings at the time they filled out the questionnaire. Furthermore, participants' responses may be affected by demand characteristics, such as social desirability bias or the 'good-participant role' whereby the

participant attempts to discern the experimenter's hypotheses and to confirm them (Nichols & Maner, 2008). Accordingly, some participants may have felt the need to say they felt better when they did not. Alternatively, if they were unhappy with the service, they may have stated they were feeling worse than they actually were. However, despite these issues, there is no purely objective method of measuring psychological distress, life satisfaction, hope, or expectations. As such, self-report is still the best method of collecting data regarding feelings and emotions that are inherently subjective.

While it was determined that measures such as the K-10 and the Brief Multidimensional Students' Life Satisfaction Scale would be effective in measuring treatment outcomes by assessing both symptoms of distress and general wellbeing, these measures may not have been sensitive enough to measure changes relevant to the participants' experience of the service. More sensitive and immediate measures, such as session impact, may better determine exactly what online counselling processes affect client outcomes and how these can be used to improve online clients' experiences. Furthermore, while significant changes in hope were noted, the Children's Hope Scale did not differentiate between agency and pathway thinking, which may be particularly important in goal attainment (Feldman et al., 2009). Lastly, it would have been of interest to measure expectations again during the follow-up survey. This may have helped identify if clients' experiences of seeking help altered their expectations for future service interactions.

The current findings were also limited by a lack of measures that could help identify presenting issues. There are still significant questions related to the effectiveness of online chat in treating crisis and/or serious disorders (Finn & Barak, 2010). The current research only presented limited information on the young persons' presenting problems and was unable to provide any diagnoses. As such, the research was unable to conduct analyses to determine whether the service was better suited to treating specific types of problems. Future

research should focus on identifying clients with particular presenting issues and provide them with treatment via online chat. This is much needed research and would help online clinicians manage risk by helping them determine which clients could be treated online and which clients would be better to be referred to more intensive services.

Lastly, this research would have benefitted from having a control or comparison group. While there was a large proportion of participants who did not attend a session of online counselling, these could not be considered a valid control group given that they were not randomly selected and could still have potentially received treatment if they had waited for an available clinician. As such, they may not have felt they needed treatment as much as other participants, or perceived the wait as a negative experience. In particular, a comparison with a face-to-face sample would have enhanced the findings, as this is the traditional treatment medium (Barak et al., 2008). Specifically, it would have been interesting to know how a face-to-face session differs to an online chat session in terms of progress and depth, as there is limited research on how closely face-to-face clinicians adhere to their own treatment models (Perepletchikova & Kazdin, 2005). Nevertheless, it should be acknowledged that it would be difficult to justify the inclusion of a control group, especially one that was randomised, as it would be arguably unethical to deprive young people from seeking treatment when they would otherwise be seeking help (Danaher & Seeley, 2009).

Future research directions

Online counselling is a rapidly developing field for the provision of psychological interventions and there are many avenues open for further research, particularly regarding the processes and effectiveness of online chat. The current research has highlighted five areas for future research: client variables, placebo (hope and expectations), techniques, the therapeutic relationship, and the proposed online chat intervention.

There is a variety of client variables that can be further explored within the online chat environment. Perhaps most importantly, research needs to determine what psychological presentations are best suited for treatment online, and with whom (King et al., 2010). Furthermore, the constructs of client hope and expectations need more exploration, particularly in terms of managing incongruences during client sessions (Leung et al., 2009; Swift & Derthick, 2013). Research exploring the techniques and processes of online chat is relatively recent, and as clinicians become more familiar with the medium, and the evidence, a broader range of online interventions is likely. Online chat sessions provide a very credible source for assessing counselling processes and how they affect treatment outcomes because of the very nature of the written exchange between client and clinician (Chardon et al., 2011). Research regarding the therapeutic relationship online has been mixed, and one of the most important areas for future research will be to investigate how necessary the therapeutic relationship is to online interventions, particularly for single session interventions. Moreover, if the therapeutic relationship is found not to be related to online treatment outcomes, as found by King, Bambling, Reid, et al. (2006), then it will be important to identify what aspects of online counselling are more relevant for success.

The proposed intervention guidelines, while grounded in the current literature, need to be applied and validated. Clinicians may be reluctant to implement the proposed model, as many of the suggestions diverge from traditional approaches to therapy (Carey et al., 2013; Perkins & Scarlett, 2008). Specifically, online intake forms, continual assessment, queueing algorithms, single session interventions, adjunct online interventions, and patient-led scheduling are generally novel approaches. However, it is clear from the current research that more can be achieved online than is currently the case, and that simply transplanting traditional service models into the online environment may not be the best way to harness this medium.

Conclusion

The aim of this project was to further knowledge regarding the processes and effectiveness in the rapidly growing field of online counselling and therapy. The results of this research add to the very limited literature on the subject and progresses the understanding of best practice for online clinicians. The results inform future therapeutic practice, theory and research in several domains: (a) increasing the understanding of online clinicians' perceptions of online counselling and highlighting the variety of roles and difficulties in keeping young people engaged; (b) improving understanding of the characteristics of clients who seek help online, by finding the majority are highly distressed adolescent females with low hope but high expectations; (c) providing evidence of the effectiveness of brief online counselling sessions over a six week period, specifically in raising client levels of hope; and (d) describing the counselling processes specific to online counselling and their relationship to treatment outcomes, finding that problem clarification and action planning processes were associated with improvements, and that goal exploration was virtually neglected. The implications of the results for online clinicians have been discussed, specifically the unique time constraints of online chat, the high attrition rates, and lack of role clarity. A brief intervention model has been proposed that will enable online clinicians to better manage their time and provide an improved service to young people seeking help online. Finally, the research has demonstrated the potential and limitations of online chat. In particular, online chat appears suitable to address a large, but specific, niche within the early intervention spectrum, by way of providing young people with easy access to mental health resources and interventions at a time when they are most distressed and receptive to receiving help.

References

Abbott, J., Klein, B., & Ciechomski, L. (2008). Best practices in online therapy. *Journal of Technology in Human Services, 26*(2), 360-375.

ABS, Australian Bureau of Statistics. (2010). *Mental health of young people, 2007*. (4840.0.55.001). Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4840.0.55.001/.

AIHW, Australian Institute of Health and Welfare. (2010). *Health system expenditure on disease and injury in Australia, 2004-05*. Retrieved from http://www.aihw.gov.au/publication-detail/?id=6442468349&tab=2.

Anderson, I. (2011). The uses and gratifications of online care pages: A study of CaringBridge. *Health Communication, 26*(6), 546-559. doi: 10.1080/10410236.2011.558335

Andersson, G. (2009). Using the Internet to provide cognitive behaviour therapy. *Cognitive Behaviour Therapy, 47*(3), 175-180. doi: 10.1016/j.brat.2009.01.010

Andersson, G., & Titov, N. (2014). Advantages and limitations of internet-based interventions for common mental disorders. *World Psychiatry, 13*(1), 4-11. doi: 10.1002/wps.20083

Andrews, G., Cuijpers, P., Craske, M. G., McEvoy, P., & Titov, N. (2010). Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: A meta-analysis. *PLoS One, 5*(10), 1-6. doi: 10.1371/journal.pone.0013196

APS, Australian Psychological Society. (2011). *Guidelines for providing psychological services and products using the internet and telecommunications technologies.* Retrieved from https://www.psychology.org.au/Assets/Files/EG-Internet.pdf

Athay, M. M. (2012). Satisfaction with Life Scale (SWLS) in caregivers of clinically-referred youth: Psychometric properties and mediation analysis. *Administration and Policy in Mental Health, 39*(1-2), 41-50. doi: 10.1007/s10488-011-0390-8

Bagraith, K., Chardon, L., & King, R. (2010). Rating counselor–client behavior in online counseling: Development and preliminary psychometric properties of the Counseling Progress and Depth Rating Instrument. *Psychotherapy Research, 20*(6), 722-730. doi: 10.1080/10503307.2010.519739

Baker, K., & Ray, M. (2011). Online counseling: The good, the bad, and the possibilities. *Counselling Psychology Quarterly, 24*(4), 341-346. doi: 10.1080/09515070.2011.632875

Bambling, M., King, R., Reid, W., & Wegner, K. (2008). Online counselling: The experience of counsellors providing synchronous single-session counselling to young people. *Counselling and Psychotherapy Research, 8*(2), 110-116. doi: 10.1080/14733140802055011

Barak, A., & Grohol, J. (2011). Current and future trends in Internet-supported mental health interventions. *Journal of Technology in Human Services, 29*(3), 155-196. doi: 10.1080/15228835.2011.616939

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services, 26*, 109-160. doi: 10.1080/15228830802094429

Barak, A., Klein, B., & Proudfoot, J. (2009). Defining internet-supported therapeutic interventions. *Annals of Behavioral Medicine, 38*, 4-17. doi: 10.1007/s12160-009-9130-7

Bardone-Cone, A. M., & Cass, K. M. (2007). What does viewing a pro-anorexia website do? An experimental examination of website exposure and moderating effects. *International Journal of Eating Disorders, 40*(6), 537-548. doi: 10.1002/eat.20396

Barkham, M., Connell, J., Stiles, W., Miles, J. N., Margison, F., Evans, C., & Mellor-Clark, J. (2006). Dose-effect relations and responsive regulation of treatment duration: The good enough level. *Journal of Consulting and Clinical Psychology, 74*(1), 160-167. doi: 10.1037/0022-006X.74.1.160

Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., . . . McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology, 69*(2), 184-196. doi: 10.1037/0022-006X.69.2.184

Barnett, J. (2005). Online counseling: New entity, new challenges. *The Counseling Psychologist, 33*(6), 872-880. doi: 10.1177/0011000005279961

Bazeley, P. (2007). *Qualitative data analysis with NVivo*. London: Sage.

Beattie, A., Shaw, A., Kaur, S., & Kessler, D. (2009). Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: A qualitative study. *Health Expectations, 12*(1), 45-59. doi: 10.1111/j.1369-7625.2008.00531.x

Bebbington, P., Meltzer, H., Brugha, T., Farrell, M., Jenkins, R., Ceresa, C., & Lewis, G. (2000). Unequal access and unmet need: Neurotic disorders and the use of primary care services. *Psychological Medicine, 30*(6), 1359-1367.

