

R u there? The user experience of Mobile Instant Messenger Counselling

Nicholas Jay Groll - GRLNIC002

A minor dissertation submitted in partial fulfillment of the requirements for the award of the
degree of Master of Arts in Clinical Psychology

Faculty of the Humanities

University of Cape Town

2014

COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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ACKNOWLEDGEMENTS

I would like to thank a few people who have played a part in contributing to the completion of this minor dissertation:

Firstly, my supervisor, Colin Tredoux, for his enthusiasm and confidence in my research topic and for supervising and supporting me in writing this dissertation.

Victoria Nembaware, for her unyielding support of my project, both as a friend and in her role as second coder. My former colleagues at Cell-Life, Katherine De Tolly and Peter Benjamin, for introducing me to the subject of mHealth in South Africa.

Marlon Parker (of RLabs), for his receptive attitude to my research idea, for granting total access to his counselling centre and counsellors, and for allocating one of his prized programmers to construct my questionnaire. Kurt Appolis, the prized programmer, for the swift delivery of such high quality work. Thank you also for your friendly and cooperative attitude, despite my many requests and revisions.

Sarah, who heard about this research idea as my girlfriend, and welcomed its completion as my wife. Thanks for standing by with patience and support.

Finally, to all the counsellors who are the cogs of the ‘Angel’/DAS Mobile Instant Messaging counselling machine! Thank you for volunteering your time with such warm and loving attitudes, and for inviting me into your counselling space.

Abstract

Mental health care provision has always lagged behind general health services, especially in rural, poor countries. With the widespread adoption of mobile phones, many South Africans now have easy access to health-related information and services, including counselling via Mobile-Instant-Messenger (MIM). This research hopes to address the paucity of literature on MIM-based counselling. Using an adaptive, Mobile-based questionnaire, I collected quantitative and qualitative data about the service users ($n = 568$) of a popular MIM-counselling service called 'DAS/Angel', offered free of charge, via MXit - a popular Mobile-Instant-Messenger program. The service user group was found to be predominantly young ($M_{age} = 20.17$, $sd = 4.97$), largely unemployed (44.19%), Black African (72.98%) with a gender split (53.79% female, 46.21% male) similar to population gender demography, $\chi^2(1, N = 567) = .43$, $p = .51$. Despite the MIM-counselling being offered in English, service users' first languages varied widely, across all 11 official South African languages. Qualitative data about the experience of using MIM-counselling was analysed using thematic analysis with two coders, with a significant level of agreement ($\kappa > .80$) across all 4 categorical datasets. The MIM-counselling experience was described positively as safe and accessible, which encouraged openness, and negatively in terms of practical concerns related to service access times, and specific shortfalls related to the quality of counselling provision. Reasons for non-use of MIM-counselling ($n = 2285$) were explored, as were experiences of using telephone counselling and face-to-face counselling. The findings are discussed in terms of concerns from the literature such as the lack of face-to-face contact and ethical issues of the medium. The ability of the medium to overcome access barriers to mental health care is considered in terms of the potential role of MIM-counselling.

Keywords: Online Counselling, Mobile-Instant-Messenger, mHealth, MXit, User Experience

Table of Contents

ACKNOWLEDGEMENTS	I
ABSTRACT	II
TABLE OF CONTENTS.....	III
LIST OF TABLES	VII
LIST OF FIGURES.....	VIII
R U THERE? THE USER EXPERIENCE OF MOBILE-INSTANT-MESSENGER COUNSELLING	1
AIMS OF CURRENT STUDY	4
STRUCTURE OF DISSERTATION.....	5
LITERATURE REVIEW	5
INTRODUCTION.....	5
MENTAL HEALTH TREATMENT GAP	6
BARRIERS TO SERVICES.....	6
COUNSELLING IN SOUTH AFRICA	7
TELEPHONE COUNSELLING	8
<i>Barriers affecting telephone counselling.....</i>	<i>9</i>
ONLINE COUNSELLING	10
<i>Working alliance in Online Counselling.....</i>	<i>10</i>
<i>Ethical concerns in Online Counselling.....</i>	<i>11</i>
Informed consent.....	12
Confidentiality.....	12
Authenticity.....	13
<i>Characteristics of online counselling service users.....</i>	<i>13</i>
<i>Experience of online counselling service users.....</i>	<i>13</i>
<i>Synchronous communication</i>	<i>15</i>
MHEALTH.....	15
<i>Mobile penetration in Africa.....</i>	<i>16</i>
<i>mHealth in South Africa.....</i>	<i>16</i>
<i>mHealth and mental health care.....</i>	<i>17</i>
MOBILE INSTANT MESSENGER.....	17
<i>Use of MXit for social interventions.....</i>	<i>17</i>
MXIT-BASED COUNSELLING	18
LITERATURE ON MXIT-BASED COUNSELLING.....	20
<i>Characteristics of MXit-based counselling service users.....</i>	<i>21</i>
<i>Experience of MXit-based counselling service users.....</i>	<i>21</i>