Bernstein, M. S., Monroy-Hernandez, A. , Harry, D., Andre, P. , Panovich, K., & Vargas, G. (2011, July). *4chan and /b/: An analysis of anonymity and ephemerality in a large online community*. Paper presented at the Fifth International Conference on Weblogs and Social Media, Menlo Park, CA. Retrieved from http://projects.csail.mit.edu/chanthropology/4chan.pdf

Bickman, L., Kelley, S. D., Breda, C., de Andrade, A., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: Results of a randomized trial. *Psychiatric Services, 62*(12), 1423-1429. doi: 10.1176/appi.ps.002052011

Blanchard, M., Hosie, A., & Burns, J. (2013). *Embracing technologies to improve well-being for young people: An Australian view of evidence and policy implications*. Melbourne: Nexus Strategic Partnerships for the Commonwealth Secretariat. Retrieved from http://www.youngandwellcrc.org.au/knowledge-hub/publications/embracing-technologies-improve-wellbeing-young-people/.

Bloom, Bernard L. (2001). Focused single-session psychotherapy: A review of the clinical and research literature. *Brief Treatment and Crisis Intervention, 1*(1), 75-86.

Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, Practice, Training, 16*, 252-260. doi: 10.1037/h0085885

Bordin, E. (1994). Theory and research on the therapeutic working alliance: New directions. In A. Horvath & A. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 13-37). New York: Wiley.

Boschen, Mark J., & Casey, Leanne M. (2008). The use of mobile telephones as adjuncts to cognitive behavioral psychotherapy. *Professional Psychology: Research and Practice, 39*(5), 546-552. doi: 10.1037/0735-7028.39.5.546

Bradford, S., & Rickwood, D. (2012a). Adolescent's preferred modes of delivery for mental health services. *Child and Adolescent Mental Health, 19*(1), 39-45. doi: 10.1111/camh.12002

Bradford, S., & Rickwood, D. (2012b). Psychosocial assessments for young people: A systematic review examining acceptability, disclosure and engagement, and predictive

utility. *Adolescent Health, Medicine and Therapeutics, 2012*(3), 111-125. doi: 10.2147/AHMT.S38442

Bradford, S., & Rickwood, D. (2014). Young people's views on electronic mental health assessments: Prefer to type than talk? *Journal of Child and Family Studies*. doi: 10.1007/s10826-014-9929-0

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi: 10.1191/1478088706qp063oa

Brener, N., Billy, J., & Grady, W. (2003). Assessment of factors affecting the validity of self-reported health-risk behavior among adolescents: Evidence from the scientific literature. *Journal of Adolescent Health, 33*, 436-457. doi: 10.1016/S1054-139X(03)00052-1

Brent, D., Kolko, D., Birmaher, B., Baugher, M., & Bridge, J. (1999). A clinical trial for adolescent depression: Predictors of additional treatment in the acute and follow-up phases of the trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(3), 263-271. doi: 10.1001/archpsyc.1997.01830210125017

Burgess, P., Pirkis, J., Slade, T., Johnston, A., Meadows, G., & Gunn, J. (2009). Service use for mental health problems: Findings from the 2007 National Survey of Mental Health and Wellbeing. *The Australian and New Zealand Journal of Psychiatry, 43*(7), 615-623. doi: 10.1080/00048670902970858

Burns, J. M., Davenport, T. A., Durkin, L. A., Luscombe, G. M., & Hickie, I. B. (2010). The internet as a setting for mental health service utilisation by young people [Supplementary material]. *Medical Journal of Australia, 192*(11), S22-26.

Callahan, A., & Inckle, K. (2012). Cybertherapy or psychobabble? A mixed methods study of online emotional support. *British Journal of Guidance & Counselling, 40*(3), 261-278. doi: 10.1080/03069885.2012.681768

Callahan, J., Aubechon-Endsley, N., Borja, S., & Swift, J. (2009). Pretreatment expectancies and premature termination in a training clinic environment. *Training and Education in Professional Psychology, 3*(4), 111-119. doi: 10.1037/a0012901

Callahan, J., Gustafson, S., Misner, J., Paprocki, C., Sauer, E., Saules, K., . . . Wise, E. (2014). Introducing the association of psychology training clinics' collaborative research network: A study on client expectancies. *Training and Education in Professional Psychology, 8*(2), 95-104. doi: 10.1037/tep0000047

Campbell, A., Cumming, S., & Hughes, I. (2006). Internet use by the socially fearful: Addiction or therapy? *CyberPsychology and Behavior, 9*, 69-81. doi: 10.1089/cpb.2006.9.69

Campbell, A., & Robards, F. (2013). *Using technologies safely and effectively to promote young people's wellbeing: A better practice guide for services*. Abbotsford, Victoria: Young and Well Cooperative Research Centre. Retrieved from http://www.youngandwellcrc.org.au/knowledge-hub/publications/using-technologies-safely-effectively-promote-young-peoples-wellbeing/.

Carey, T. (2006). *The method of levels : How to do psychotherapy without getting in the way*. Hayward, CA: Living Control Systems Pub.

Carey, T., Tai, S. J., & Stiles, W. B. (2013). Effective and efficient: Using patient-led appointment scheduling in routine mental health practice in remote Australia. *Professional Psychology: Research and Practice, 44*(6), 405-414. doi: 10.1037/a0035038

Castelnuovo, G., Gaggioli, A., Mantovani, F., & Riva, G. (2003). From psychotherapy to etherapy: The integration of traditional techniques and new communication tools in clinical settings. *CyberPsychology & Behavior, 6*, 375-382. doi: 10.1089/109493103322278754

Chan, D., & Cheng, G. (2004). A comparison of offline and online friendship qualities at different stages of relationship development. *Journal of Social and Personal Relationships, 21*(3), 305-320. doi: 10.1177/0265407504042834

Chang, T. (2005). Online counseling: Prioritizing psychoeducation, self-help, and mutual help for counseling psychology research and practice. *The Counseling Psychologist, 33*(6), 881-890. doi: 10.1177/0011000005279962

Chardon, L., Bagraith, K., & King, R. J. (2011). Counseling activity in single-session online counseling with adolescents: An adherence study. *Psychotherapy Research, 21*(5), 583-592. doi: 10.1080/10503307.2011.592550

Christensen, H., Griffiths, K., Groves, C., & Korten, A. (2006). Free range users and one hit wonders: Community users of an internet-based cognitive behaviour therapy program. *The Australian and New Zealand Journal of Psychiatry, 40*(1), 59-62. doi: 10.1111/j.1440-1614.2006.01743.x

Cohen, G., & Kerr, A. (1998). Computer-mediated counseling: An empirical study of a new mental health treatment. *Computers in Human Services, 15*(4), 13-27. doi: 10.1300/J407v15n04_02

Coleman, L. H., Paternite, C. E., & Sherman, R. C. (1999). A reexamination of deindividuation in synchronous computer-mediated communication. *Computers in Human Behavior, 15*(1), 51-65. doi: 10.1016/S0747-5632(98)00032-6

Constantino, M. J., Arnkoff, D. B., Glass, C. R., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. *Journal of Clinical Psychology, 67*(2), 184-192. doi: 10.1002/jclp.20754

Cook, J., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face therapy: Preliminary results. *CyberPsychology & Behavior, 5*(2), 95-105. doi: 10.1089/109493102753770480

Creswell, J. (2008). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Cross, S., Hermens, D., Scott, E., Ottavio, A., McGorry, P., & Hickie, I. (2014). A clinical staging model for early intervention youth mental health services. *Psychiatric Services, 65*(7), 939-943. doi: 10.1176/appi.ps.201300221

Danaher, B., & Seeley, J. (2009). Methodological issues in research on web-based behavioral interventions. *Annals of Behavioral Medicine, 38*, 28-39. doi: 10.1007/s12160-009-9129-0

DeFife, J., & Hilsenroth, M. (2011). Starting off on the right foot: Common factor elements in early psychotherapy process. *Journal of Psychotherapy Integration, 21*(2), 172-191. doi: 10.1037/a0023889

Denzin, N. (2006). *Sociological methods: A sourcebook* (5 ed.). Chicago: Aldine Pub. Co.

Dew-Reeves, S. E., & Athay, M. M. (2012). Validation and use of the youth and caregiver Treatment Outcome Expectations Scale (TOES) to assess the relationships between expectations, pretreatment characteristics, and outcomes. *Administration and Policy in Mental Health, 39*(1-2), 90-103. doi: 10.1007/s10488-012-0406-z

Dew-Reeves, S. E., Athay, M. M., & Kelley, S. D. (2012). Validation and use of the Children's Hope Scale-revised PTPB edition (CHS-PTPB): High initial youth hope and elevated baseline symptomatology predict poor treatment outcomes. *Administration and Policy in Mental Health, 39*(1-2), 60-70. doi: 10.1007/s10488-012-0411-2

Dew, S. E., & Bickman, L. (2005). Client expectancies about therapy. *Mental Health Services Research, 7*(21-33). doi: 10.1007/s11020-005-1963-5

DoHA, Department of Health and Ageing. (2012). *E-mental health strategy for Australia*. Retrieved from

http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-e-emstrat.

DoHAC, Department of Health and Aged Care. (2000). *National action plan for promotion, prevention and early intervention for mental health*. Retrieved from http://health.act.gov.au/c/health?a=dlpubpoldoc&document=823.

Dowling, M., & Rickwood, D. (2013). Online counseling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. *Journal of Technology in Human Services, 31*(1), 1-21. doi: 10.1080/15228835.2012.728508

Dowling, M., & Rickwood, D. (2014). Experiences of counsellors providing online chat counselling to young people. *Australian Journal of Guidance and Counselling, 24*(2), 183-196. doi: doi:10.1017/jgc.2013.28

DuBois, D. (2004). Clinical and demographic features of the online counselling client population. *Counselling and Psychotherapy Research, 4*, 18-22. doi: 10.1080/14733140412331384028

Egan, G. (2014). *The skilled helper: A problem-management and opportunity-development approach to helping* (10th ed.). Belmont, CA: Brooks/Cole, Cengage Learning.

Elliott, J., Nembhard, M. , Giannone, V., Surko, M., Medeiros, D., & Peake, K. (2005). Clinical uses of an adolescent intake questionnaire. *Social Work in Mental Health, 3*(1-2), 83-102. doi: 10.1300/J200v03n01_05

Ellis, L. A., Collin, P., Davenport, T. A., Hurley, P. J., Burns, J. M., & Hickie, I. B. (2012). Young men, mental health, and technology: Implications for service design and delivery in the digital age. *Journal of Medical Internet Research, 14*(6), p145-p153. doi: 10.2196/jmir.2291

Erikson, E., & Erikson, J. (1998). *The life cycle completed*. New York: WW Norton.