LIMITATIONS OF PREVIOUS RESEARCH.....	22
CONCLUSION	22
METHOD	25
RESEARCH AIMS.....	25
CONTEXT OF THE RESEARCH	25
STUDY DESIGN.....	27
SAMPLE	27
DATA COLLECTION	28
<i>Questionnaire.....</i>	<i>28</i>
DATA ANALYSIS	29
<i>Data cleaning.....</i>	<i>29</i>
<i>Univariate analysis.....</i>	<i>29</i>
<i>Simple response categorisation.....</i>	<i>29</i>
<i>Identifying recognised service providers.....</i>	<i>30</i>
<i>Analysis of sample representativeness.....</i>	<i>30</i>
<i>Thematic analysis.....</i>	<i>30</i>
<i>Excluded from analysis.....</i>	<i>32</i>
ETHICAL CONSIDERATIONS.....	32
<i>Risks and benefits.....</i>	<i>32</i>
<i>Autonomy.....</i>	<i>32</i>
<i>Nonmaleficence.....</i>	<i>33</i>
<i>Beneficence.....</i>	<i>33</i>
<i>Justice.....</i>	<i>33</i>
<i>Waiver of handwritten consent.....</i>	<i>33</i>
<i>Waiver of parental consent for minors.....</i>	<i>33</i>
RESULTS.....	35
DEMOGRAPHIC CHARACTERISTICS OF MXIT-BASED COUNSELLING SERVICE USERS.....	35
<i>Age.....</i>	<i>35</i>
<i>Sex.....</i>	<i>37</i>
<i>Location.....</i>	<i>37</i>
<i>Race.....</i>	<i>38</i>
<i>First language.....</i>	<i>38</i>
<i>Employment or student status.....</i>	<i>39</i>
School-going age vs non-school going age.....	40
USE OF COUNSELLING MODALITIES	41
<i>Use of telephone counselling.....</i>	<i>42</i>

Usage statistics.....	42
Use of recognised telephone counselling service providers.	43
Reasons for non-use of telephone counselling.	43
<i>Use of face to face counselling.</i>	44
Usage statistics.....	44
Face to face counselling provision.	45
Reasons for non-use of face to face counselling.	46
<i>Use of MXit-based counselling.</i>	46
Usage statistics.....	46
Positive aspects of MXit-based counselling.	47
Negative aspects of Mxit-based counselling.	49
Reasons for non-use of Mxit-based counselling.	52
<i>Use of multiple counselling modalities.</i>	53
ADDITIONAL FINDINGS.....	54
<i>Mobile phone ownership.</i>	54
<i>Use of Angel/DAS for drug-related counselling.</i>	54
CONCLUSION	55
DISCUSSION	57
SUMMARY OF MAJOR FINDINGS	57
<i>Majority of service users are young adults.</i>	57
<i>Black South Africans are accessing emotional support via MXit.</i>	57
<i>First language of service users is not only English.</i>	58
<i>Disinhibition of the medium.</i>	59
<i>Lack of physical presence.</i>	60
<i>Working alliance in online counselling.</i>	61
<i>Inefficiencies of text-based communication.</i>	62
<i>Time-related issues in MXit-based counselling.</i>	63
Time-related issues as benefit.	64
MIM-BASED COUNSELLING CAN OVERCOME PRACTICAL ACCESS BARRIERS.	64
ETHICAL ISSUES OF MIM-BASED COUNSELLING.....	65
<i>Regulation of service providers.</i>	65
<i>Informed consent.</i>	66
<i>Screening of clients.</i>	66
THE BEST ROLE FOR MIM-BASED COUNSELLING.....	67
<i>Certain population groups.</i>	67
<i>Dynamic access to health information.</i>	67
<i>Adjunct or introduction to other services.</i>	67
CONCLUSION	69

STRENGTHS OF CURRENT RESEARCH	70
LIMITATIONS OF CURRENT RESEARCH	71
RECOMMENDATIONS FOR FUTURE RESEARCH.....	71
<i>Takeaways for potential service providers.</i>	72
Flexibility	72
Clarity.....	72
Safety	72
REFERENCES.....	74
APPENDIX A.....	91
ANGEL SURVEY QUESTIONNAIRE.....	91
APPENDIX B.....	96
PARENTS POLL	96
APPENDIX C.....	98
PARENTS POLL RESULTS	98
APPENDIX D.....	99
MXIT-BASED COUNSELLING SERVICE USERS LOCATIONS	99

LIST OF TABLES

Table 1 - Positive Aspects of MXit-based Counselling.....	48
Table 2 - Negative Aspects of MXit-based Counselling	51
Table 3 - Use of Counselling Modalities: MXit-based Counselling Service Users (MBCSUs) vs. Non-MXit-based Counselling Service Users (Non-MBCSUs).....	53