Eysenbach, G. (2005). The law of attrition. *Journal of Medical Internet Research, 7*(1), e11. doi: 10.2196/jmir.7.1.e11

Farvolden, P., Denisoff, E., Selby, P., Bagby, R. M., & Rudy, L. (2005). Usage and longitudinal effectiveness of a web-based self-help cognitive behavioral therapy program for panic disorder. *Journal of Medical Internet Research, 7*(1), e7. doi: 10.2196/jmir.7.1.e7

Feldman, D. B., & Dreher, D. E. (2012). Can hope be changed in 90 minutes? Testing the efficacy of a single-session goal-pursuit intervention for college students. *Journal of Happiness Studies, 13*(4), 745-759. doi: 10.1007/s10902-011-9292-4

Feldman, D. B., Rand, K. L., & Kahle-Wrobleski, K. (2009). Hope and goal attainment: Testing a basic prediction of hope theory. *Journal of Social and Clinical Psychology, 28*(4), 479-497. doi: 10.1521/jscp.2009.28.4.479

Fenichel, M., Suler, J., Barak, A., Zelvin, E., Jones, G., Munro, K., . . . Walker-Schmucker, W. (2002). Myths and realities of online clinical work. *CyberPsychology & Behavior, 5*(5), 481-497. doi: 10.1089/109493102761022904

Finn, J., & Barak, A. (2010). A descriptive study of e-counsellor attitudes, ethics, and practice. *Counselling and Psychotherapy Research, 10*(4), 268-277. doi: 10.1080/14733140903380847

Finn, J., & Bruce, S. (2008). The LivePerson model for delivery of etherapy services: A case study. *Journal of Technology in Human Services, 26*, 282-309. doi: 10.1080/15228830802096820

Fletcher-Tomenius, Leon JosephVossler Andreas. (2009). Trust in online therapeutic relationships: The therapist's experience. *Counselling Psychology Review, 24*(2), 24-33.

Fukkink, R., & Hermanns, J. (2009a). Children's experiences with chat support and telephone support. *Journal of Child Psychology & Psychiatry, 50*(6), 759-766. doi: 10.1111/j.1469-7610.2008.02024.x

Fukkink, R., & Hermanns, J. (2009b). Counseling children at a helpline: Chatting or calling? *Journal of Community Psychology, 37*(8), 939-948. doi: 10.1002/jcop.20340

Gaffney, H., Mansell, W., Edwards, R., & Wright, J. (2013). Manage Your Life Online (MYLO): A pilot trial of a conversational computer-based intervention for problem solving in a student sample. *Behavioural and Cognitive Psychotherapy*, 1-16. doi: 10.1017/s135246581300060x

Gainsbury, S., & Blaszczynski, A. (2011). A systematic review of internet-based therapy for the treatment of addictions. *Clinical Psychology Review, 31*(3), 490-498. doi: 10.1016/j.cpr.2010.11.007

Gibb, S. J., Fergusson, D. M., & Horwood, L. J. (2010). Burden of psychiatric disorder in young adulthood and life outcomes at age 30. *The British Journal of Psychiatry, 197*(2), 122-127. doi: 10.1192/bjp.bp.109.076570

Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice, 23*(3), 266-283. doi: 10.1177/1049731512470859

Glasheen, K., Campbell, M., & Shochet, I. (2013). Opportunities and Challenges: School Guidance Counsellors' Perceptions of Counselling Students Online. *Australian Journal of Guidance & Counselling, 23*(2), 222-235. doi: 10.1017/jgc.2013.15

Glass, C. R., Arnkoff, D. B., & Shapiro, S. J. (2001). Expectations and preferences. *Psychotherapy: Theory, Research, Practice, Training, 38*(455-461). doi: 10.1037/0033-3204.38.4.455

Goates-Jones, M., & Hill, C. E. (2008). Treatment preference, treatment-preference match, and psychotherapist credibility: Influence on session outcome and preference shift. *Psychotherapy (Chic), 45*(1), 61-74. doi: 10.1037/0033-3204.45.1.61

Goldenring, J., & Rosen, D. (2004). Getting into adolescent heads: An essential update. *Contemporary Pediatrics, 21*(1), 64-92.

Gollings, E. K., & Paxton, S. J. (2006). Comparison of internet and face-to-face delivery of a group body image and disordered eating intervention for women: A pilot study. *Eating Disorders, 14*(1), 1-15. doi: 10.1080/10640260500403790

Graen, G. B. (1976). Role-making processes within complex organizations. In M. Dunnette (Ed.), *Handbook of Industrial and Organizational Psychology*. Chicago: Rand-McNally.

Green, L., Brady, D., Olafsson, K., Hartley, J., & Lumby, C. (2011). Risks and safety for Australian children on the internet: Full findings from the AU kids online survey of 9-16 year olds and their parents. *Cultural Science, 4*(1), 1-73.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*(5), 372-378. doi: 10.1037/0735-7028.21.5.372

Griffiths, K., & Christensen, H. (2006). Review of randomised controlled trials of internet interventions for mental disorders and related conditions. *Clinical Psychologist, 10*(1), 16-29. doi: 10.1080/13284200500378696

Griffiths, K., Farrer, L., & Christensen, H. (2010). The efficacy of internet interventions for depression and anxiety disorders: A review of randomised controlled trials. *Medical Journal of Australia, 192*(11), S4-11.

Gulliver, A., Griffiths, K., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10*(1), 113. doi: 10.1186/1471-244X-10-113

Haberstroh, S., Duffey, T., Evans, M., Gee, R., & Trepal, H. (2007). The experience of online counseling. *Journal of Mental Health Counseling, 29*, 269-282.

Haberstroh, S., Parr, G., Bradley, L., Morgan-Fleming, B., & Gee, R. (2008). Facilitating online counseling perspectives from counselors in training. *Journal of Counseling and Development, 86*, 460-470. doi: 10.1002/j.1556-6678.2008.tb00534.x

Hanley, T. (2009). The working alliance in online therapy with young people: Preliminary findings. *British Journal of Guidance & Counselling, 37*(3), 257-269. doi: 10.1080/03069880902956991

Hanley, T. (2011). Understanding the online therapeutic alliance through the eyes of adolescent service users. *Counselling and Psychotherapy Research*. doi: 10.1080/14733145.2011.560273

Hanley, T., & Reynolds, D. (2009). Counselling psychology and the internet: A review of the quantitative research into online outcomes and alliances within text-based therapy. *Counselling Psychology Review, 24*(2), 4-13.

Hansen, N., Lambert, M., & Forman, E. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343. doi: 10.1093/clipsy.9.3.329

Harnett, P., O'Donovan, A., & Lambert, M. (2010). The dose response relationship in psychotherapy: Implications for social policy. *Clinical Psychologist, 14*, 39-44. doi: 10.1080/13284207.2010.500309

Harrison, P., Beebe, T., & Park, E. (2001). The adolescent health review: A brief, multidimensional screening instrument. *Journal of Adolescent Health, 29*, 131-139. doi: 10.1016/S1054-139X(01)00263-4

Harun, L., Sainudin, Z., & Hamzah, R. (2001, August). *E-counselling: The willingness to participate*. Paper presented at the International Education Conference, Selangor, Malaysia. Retrieved from http://files.eric.ed.gov/fulltext/ED474645.pdf

Harvey-Berino, J., Pintauro, S., Buzzell, P., DiGiulio, M., Casey Gold, B., Moldovan, C., & Ramirez, E. (2002). Does using the internet facilitate the maintenance of weight loss? *International Journal of Obesity and Related Metabolic Disorders, 26*(9), 1254-1260. doi: 10.1038/sj.ijo.0802051

Harvey-Berino, J., Pintauro, S., Buzzell, P., & Gold, E. C. (2004). Effect of internet support on the long-term maintenance of weight loss. *Obesity Research, 12*(2), 320-329. doi: 10.1038/oby.2004.40

Hassan, S. (2013). The importance of role clarification in workgroups: Effects on perceived role clarity, work satisfaction, and turnover rates. *Public Administration Review, 73*(5), 716-725. doi: 10.1111/puar.12100

Hasson, D., Anderberg, U., Theorell, T., & Arnetz, B. (2005). Psychophysiological effects of a web-based stress management system: A prospective, randomized controlled intervention study of IT and media workers. *BMC Public Health, 5*(78). doi: 10.1186/1471-2458-5-78

Hatfield, D., & Ogles, B. (2006). The influence of outcome measures in assessing client change and treatment decisions. *Journal of Clinical Psychology, 62*, 325-338. doi: 10.1002/jclp.20235

headspace, National Office. (2014). *Final Evaluation Report: eheadspace*. Melbourne: headspace National Youth Mental Health Foundation, Evidence Building and Knowledge Transfer Division.

Heinlen, K., Welfel, E., Richmond, E., & O'Donnell, M. (2003). The nature, scope, and ethics of therapists' e-therapy web sites: What consumers find when surfing the web. *Psychotherapy: Theory, Research, Practice, Training, 40*(1/2), 112-124. doi: 10.1037/0033-3204.40.1-2.112.

Hilton, M., Scuffham, P., Vecchio, N., & Whiteford, H. (2010). Using the interaction of mental health symptoms and treatment status to estimate lost employee productivity. *Australian and New Zealand Journal of Psychiatry, 44*(2). doi: 10.3109/00048670903393605

Hollinghurst, S., Peters, T., Kaur, S., Wiles, N., Lewis, G., & Kessler, D. (2010). Cost-effectiveness of therapist-delivered online cognitive behavioural therapy for depression: Randomised controlled trial. *British Journal of Psychiatry, 197*(4), 297-304. doi: 10.1192/bjp.bp.109.073080

Hopps, S., Pepin, M., & Boisvert, J. (2003). The effectiveness of cognitive behavioral group therapy for loneliness via inter-relay-chat among people with physical disabilities. *Psychotherapy: Theory, Research, Practice, Training, 40*, 136-147.

Horvath, P. (1990). Treatment expectancy as a function of the amount of information presented in therapeutic rationales. *Journal of Clinical Psychology, 46*(5), 636-642.

Howard, K., Lueger, R., Maling, M., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: causal mediation of change. *Journal of Consulting and Clinical Psychology, 61*(4), 678-685. doi: 10.1037//0022-006X.61.4.678

Hoyt, M., Rosenbaum, R., & Talmon, M. (1992). Planned single-session psychotherapy. In S. Budman, M. Hoyt & S. Friedman (Eds.), *The first session in brief therapy* (pp. 59-86). New York, NY: Guilford Press.

Hoyt, W. (1996). Antecedents and effects of perceived therapist credibility: A meta-analysis. *Journal of Counseling Psychology, 43*(4), 430-447. doi: 10.1037/0022-0167.43.4.430

Hymmen, P., Stalker, C. A. , & Cheryl-Anne, C. (2013). The case for single-session therapy: Does the empirical evidence support the increased prevalence of this service delivery model? *Journal of Mental Health, 22*(1), 60-71. doi: 10.3109/09638237.2012.670880

Joinson, A. N. (2001). Self-disclosure in computer-mediated communication: The role of self-awareness and visual anonymity. *European Journal of Social Psychology, 31*(2), 177-192. doi: 10.1002/ejsp.36

Kaltenthaler, E., Parry, G., & Beverley, C. (2004). Computerized cognitive behaviour therapy: A systematic review. *Behavioural and Cognitive Psychotherapy, 32*, 31-55. doi: 10.1017/S135246580400102X

Katz, D., & Kahn, R. L. (1978). *The social psychology of organizations* (2nd ed.). New York, NY: Wiley.

Kessler, D., Lewis, G., Kaur, S., Wiles, N., King, M., Weich, S., . . . Peters, T. (2009). Therapist-delivered internet psychotherapy for depression in primary care: A randomised controlled trial. *Lancet, 374*(9690), 628-634. doi: 10.1016/S0140-6736(09)61257-5

Kessler, R., Andrews, G., Colpe, L., Hiripi, E., Mroczek, D., Normand, S., . . . Zaslavsky, A. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959-976. doi: 10.1017/S0033291702006074

Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K., & Walters, E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602. doi: 10.1001/archpsyc.62.6.593

Kessler, R., Chiu, W. T., Demler, O., Merikangas, K., & Walters, E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6), 617-627. doi: 10.1001/archpsyc.62.6.617

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice, 18*(2), 107-116. doi: 10.1177/1049731507307807

King, R., Bambling, M., Lloyd, C., Gomurra, R., Smith, S., Reid, W., & Wegner, K. (2006). Online counselling: The motives and experiences of young people who choose the Internet instead of face to face or telephone counselling. *Counselling and Psychotherapy Research, 6*(3), 169-174. doi: 10.1080/14733140600848179

King, R., Bambling, M., Reid, W., & Thomas, I. (2006). Telephone and online counselling for young people: A naturalistic comparison of session outcome, session impact and therapeutic alliance. *Counselling and Psychotherapy Research, 6*, 175-181. doi: 10.1080/14733140600874084

King, R., Bickman, L., Shochet, I., McDermott, B., & Bor, B. (2010). Use of the internet for provision of better counselling and psychotherapy services to young people, their families and carers. *Psychotherapy in Australia, 17*(1), 66-74.

Knuttila, L. (2011). User unknown: 4chan, anonymity and contingency. *First Monday, 16*(10). Retrieved from http://firstmonday.org/ojs/index.php/fm/article/view/3665

Koçağa, Y., & Ward, A. (2010). Admission control for a multi-server queue with abandonment. *Queueing Systems, 65*(3), 275-323. doi: 10.1007/s11134-010-9176-z

Lambert, M. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. Norcross & C. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.

Lambert, M., & Ogles, B. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5 ed., pp. 139-193). New York: Wiley.

Lambert, M., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology: Science and Practice, 10*(3), 288-301. doi: 10.1093/clipsy.bpg025

Lange, A., van de Ven, J., Schrieken, B., Bredeweg, B., & Emmelkamp, P. (2000). Internet-mediated, protocol driven treatment of psychological dysfunction. *Journal of Telemedicine and Telecare, 6*, 15-21.

Lapidot-Lefler, Noam, & Barak, Azy. (2012). Effects of anonymity, invisibility, and lack of eye-contact on toxic online disinhibition. *Computers in Human Behavior, 28*(2), 434-443. doi: 10.1016/j.chb.2011.10.014

Larsen, D., & Stege, R. (2012). Client accounts of hope in early counselling sessions: A qualitative study. *Journal of Counseling & Development, 90*, 45-54.

Leibert, T. (2011). The dimensions of common factors in counseling. *International Journal for the Advancement of Counselling, 33*(2), 127-138. doi: 10.1007/s10447-011-9115-7

Leibert, T., Archer, J., Munson, J., & York, G. (2006). An exploratory study of client perceptions of internet counselling and the therapeutic alliance. *Journal of Mental Health Counselling, 28*(1), 69-83.

Leung, K. K., Silvius, J. L. , Pimlott, N., Dalziel, W., & Drummond, N. (2009). Why health expectations and hopes are different: The development of a conceptual model. *Health Expectations, 12*, 347-360. doi: 10.1111/j.1369-7625.2009.00570.x

Lieberman, M. A., Winzelberg, A., Golant, M., Wakahiro, M., DiMinno, M., Aminoff, M., & Christine, C. (2005). Online support groups for Parkinson's patients: A pilot study of effectiveness. *Social Work in Health Care, 42*(2), 23-38. doi: 10.1300/J010v42n02_02

Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analysis. *American Psychologist, 48*(12), 1181-1209. doi: 10.1037//0003-066X.48.12.1181

Locke, Edwin A., & Latham, Gary P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist, 57*(9), 705-717. doi: 10.1037/0003-066X.57.9.705

Lopez, S., Snyder, C. R., Magyar-Moe, J., Edwards, L., Pedrotti, J., Janowski, K., . . . Pressgrove, C. (2004). Strategies for accentuating hope. In P. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp. 388-404). Hoboken, NJ: John Wiley & Sons.

Lovejoy, T., Demireva, P., Grayson, J., & McNamara, J. (2009). Advancing the practice of online psychotherapy: An application of Rogers' diffusion of innovations theory. *Psychotherapy Theory, Research, Practice, Training, 46*(1), 112-124. doi: 10.1037/a0015153

Lyons, T. F. (1971). Role clarity, need for clarity, satisfaction, tension, and withdrawal. *Organizational Behavior and Human Performance, 6*(1), 99-110. doi: 10.1016/0030-5073(71)90007-9

Mallen, M., Jenkins, I., Vogel, D., & Day, S. (2011). Online counselling: An initial examination of the process in a synchronous chat environment. *Counselling and Psychotherapy Research, 11*(3), 220-227. doi: 10.1080/14733145.2010.486865

Mallen, M., & Vogel, D. (2005). Introduction to the major contribution: Counseling psychology and online counseling. *The Counseling Psychologist, 33*(6), 761-775. doi: 10.1177/0011000005278623

Manzoni, G. M., Pagnini, F., Corti, S., Molinari, E., & Castelnuovo, G. (2011). Internet-based behavioral interventions for obesity: An updated systematic review. *Clinical Practice and Epidemiology in Mental Health, 7*, 19-28. doi: 10.2174/1745017901107010019

McMurtry, S., & Hudson, W. (2000). The client satisfaction inventory: Results of an initial validation study. *Research on Social Work Practice, 10*, 644-663.

Merikangas, K., He, J., Burstein, M., Swanson, S., Avenevoli, S., Cui, L., . . . Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(10), 980-989. doi: 10.1016/j.jaac.2010.05.017

Midkiff, D., & Wyatt, J. (2008). Ethical issues in the provision of online mental health services (etherapy). *Journal of Technology in Human Sciences, 26*(2-4), 310-332. doi: 10.1080/15228830802096994

Murphy, L., MacFadden, R., & Mitchell, D. (2008). Cybercounseling online: The development of a university-based training program for e-mail counseling. *Journal of Technology in Human Services, 26*(2-4), 447-469. doi: 10.1080/15228830802102081

Murphy, L., Mitchell, D., & Hallett, R. (2011). A comparison of client characteristics in cyber and in-person counseling. *Stud Health Technol Inform, 167*, 149-153.

Murphy, L., Parnass, P., Mitchell, D., Hallett, R., Cayley, P., & Seagram, S. (2009). Client satisfaction and outcome comparisons of online and face-to-face counselling methods. *British Journal of Social Work, 39*(4), 627-640. doi: 10.1093/bjsw/bcp041

Murray, E. , White, I., Varagunam, M., Godfrey, C., Khadjesari, Z., & McCambridge, J. (2013). Attrition revisited: Adherence and retention in a web-based alcohol trial. *Journal of Medical Internet Research, 15*(8), e162. doi: 10.2196/jmir.2336

Neal, D. M., Campbell, A., Williams, L. Y., Liu, Y., & Nussbaumer, D. (2011). "I did not realize so many options are available": Cognitive authority, emerging adults, and e-mental health. *Library & Information Science Research, 33*(1), 25-33. doi: 10.1016/j.lisr.2010.07.015

Newman, M., Szkodny, L., Llera, S., & Przeworski, A. (2011). A review of technology-assisted self-help and minimal contact therapies for anxiety and depression: Is human contact necessary for therapeutic efficacy? *Clinical Psychology Review, 31* 89-103. doi: 10.1016/j.cpr.2010.09.008

Nguyen, M., Bin, Y. S., & Campbell, A. (2012). Comparing online and offline self-disclosure: A systematic review. *CyberPsychology, Behavior & Social Networking, 15*(2), 103-111. doi: 10.1089/cyber.2011.0277

NHMRC, National Health and Medical Research Council, Australian Research Council, & Vice-Chancellors' Committee. (2007). *National statement on ethical conduct in human research 2007 (updated may 2013).* Retrieved from https://www.nhmrc.gov.au/guidelines/publications/e72.

Nichols, A. L., & Maner, J. K. (2008). The good-subject effect: Investigating participant demand characteristics. *Journal of General Psychology, 135*(2), 151-166. doi: 10.3200/GENP.135.2.151-166

Nock, M., & Kazdin, A. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies, 10*(2), 155-180. doi: 10.1023/A:1016699424731

Parker, A., Hetrick, S., & Purcell, R. (2010). Psychosocial assessment of young people - refining and evaluating a youth friendly assessment interview. *Australian family physician, 39*(8), 585-588.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369*(9569), 1302-1313. doi: 10.1016/s0140-6736(07)60368-7

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). London: Sage.

Pennebaker, J. W. (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science, 8*(3), 162-166. doi: 10.1111/j.1467-9280.1997.tb00403.x

Perepletchikova, F., & Kazdin, A. (2005). Treatment integrity and therapeutic change: Issues and research recommendations. *Clinical Psychology: Science and Practice, 12*, 365-383. doi: 10.1093/clipsy/bpi045

Perkins, R. (2006). The effectiveness of one session of therapy using a single-session therapy approach for children and adolescents with mental health problems. *Psychology & Psychotherapy: Theory, Research & Practice, 79*(2), 215-227. doi: 10.1348/147608305X60523

Perkins, R., & Scarlett, G. (2008). The effectiveness of single session therapy in child and adolescent mental health. Part 2: An 18-month follow-up study. *Psychology & Psychotherapy: Theory, Research & Practice, 81*(2), 143-156. doi: 10.1348/147608308X280995

Perle, J., Langsam, L., & Nierenberg, B. (2011). Controversy clarified: An updated review of clinical psychology and tele-health. *Clinical Psychology Review, 31*, 1247–1258. doi: 10.1080/15228835.2012.760332

Peterson, M. , & Beck, R. (2003). E-mail as an adjunctive tool in psychotherapy: Response and responsibility. *American Journal of Psychotherapy, 57*(2), 167-181.

Postel , M., de Haan, H., & De Jong, C. (2008). E-therapy for mental health problems: A systematic review. *Telemedicine and e-Health, 14*(7), 707-714. doi: 10.1089/tmj.2007.0111

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 418-431. doi: 10.1037/a0017901

Reese, R. J., Toland, M. D., & Hopkins, N. B. (2011). Replicating and extending the good-enough level model of change: Considering session frequency. *Psychotherapy Research, 21*(5), 608-619. doi: 10.1080/10503307.2011.598580

Richards, D., & Viganó, N. (2013). Online counseling: A narrative and critical review of the literature. *Journal of Clinical Psychology, 69*(9), 994-1011. doi: 10.1002/jclp.21974

Rickwood, D. (2012). Entering the e-spectrum: An examination of new interventions for youth mental health. *Youth Studies Australia, 31*(4), 18-27.

Rickwood, D., Deane, F., Wilson, C., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4*(3), 1-34.

Rickwood, D., Telford, N., Parker, A., Tanti, C., & McGorry, P. (2014). headspace - Australia's innovation in youth mental health: Who are the clients and why are they presenting? *The Medical Journal of Australia, 200*(2), 108-111. doi: 10.5694/mja13.11235

Rimondi, W. (2002). *Differences in intimacy and selfdisclosure scores between face-to-face and Internet friendships.* New Jersey: Kean University.

Robson, C. (2002). *Real world research: A resource for social scientists and practitioner researchers.* London: Blackwell.

Rochlen, A., Zack, J., & Speyer, C. (2004). Online therapy: Review of relevant definitions, debates, and current empirical support. *Journal of Clinical Psychology, 60*, 269-283.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103. doi: 10.1037/h0045357

Roy, H., & Gillett, T. (2008). E-mail: A new technique for forming a therapeutic alliance with high-risk young people failing to engage with mental health services? A case study. *Clinical Child Psychology & Psychiatry, 13*(1), 95-103. doi: 10.1177/1359104507086344

Rummell, C. , & Joyce, N. (2010). 'So wat do u want to wrk on 2day?': The ethical implications of online counseling. *Ethics & Behavior, 20*(6), 482-496. doi: 10.1080/10508422.2010.521450

Sawyer, M. G., Miller-Lewis, L. R., & Clark, J. J. (2007). The mental health of 13–17 year-olds in Australia: Findings from the national survey of mental health and well-being. *Journal of Youth and Adolescence, 36*, 185-194. doi: 10.1007/s10964-006-9122-x

Schiffrin, H., Edelman, A., Falkenstern, M., & Stewart, C. (2010). The associations among computer-mediated communication, relationships, and well-being. *Cyberpsychology, Behavior and Social Networking, 13*(3), 299-306. doi: 10.1089/cyber.2009.0173

Sethi, S., Campbell, A., & Ellis, L. A. (2010). The use of computerized self-help packages to treat adolescent depression and anxiety. *Journal of Technology in Human Services, 28*, 144-160.

Shadish, W., Cook, T., & Campbell, D. (2002). *Experimental and quasi-experimental designs for generilized causal inference*. Boston: Houghton Mifflin.

Shadish, W., Matt, G. E., Navarro, A. M., Siegle, G., Crits-Christoph, P., Hazelrigg, M. D., . . . Weiss, B. (1997). Evidence that therapy works in clinically representative conditions. *Journal of Consulting and Clinical Psychology, 65*(3), 355-365.

Sheese, B., Brown, E., & Graziano, W. (2004). Emotional expression in cyberspace: Searching for moderators of the Pennebaker disclosure effect via e-mail. *Health Psychology, 23*(5), 457-464. doi: 10.1037/0278-6133.23.5.457

Silber, T., & Rosenthal, J. (1986). Usefulness of a review os systems questionnaire in the assessment of the hospitalized adolescent. *Journal of Adolescent Health, 7*, 49-82.

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). *The mental health of Australians 2: Report on the 2007 national survey of mental health and wellbeing*. Canberra: Department of Health and Ageing.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimor, MD: Johns Hopkins University Press.

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry, 13*(4), 249-275. doi: 10.1207/S15327965PLI1304_01

Snyder, C. R., Ilardi, S., Michael, S., & Cheavens, J. (2000). Hope theory: Updating a common process for psychological change. In C. R. Snyder & R. Egram (Eds.), *Handbook of psychological change: Psychotherapy processes & practices for the 21st century* (pp. 128-153). Hoboken, NJ: John Wiley & Sons.

Suler, J. (2004). The online disinhibition effect. *CyberPsychology & Behavior, 7*(3), 321-326.

Swift, J., & Derthick, A. (2013). Increasing hope by addressing clients' outcome expectations. *Psychotherapy, 50*(3), 284-287. doi: 10.1037/a0031941

Talmon, M. (1990). *Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter*. San Francisco, CA: Jossey-Bass.

Tanielian, T., Jaycox, L., Paddock, S., Chandra, A., Meredith, L., & Burnam, M. (2009). Improving treatment seeking among adolescents with depression: Understanding readiness for treatment. *Journal of Adolescent Health, 45*(5), 490-498. doi: 10.1016/j.jadohealth.2009.03.005

Taylor, W., & Furlonger, B. (2011). A review of vicarious traumatisation and supervision among Australian telephone and online counsellors. *Australian Journal of Guidance & Counselling, 21*(2), 225-235. doi: 10.1375/ajgc.21.2.225

Thompson, A. G., & Sunol, R. (1995). Expectations as determinants of patient satisfaction: Concepts, theory and evidence. *International Journal for Quality in Health Care, 7*(2), 127-141. doi: 10.1093/intqhc/7.2.127

Timlin-Scalera, R., Ponterotto, J., Blumberg, F., & Jackson, M. (2003). A grounded theory study of help-seeking behaviors among white male high school students. *Journal of Counseling Psychology, 50*(3), 339-350. doi: 10.1037/0022-0167.50.3.339

Tinsley, H. E., Workman, K. R., & Kass, R. A. (1980). Factor analysis of the domain of client expectancies about counseling. *Journal of Counseling Psychology, 27*(6), 561-570. doi: 10.1037/0022-0167.27.6.561

Titov, N., Andrews, G., Robinson, E., Schwencke, G., Johnston, L., Solley, K., & Choi, I. (2009). Clinician-assisted internet treatment is effective for generalized anxiety disorder: Randomized controlled trial. *Australian and New Zealand Journal of Psychiatry, 43*(10), 905-912. doi: 10.1080/00048670903179269

Tsan, J., & Day, S. (2007). Personality and gender as predictors of online counseling use. *Journal of Technology in Human Services, 25*, 39-55. doi: 10.1300/J017v25n03_03

Valle, M. F., Huebner, E. S., & Suldo, S. M. (2006). An analysis of hope as a psychological strength. *Journal of School Psychology, 44*(5), 393-406. doi: 10.1016/j.jsp.2006.03.005

van Straten, A., Seekles, W., Veer-Tazelaar, N., Beekman, A., & Cuijpers, P. (2010). Stepped care for depression in primary care: What should be offered and how? *Medical Journal of Australia, 192*(11), S36-S39.

Wang, P., Lane, M., Olfson, M., Pincus, H., Wells, K., & Kessler, R. (2005). Twelve-month use of mental health services in the United States: Results from the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 629-640. doi: 10.1001/archpsyc.62.6.629

Watsford, C., & Rickwood, D. (2013a). Disconfirmed expectations of therapy and young people's clinical outcome, help-seeking intentions, and mental health service use. *Advances in Mental Health, 12*(1), 69-80. doi: 10.5172/jamh.2013.12.1.75.

Watsford, C., & Rickwood, D. (2013b). Young people's expectations, preferences and actual experience of youth mental health care. *International Journal of Adolescence and Youth, Published online 7 June 2013*, 1-11. doi: 10.1080/02673843.2013.799038

Watsford, C., & Rickwood, D. (2014). Young people's expectations, preferences, and experiences of therapy: Effects on clinical outcome, service use, and help-seeking intentions. *Clinical Psychologist, 18*(1), 43-51. doi: 10.1111/cp.12034

Watsford, C., Rickwood, D., & Vanags, T. (2013). Exploring young people's expectations of a youth mental health care service. *Early Intervention in Psychiatry, 7*(2), 131-137. doi: 10.1111/j.1751-7893.2012.00361.x

Whitley, B. E. (2002). *Principles of research in behavioral science* (2nd ed.). New York: McGraw-Hill Companies.

WHO, World Health Organization. (2006). *Dollars, DALYs and decisions: Economic aspects of the mental health system*. Retrieved from http://www.who.int/mental_health/evidence/.

Williams, R., Bambling, M., King, R., & Abbott, Q. (2009). In-session processes in online counselling with young people: An exploratory approach. *Counselling and Psychotherapy Research, 9*(2), 93-100. doi: 10.1080/14733140802490606

Woodruff, S., Edwards, C., Conway, T., & Elliott, S. (2001). Pilot test of an internet virtual chat room for rural teen smokers. *Journal of Adolescent Health, 29*, 239-243. doi: 10.1016/S1054-139X(01)00262-2

Wright, J., Sudak, D., Turkington, D., & Thase, M. (2010). *High-yield cognitive-behavior therapy for brief sessions: An illustrated guide*. Washington, DC: American Psychiatric Publishing.

Ybarra, M., & Eaton, W. (2005). Internet-based mental health interventions. *Mental Health Services Research, 7*(76-87). doi: 10.2196/jmir.1864

Young, K. (2005). An empirical examination of client attitudes towards online counseling. *CyberPsychology & Behavior, 8*(8), 172-177. doi: 10.1089/cpb.2005.8.172

Zabinski, M. F., Wilfley, D. E., Calfas, K. J., Winzelberg, A., & Taylor, C. (2004). An interactive psychoeducational intervention for women at risk of developing an eating disorder. *Journal of Consulting and Clinical Psychology, 72*(5), 914-919. doi: 10.1037/0022-006X.72.5.914

Appendix A: Ethical Approval

UNIVERSITY OF CANBERRA
AUSTRALIA'S CAPITAL UNIVERSITY

3 September 2012

APPROVED - Project number 12-143

Mr Mitchell Dowling
Faculty of Health
University of Canberra
Canberra ACT 2601

Dear Mitchell,

The Human Research Ethics Committee has considered your application to conduct research with human subjects for the project **The fidelity and effectiveness of online counselling and therapy for young people.**

Approval is granted until 01/03/2013, the anticipated completion date stated in the application.

The following general conditions apply to your approval.

These requirements are determined by University policy and the *National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2007).

Consent:	Waiving of parental consent for children under the age of 16 has not been approved. Therefore, parental consent for children under the age of 16 is required.
Monitoring:	You, in conjunction with your supervisor, must assist the Committee to monitor the conduct of approved research by completing and promptly returning project review forms, which will be sent to you at the end of your project and, in the case of extended research, at least annually during the approval period.
Discontinuation of research:	You, in conjunction with your supervisor, must inform the Committee, giving reasons, if the research is not conducted or is discontinued before the expected date of completion.
Extension of approval:	If your project will not be complete by the expiry date stated above, you must apply in writing for extension of approval. Application should be made before current approval expires; should specify a new completion date; should include reasons for your request.
Retention and storage of data:	University policy states that all research data must be stored securely, on University premises, for a minimum of five years. You must ensure that all records are transferred to the University when the project is complete.
Contact details and notification of changes:	All email contact should use the UC email address. You should advise the Committee of any change of address during or soon after the approval period including, if appropriate, email address(es).

Please add the Contact Complaints form (attached) for distribution with your project.

Yours sincerely
Human Research Ethics Committee

www.canberra.edu.au

Postal Address:
University of Canberra ACT 2601 Australia
Location:
University Drive Bruce ACT

Australian Government Higher Education Registered
Provider Number (CRICOS): 00212K

Hendryk Flaegel
Ethics & Compliance Officer
Research Services Office
T (02) 6201 5220 F (02) 6201 5466
E hendryk.flaegel@canberra.edu.au

Appendix B: Participant Complaint Form

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HUMAN RESEARCH ETHICS COMMITTEE

PROJECT INFORMATION

The following study has been reviewed and approved by the University of Canberra's *Human Research Ethics Committee.*

Project title:
The fidelity and effectiveness of online counselling and therapy for young people

Project number:	Principal researcher:
12-143	*Mr Mitchell Dowling*

INDEPENDENT COMPLAINTS PROCEDURE

1. As a participant or potential participant in research, you will have received written information about the research project. If you have questions or problems which are not answered in the information you have been given, you should consult the researcher or (if the researcher is a student) the research supervisor. For this project, the appropriate person is:

   Name: Professor Debra Rickwood

   Contact details: University of Canberra

   Ph: (02) 6201 2701

2. If you wish to discuss with an independent person a complaint relating to:
   - conduct of the project, *or*
   - your rights as a participant, *or*
   - University policy on research involving human participants,

   Please Contact:

   Mr Hendryk Flaegel
   Ethics and Compliance Officer
   Telephone (02) 6201 5220
   UNIVERSITY OF CANBERRA ACT 2601

Providing research participants with this information is a requirement of the National Health and Medical Research Council *National Statement on Ethical Conduct in Human Research*, which applies to all research with human participants conducted in Australia.

Further information on University of Canberra research policy is available in the *University of Canberra Responsible Conduct of Research Policy* and the Human Research Ethics Committee *Human Ethics Manual.*

Appendix C: Focus Group Participant Information and Consent Forms

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Participant Information Sheet

The fidelity and effectiveness of online counselling and therapy for young people

The purpose of the study
The purpose of this study is to gather the rich details of online clinicians' experiences and perceptions of providing therapeutic interventions via online chat. The existing knowledge of what occurs during online chat sessions is inadequate and an in depth exploration of the issues would be pertinent. This study is being conducted by Mitchell Dowling as part of the requirements for the PhD in Clinical Psychology at the University of Canberra under the supervision of Debra Rickwood.

Participation and withdrawal
Participation in this study is completely voluntary and you are free to withdraw from this study at any time without prejudice or penalty. If you wish to withdraw, you may withdraw from the focus group at any time, or you may contact the principal researcher at any time. If you do withdraw from the study, the comments that you have made will be deleted and will not be included in the study.

What is involved
Participants are asked to participate in a 30 minute focus group. There will be 4 groups of 8 participants. They will be asked questions related to the provision of psychological interventions to young people via online chat. The participants will also be asked to discuss the adaptation of treatments for online practice and what decisions bring about the best treatment outcomes for clients. Participant responses will be audio recorded and later transcribed. All participant responses will be de-identified once transcription is completed. These transcripts will then be thematically analysed.

Risks
Participation in this study should involve no physical or mental discomfort, and no risks beyond those of everyday living. If, however, you should find any question or procedure to be invasive or offensive, you are free to omit answering or participating in that aspect of the study.

Confidentiality and security of data
All data collected in this study will be stored confidentially. Only members of the research team will have access to identified data. All data will be coded in a de-identified manner and subsequently analysed and reported in such a way that responses will not be able to be linked to any individual. The data you provide will only be used for the specific research purposes of this study.

Ethics Clearance and Contacts
This study has been cleared in accordance with the ethical review processes of the University of Canberra and within the guidelines of the National Statement on Ethical Conduct in Human Research. You are, of course, free to discuss your participation with project staff (contactable on: 0409486647). If you would like to speak to an officer of the University not involved in the study, you may contact the Secretary of the University Research Committee: Sharon Da Silva, on (02) 6201 2884 or email Sharon.Da Silva@canberra.edu.au

If you would like to learn the outcome of the study in which you are participating, you can contact me at Mitch.Dowling@Canberra.edu.au after 1 July 2013 and I will send you an Abstract of the study and findings.

Thank you for your participation in this study.

Mitchell Dowling

Participant Consent Sheet

<u>The fidelity and effectiveness of online counselling and therapy for young people</u>

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project, as described.

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) ....

Signature   Date

Declaration by researcher: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) ....

Signature   Date

Appendix D: Online Questionnaire

Thanks for your interest in participating in our study.

What's it all about?

You are being invited to take part in a research study looking what happens after a young person decides to seek help from eheadspace. We want to find out about what sort of an effect chatting with an online clinician has on your well-being and satisfaction with life. We would also like to find out about what worked (or didn't work) for you during your chat sessions.   This study is being conducted by Mitchell Dowling as part of the requirements for the PhD in Clinical Psychology at the University of Canberra. He is under the supervision of Professor Debra Rickwood and is working in conjunction with eheadspace.   The following information outlines the details of the study and what participation will involve. Please take time to read the information carefully.

What do I have to do?

You do not have to take part in the study, but if you do it will be of great help to us.
We would like you to fill out two questionnaires about how you feel about different aspects of your life. We would like you to fill one out now, before you have a chat session with an online clinician. We would then like to contact you 6 weeks after your final chat session via email, asking you to fill out a second questionnaire. The second questionnaire will include some of the same questions we asked before, but will also include some questions about your experience with eheadspace.

There are no 'right' or 'wrong' answers and each questionnaire should take about 10-15 minutes to complete. You do not have to answer all the questions if you don't want to.

– Will my information be confidential?
All information given to us will be strictly confidential. Your questionnaire is only identifiable by the email address you have provided, and this will be kept separate from the rest of your data. This means that you cannot be recognised from the data you provide in the online questionnaire. The data you provide will only be used for this study.

– What will you do with the results of the study?
The results will be published in research journals and in reports for people working online with mental health problems. They will also be presented at meetings to promote practices that could benefit mental health other young people. You will not be identifiable from any report or publication.

– What are the possible disadvantages and risk of taking part?
Apart from the time required to complete the survey, no known disadvantages or risk are associated with taking part. However, if you do become upset by some of the questions and need to speak to someone urgently we can arrange a priority session for you with an eheadspace clinician. Alternatively, you can contact kids help line (1800 55 1800), or Lifeline Australia (13 11 14).

– Who can tell me more about it?
If you have any questions or queries about taking part, the principal Researcher (Mitch.Dowling@canberra.edu.au or 0409486647) will be happy to help.

– Who can I speak to if I have any concerns?
If you would like to speak to someone who is aware of the study but who is not directly involved in the research team, or if you have a concern or complaint, you can contact the Ethics and Compliance Officer: Mr Hendryk Flaegel, on (02) 6201 5220

– Reimbursement
If you complete both of the questionnaires, you can enter into the running to win one of 5 iTunes gift vouchers (valued at $50 each). This project is funded by the University of Canberra.

Thanks for reading through all this information.
If you would like to participate, please click on the 'I consent to participate in this study' button below.
If you don't that's absolutely fine, thanks anyway for your time and interest. You can either click 'exit this survey', or select the option, 'I don't consent to participate in this study'.

Having read the participant information sheet I consent to fill out one questionnaire now and to fill out a second questionnaire in 6 weeks time
○ I consent to participate in this study
○ I DON'T consent to participate study

>>

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Email address

What is your gender?
- ○ Male
- ○ Female

Age

[▼]

Location
- ○ Urban
- ○ Rural
- ○ Remote

How many counselling sessions have you had so far?

[▼]

[>>]

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These questions concern how you have been feeling over the past 30 days. Select a box below each question that best represents how you have been.

During the last 30 days about how often did you...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Feel tired out for no good reason?	○	○	○	○	○
Feel nervous?	○	○	○	○	○
Feel so nervous that nothing could calm you down?	○	○	○	○	○
Feel hopeless?	○	○	○	○	○
Feel restless or fidgety?	○	○	○	○	○
Feel so restless you could not sit still?	○	○	○	○	○
Feel depressed?	○	○	○	○	○
Feel that everything was an effort?	○	○	○	○	○
Feel so sad that nothing could cheer you up?	○	○	○	○	○
Feel worthless?	○	○	○	○	○

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Your Satisfaction with Life

Please select the one box that best indicates how satisfied or dissatisfied you CURRENTLY are with each item below. There is no right or wrong answer.

How satisfied or dissatisfied are you with...

	Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied Nor Dissatisfied	Somewhat Satisfied	Very Satisfied
Your family life?	○	○	○	○	○
Your friendships?	○	○	○	○	○
Your school experience? *If you are not in school now, please answer what you would expect if you were in school now.	○	○	○	○	○
Yourself?	○	○	○	○	○
Where you live?	○	○	○	○	○
Your life overall?	○	○	○	○	○

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Survey Powered By Qualtrics

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Questions About Your Goals
The sentences below describe how young people might think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Then, select the one box that best matches your answer. There is no right or wrong answer.

	None Of The Time	A Little Of The Time	Some Of The Time	A Lot Of The Time	Most Of The Time	All Of The Time
I think I am doing pretty well.	○	○	○	○	○	○
I am doing just as well as other youths my age.	○	○	○	○	○	○
When I have a problem I can come up with lots of ways to solve it.	○	○	○	○	○	○
Even when others want to quit, I know that I can find ways to solve the problem.	○	○	○	○	○	○

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What You Expect Counselling to Do for you.
Youths who see a counsellor often expect different things from counselling. Below is a list of
statements about what people might or might not expect. For each item, think about your own
expectations and select the one box that best indicates whether you do not expect, are not sure,
or do expect each item from counseling. There is no right or wrong answer.

	I Do Not Expect This	I Am Not Sure	I Do Expect This
Counselling will help improve my relationship with my caregiver(s). *Caregiver means the person(s) who mainly takes care of you, such as a parent, foster parent, or grandparent.	○	○	○
Counselling will help me learn how to deal with thoughts that are bothering me.	○	○	○
Counselling will help me learn how to deal with my painful feelings.	○	○	○
Counselling will help me learn how to solve my own problems.	○	○	○
Counselling will improve my behaviour at home.	○	○	○
Counselling will help me have the kind of life I want to live.	○	○	○
In counselling, I will learn to use my strengths to help with my problems.	○	○	○
Counselling will improve my behaviour at school. *If you are not in school now, please answer what you would expect if you were in school now.	○	○	○

\>\>

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Thank you for your participation!

Thank you for answering these questions.
We will email you in 6 weeks with the follow-up questionnaire :)
If you complete the follow-up questionnaire you can enter into the draw to win a prize. Sweet!

++++++++++++++++++++ ADDITIONAL STUDY ++++++++++++++++++++

Thank you once again for participating in our study. We would like to take this opportunity to participate in an additional study.We would like to review some of your eheadspace session records. This is so we can gain a better understanding of what does (or doesn't) work during an online counselling session. Because your sessions are automatically recorded, participating in this part of the study will not take up any more of your time. We would like your permission to access these records. If you do not want us to access your records, we won't, and this will not affect your participation in the rest of the study.

- Will people be able to recognise me from this information?
It's very important that your privacy is protected and that other people don't know you've shared your information (unless, of course, you decide to tell them yourself). If you decide to participate in this part of the study, your records will be de-identified before being analysed. Any information which could be used to identify you, such as the names of people or places, will be deleted before being given to the researchers.
The only identifying information that we would need to have about you is an email address that they can contact you on, and the email address you use to log-in to eheadspace. The reason we need the email address you use to log-in to eheadspace, is to access your electronic eheadspace records. Your email address will be stored separately from your records, and only linked using a non-identifiable ID code, on a password-protected computer at the University of Canberra. Only members of the research team would have access to it.

- What are the possible risks?
Since your information will be de-identified before being analysed by the researchers, there is no reason to believe that participating in this study will cause you any harm. However, if you feel upset and need to speak to someone urgently we can arrange a priority session for you with an eheadspace clinician. Alternatively, you can contact kids help line (1800 55 1800), or Lifeline Australia (13 11 14).

- What are the possible benefits?
By participating in this research, you will help us gain a better understanding of what does (and doesn't) work during online counselling. This will help us provide better help in the future.

- What if I want to withdraw from the study?
You can withdraw from the study at any time. Simply contact the Principal Researcher (Mitch.Dowling@canberra.edu.au or 0409486647) and ask for your records not to be used during the research.

- Who can I contact if I have more questions?
If you have any other questions about the research, you can contact the Principal Researcher (Mitch.Dowling@canberra.edu.au or 0409486647) and they will be happy to answer any of your questions.

- Who can I talk to if I have any concerns?
If you would like to speak to someone who is aware of the study but who is not directly involved in the research team, or if you have a concern or complaint, you can contact the Ethics and Compliance Officer: Mr Hendryk Flaegel, on (02) 6201 5220

Having read the participant information sheet I consent to have my electronic eheadspace records accessed and provide a de-identified transcript to the research team.

- ○ I consent to have my session transcripts accessed.
- ○ I DON'T consent to have my session transcripts accessed.

[>>]

Appendix E: Six-Week Follow-Up

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Thanks for returning to participate in our study.

What's it all about?

This is a follow-up study looking what happens after a young person decides to seek help from eheadspace. We want to find out about what sort of an effect chatting with an online clinician has on your well-being and satisfaction with life. We would also like to find out about how satisfied you are with the services you received.
This study is being conducted by Mitchell Dowling as part of the requirements for the PhD in Clinical Psychology at the University of Canberra. He is under the supervision of Professor Debra Rickwood and is working in conjunction with eheadspace.
The following information outlines the details of the study and what participation will involve. Please take time to read the information carefully.

What do I have to do?

You do not have to take part in the study, but if you do it will be of great help to us.
We would like you to fill out two questionnaires about how you feel about different aspects of your life. We would like you to fill one out now, before you have a chat session with an online clinician. We would then like to contact you 6 weeks after your final chat session via email, asking you to fill out a second questionnaire. The second questionnaire will include some of the same questions we asked before, but will also include some questions about your experience with eheadspace.

There are no 'right' or 'wrong' answers and each questionnaire should take about 10-15 minutes to complete. You do not have to answer all the questions if you don't want to.

– Will my information be confidential?
All information given to us will be strictly confidential. Your questionnaire is only identifiable by the email address you have provided, and this will be kept separate from the rest of your data. This means that you cannot be recognised from the data you provide in the online questionnaire. The data you provide will only be used for this study.

– What will you do with the results of the study?
The results will be published in research journals and in reports for people working online with mental health problems. They will also be presented at meetings to promote practices that could benefit mental health other young people. You will not be identifiable from any report or publication.

– What are the possible disadvantages and risk of taking part?
Apart from the time required to complete the survey, no known disadvantages or risk are associated with taking part. However, if you do become upset by some of the questions and need to speak to someone urgently we can arrange a priority session for you with an eheadspace clinician. Alternatively, you can contact kids help line (1800 55 1800), or Lifeline Australia (13 11 14).

– Who can tell me more about it?
If you have any questions or queries about taking part, the principal Researcher (Mitch.Dowling@canberra.edu.au or 0409486647) will be happy to help.

– Who can I speak to if I have any concerns?
If you would like to speak to someone who is aware of the study but who is not directly involved in the research team, or if you have a concern or complaint, you can contact the Ethics and Compliance Officer: Mr Hendryk Flaegel, on (02) 6201 5220

– Reimbursement
If you complete both of the questionnaires, you can enter into the running to win one of 5 iTunes gift vouchers (valued at $50 each). This project is funded by the University of Canberra.

Thanks for reading through all this information.
If you would like to participate, please click on the 'I consent to participate in this study' button below.
If you don't that's absolutely fine, thanks anyway for your time and interest. You can either click 'exit this survey', or select the option, 'I don't consent to participate in this study'.

Having read the participant information sheet please select your response below.
○ I consent to participate in this study
○ I DON'T consent to participate study

[>>]

Faculty of Health

Email address (this is important so we can link your responses together)

In the past six weeks, how many sessions did you have with eheadspace?

Have you been seeking help from another mental health service?

☐ No.

☐ Yes, face-to-face.

☐ Yes, telephone.

>>

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These questions concern how you have been feeling over the past 30 days. Select a box below each question that best represents how you have been.

During the last 30 days about how often did you...

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Feel tired out for no good reason?	○	○	○	○	○
Feel nervous?	○	○	○	○	○
Feel so nervous that nothing could calm you down?	○	○	○	○	○
Feel hopeless?	○	○	○	○	○
Feel restless or fidgety?	○	○	○	○	○
Feel so restless you could not sit still?	○	○	○	○	○
Feel depressed?	○	○	○	○	○
Feel that everything was an effort?	○	○	○	○	○
Feel so sad that nothing could cheer you up?	○	○	○	○	○
Feel worthless?	○	○	○	○	○

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Your Satisfaction with Life

Please select the one box that best indicates how satisfied or dissatisfied you CURRENTLY are with each item below. There is no right or wrong answer.

How satisfied or dissatisfied are you with...

	Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied Nor Dissatisfied	Somewhat Satisfied	Very Satisfied
Your family life?	○	○	○	○	○
Your friendships?	○	○	○	○	○
Your school experience? *If you are not in school now, please answer what you would expect if you were in school now.	○	○	○	○	○
Yourself?	○	○	○	○	○
Where you live?	○	○	○	○	○
Your life overall?	○	○	○	○	○

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Questions About Your Goals
The sentences below describe how young people might think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Then, select the one box that best matches your answer. There is no right or wrong answer.

	None Of The Time	A Little Of The Time	Some Of The Time	A Lot Of The Time	Most Of The Time	All Of The Time
I think I am doing pretty well.	○	○	○	○	○	○
I am doing just as well as other youths my age.	○	○	○	○	○	○
When I have a problem I can come up with lots of ways to solve it.	○	○	○	○	○	○
Even when others want to quit, I know that I can find ways to solve the problem.	○	○	○	○	○	○

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Thank you for Participating!

Would you like to enter the draw to win one of 5 $50 iTune gift vouchers? If So Click "yes" and enter your name and postal address. This information will be kept separate from your survey answers.

○ Yes

○ No

Address

Name	
Address	
Address 2	
City	
State	
Postal Code	
Country	

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Appendix F: Counselling Progress Rating Instrument Manual

Assessing Progress

Stage 0
Orientating the client to counselling

1. Greetings and general introduction between both client and counsellor (general introduction for KHL, 2006 includes transferring client to particular counsellor)
2. The counsellor's role is clarified (Gelard and Gelard, 2005)
3. Issues of confidentiality are addressed (Dryden & Feltham, 1992)
4. The clients past history of being helped is explored (Dryden & Feltham, 1992)
5. The time frame of counselling is discussed (Dryden & Feltham, 1992)
6. The counsellor assesses whether this type of counselling is the most appropriate form of help and refers if appropriate (Dryden & Feltham, 1992)
7. Clients fears or concerns regarding counselling is explored (Dryden & Feltham, 1992)

Stage 1
Information gathering & clarification of problems

Step 1a: Help Clients Tell Their Stories
1. The client is invited to talk (Gelard and Gelard, 2005) (Egan, 2002) (KHL, 2006, 2006) (N.B. this also includes non-verbal minimal encourages, eg 'uh huh' 'hmm' which may be used to prompt the client to continue to talk)
2. Client to spell out problem situation in detail (Counsellor may initiate or prompt by asking what are the concerns, problems, issues, trouble etc) (KHL, 2006)
3. Key points are selected, paraphrased from information given to assist to identifying and defining what is the central issue (Egan, 2002)
4. The counsellor seeks feedback from the client about counsellor identified issues, patterns and themes and client responds (KHL, 2006)
5. Emotions and feelings are identified and explored. (Counsellor may encourage expression of feelings. Counsellor may clarify feelings by reflecting back; validate clients feelings; explore what feelings mean to client; counsellor may respond with empathy) (KHL, 2006) (Rogers, 1942) (Gerald and Gerald, 2005)
6. Strengths, resources, natural talents and opportunities of the client are identified (KHL, 2006) (Egan, 2002)
7. Counsellor assesses severity of clients problems or a specific risk assessment conducted if required (KHL, 2006) (Egan, 2002)
8. Time between sessions is used productively (eg homework tasks) Dryden & Feltham (1992)
9. When relevant, the client is encouraged to avoid repeating the same story over and over again (KHL, 2006)

Step 1b: Challenging Blind Spots
1. The client is helped to face her/his apparent avoidance of difficult material and/or what is troubling him/her. (KHL, 2006)
2. The counsellor identifies and helps clients become aware of their blind spots in their mind-sets, thinking or behaviour (which include irrational

thoughts/beliefs, incongruent statements or discrepancies between what a client says in does). Egan (2002)

3. Counsellor helps correct faulty interpretations of experience, actions or feelings or helps client to move beyond predictable dishonesties (Egan, 2002)
4. Help clients own their problems, state them as solvable or spot opportunities (Egan, 2002)
5. When relevant, the client is assisted to recognise potential serious consequences of their behaviour (KHL, 2006)

Step 1c: Leverage –
Working on issues that make a difference

1. Issues are chosen to work on. (Crisis issues are addressed first, or problems that seems to be causing most pain for the client, and that the client is willing to work on that can lead to general improvement in condition. Problems are chosen in which the benefits outweigh the costs) (Egan, 2002)

Stage 2
Goal setting and commitment to change

Step 2a: Possibilities.
Developing a sense of direction by exploring possibilities for a better future

1. Hope for the future and confidence are discussed (may include future contemplation, motivation, will/desire) (KHL, 2006) (Egan, 2002)
2. The clients current self is explored (Egan, 2002)
3. The clients possible future selves are discussed (may include what one: might become; would like to become or is afraid of becoming) Egan (2002)
4. Most critical needs and wants for the future are identified (Egan, 2002)

Step 2b: Change Agenda
Crafting problem management goals

1. The counsellor provides information about the need to set goals (KHL, 2006) (Egan, 2002)
2. Aspects of goals setting are discussed (may include desired outcomes, resources, flexibility and timeframes) Egan (2002)
3. Specific goals are formulated, refined and reviewed. (Egan, 2002)

Step 2c: Commitment
Finding incentives for commitment to a better future

1. Clients ability to/readiness to commit to plan is explored (KHL, 2006) (Egan, 2002)
2. Client is assisted to recognize the potential consequences of commitment to formulated goals. (cost-benefit) (KHL, 2006) (Egan, 2002)
3. Clients competing agendas are addressed (Egan, 2002)

4. Counsellor helps to increase level of commitment (may include self contracts etc) Egan (2002)

Stage 3
Consideration of options & plan

Step 3a Possible Strategies –
Identifying possible strategies to achieve goals

1. Counsellor helps client identify specific resources (individuals, communities, places, etc) available to them (may include providing information, direction and assisting the client to look at further sources of information) (KHL, 2006) (Egan, 2002)
2. Counsellor helps client identify multiple possible strategies/paths to accomplishing goals (KHL, 2006) (Egan, 2002)

Step 3b Best fit –
Choosing best fit strategies

1. Potential strategies are reviewed (may include addressing whether strategies are: specific, substantive or realistic etc) Egan (2002)
2. Consequences of employing strategies are discussed (KHL, 2006) (Egan, 2002)
3. A set/package of strategies is chosen that best fits the clients resources and situation (Egan, 2002)

Step 3c Plan –
Using strategies to construct a manageable plan

1. Specific activities or actions needed to accomplish goals are identified (Egan, 2002)
2. Sequence for completing these is discussed (Egan, 2002)
3. A timeframe for engaging in and completing these in established (Egan, 2002)
4. Potential impediments are considered (Egan, 2002)
5. The plan is reviewed (Egan, 2002)

Stage T
Termination of Session

1. Preparation for the end of the counselling session (for example, client is given warning of session's imminent closure) (Dryden & Feltham, 1992)
2. Counsellor makes sure client has no other pressing concerns (Delany & Eisenberg, 1972) and encourages final feedback (Dryden & Feltham, 1992) (Delany & Eisenberg, 1972)
3. The counselling session is summarised and any, goals or action plans are reviewed (KHL, 2006) (Gelard and Gelard, 2005)
4. Client behaviour changes are reinforced (Delany & Eisenberg, 1972) and self-change is promoted (Dryden & Feltham, 1992). Subject of relapse prevention may be addressed (Dryden & Feltham, 1992)
5. Counsellor many offer a general invitation for calling back where and when appropriate (KHL, 2006) (Delany & Eisenberg, 1972)

6. Making a specific contract for further contact in the context of crisis and/or duty of care based counselling work (KHL, 2006) (Dryden & Feltham, 1992)
7. Assisting client to end counselling based contact in a positive way (KHL, 2006) (Dryden & Feltham, 1992) which may include positive feedback from counsellor (Dryden & Feltham, 1992)
8. Farewells

Assessing Depth

<u>Stage 0: Orientating the Client to Counselling</u>

Orientation (0)

Score 3: More than one item is addressed. All items are fully explored. Counsellor must provide information or probe client for detail as required for each item. If it is the clients first counselling session with KHL, 2006, at least half of the items within the orientation stage are covered.

Score 2: More than one item within the stage is discussed with some detail.

Score 1: Only greetings and general introduction (including transferring client to specific counsellors) is carried out OR other items mentioned but only addressed in brief.

<u>Stage 1: Information and Clarification of Problems</u>

Help Clients Tell their stories (1a)

Score 3: Problem situation is explored in detail and is made explicit. Counsellor probes effectively addressing at least half of the items within this stage. Counsellor must clarify the key components of the clients story and/or the feelings identified with the client.

Score 2: Problem situation is explored with at least one quarter of the items within the stage covered. Key components of the story are identified, however some aspects of the clients story may not be explored, or may be unclear.

Score 1: At least one item within the stage is covered. Key components of the clients story are unclear, or reasons for seeking counselling may not be not explicitly identified.

Challenging Blind Spots (1b)

Score 3: Key blind spots are identified by counsellor. Blind spots are explored and challenged with client.

Score 2: Key blind spots are identified and challenged in brief. Some apparent blind spots may not be addressed.

Score 1: Apparent blind spots are identified with minimal discussion/exploration of issue. Some blind spots may not be addressed.

Leverage – working on issues that make a difference (1c)
Score 3: All issues chosen to work on are explicitly chosen and agreed upon between both counsellor and client. Hierarchy for choosing issues is observed.

Score 2: Key issues chosen to work on are mutually agreed upon by counsellor and client. Either client or counsellor may direct any additional minor issues chosen to work on.

Score 1: Issues chosen to work on to is implied and not explicitly stated OR Issues may not be mutually agreed upon and predominantly directed by either client or counsellor.

Stage 2: Goal setting and committing to change

Possibilities (2a)
Score 3: Current/future selves or hope for the future AND most critical needs/wants are explored. Items are addressed in detail and current/future selves or hopes/needs are clearly identified.

Score 2: Current/future selves or hope for the future are explored in some detail AND/OR needs/wants are discussed.

Score 1: Current/future selves or hope for the future are mentioned.

Change Agenda (2b)
Score 3: Various/Multiple aspects of setting goals are considered in some depth AND specific goals are formulated and agreed upon

Score 2: Various/Multiple aspects of creating goals are explored OR actual formulated goals are discussed

Score 1: Creating goals or aspects of making goals are mentioned

Commitment (2c)
Score 3: Cost-Benefit of commitment to goals is clearly identified AND strategies are employed to reinforce/increase level of commitment to goals.

Score 2: Level of commitment or consequences of commitment is explored

Score 1: Commitment to goals is mentioned

Stage 3: Consideration of Options and Plan

Possible Strategies (3a)
Score 3: Multiple strategies are identified/proposed which are clear and specific. Potential resources are discussed in detail with direct information provided (eg contact phone numbers/addresses, websites etc). Strategies or resources must be made explicit

so that the client could potentially follow up identified resources or carry out strategies suggested.

Score 2: Multiple strategies are identified/proposed AND/OR resources potentially available to the client are explored and identified.

Score 1: A potential strategy or resource to assist the client is mentioned

Choosing best fit strategies (3b)

Score 3: Strategy/Strategies are reviewed and/or consequences of employing strategy/strategies are explored in some detail. Best strategy/strategies are selected OR intention to select strategy is discussed and counsellor promotes informed decision making.

Score 2: Strategy/Strategies are reviewed and/or consequences of employing strategy/strategies are explored in some detail

Score 1: Consequences of employing strategy/strategies is mentioned

Plan (3c)

Score 3: A clear and detailed workable plan for future is mutually formulated with most aspects considered (sequence of actions, timeframe or impediments).

Score 2: Details of a plan/course of action for future are considered.   (sequence of actions, timeframe or impediments)

Score 1: A structure/plan for future is mentioned

Stage T: Termination of Session

Termination (T)

Score 3: Termination stage of counselling session addresses at least four of the eight items within the stage. The termination process must include a summary of the session AND/OR a clear agreement between client and counsellor for post-session plans (for example, specific details for future contact).

Score 2: Item T.8 (Farewells) and at least two other items are addressed in detail during the termination stage of the counselling session.

Score 1: Counselling session may end abruptly. Minimal items within the stage are addressed OR several items are covered, but only addressed in brief. Counselling must be mutually terminated, or no score can be given.