LIST OF FIGURES

Figure 1 - Angel service menu (screenshot from MXit).....	26
Figure 2 - A DAS counsellor can hold multiple private conversations	27
Figure 3 – Age distribution of MXit-based counselling service users.....	36
Figure 4 – Age categories: MXit-based counselling service users vs. national statistics.....	36
Figure 5 – Locations of MXit-based counselling service users.....	37
Figure 6 – Race: MXit-based counselling service users vs. national statistics.....	38
Figure 7 - First language: MXit-based counselling service users vs. national statistics.....	39
Figure 8 - Employment or student status: MXit-based counselling service users.....	40
Figure 9 - Employment or student status: MXit-based counselling service users (aged 18+) 40	
Figure 10 - Employment or student status: MXit-based counselling service users (aged 15 – 18)	41
Figure 11 – Use of telephone counselling: MXit-based counselling service users	43
Figure 12 - Reasons for non-use of telephone counselling: MXit-based counselling service users	44
Figure 13 – Use of face to face counselling: MXit-based counselling service users	45

R u there? The User Experience of Mobile-Instant-Messenger Counselling

The global burden of mental health is growing at a rapid pace. Despite this, most government health services, including the South African Department of Health, have reacted slowly to the mental health needs of citizens (Petersen et al., 2009). Numerous barriers persist that interfere with the delivery of suitable, dependable, affordable, accessible, high-quality care. These include practical difficulties such as the financial and time cost of accessing services (Petersen et al., 2009), a general lack of information about illnesses and treatment availability (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003), as well as social barriers such as stigma, discrimination and feelings of shame and embarrassment (Kakuma et al., 2010; Ruane, 2010). For particular service user groups - such as individuals and communities living outside of urban centres, or people with disabilities – there are additional challenges in accessing services, including increased access difficulties and reduced service provision at local facilities (Petersen et al., 2009; Pillay, Kometsi, & Siyothula, 2009).

One inventive approach at addressing gaps in health care provision has come in the form of service delivery via mobile phone¹. In some instances, health information, adherence and appointment reminders have been distributed via Short Message Service (SMS²), while websites designed for use on mobile phones have allowed access to information about family planning, HIV/AIDS and other health conditions. This emerging field combining mobile phones and health is known as “mHealth”, and has developed alongside a dramatic rise in the use of mobile phones both globally, and in South Africa, with mobile phone subscriptions up 12.9%, from 130.6-million in 2012 to 147.5-million in 2013 (International Telecommunication Union, 2014).

As mobile phone technology has become more advanced, software has been developed which expands mobile phone usage beyond the scope of merely making and receiving calls. Though phone-to-phone SMS functionality was only introduced in 1992, its popularity grew rapidly around the world, with 5.6-billion total users ten years later (Ahonen, 2012). More recently, reduction in production costs and expansion of data networks has seen the emergence of smartphones³ in South Africa, with penetration expected to reach 50% by

¹ The term ‘mobile phone’ is used interchangeably with ‘cellular phone’, ‘cellphone’ and ‘cell phone’.

² Short Message Service (SMS) is the transfer of data in the form of a 160 character message.

³ Smartphones are mobile phones that provide more than just basic voice call and messaging functionality.

2017 (GSMA, 2012). As a result, SMS's popularity has been challenged by Mobile-Instant-Messenger (MIM), as a means of exchanging short text messages.

The main difference between SMS and MIM, is that MIM messages are sent and received via the handset's mobile internet, resulting in a much lower cost compared to SMS; whereas local SMS typically costs between 20 and 70 South African cents per message (Research ICT Africa, 2013) and are limited to 160 characters each, a MIM message of similar length costs less than 2 South African cents per message (MXit Lifestyle, 2012), while there is no restriction on message length.

MIM chats usually take a different form to SMS exchanges, in that there is a faster, more casual, spontaneous and unedited interchange of messages (Volda, Newstetter, & Mynatt, 2002), perhaps due to the reduced cost to sender and receiver (Church & de Oliveira, 2013). This interchange mimics that of a face-to-face⁴ exchange in terms of tempo and structure, in that individuals generally take it in turns to speak (type) and listen (read), and then (usually) respond within seconds (Schwarz, 2011). If a response is not immediately forthcoming, the previous messages of the exchange remains visible and may be responded to at a later time, which is also common practice (Nardi, Whittaker, & Bradner, 2000).

While an SMS is sent to a cell phone number, MIM messages are sent to users of the same MIM application, who have a customisable and unique handle, known as a 'username' or 'user ID', who have been added specifically as 'contacts' for the sake of being contacted via MIM. While research from Belgium and South Korea have suggested that MIM 'contact lists' are generally comprised of 'close ties' (Kim, Kim, Park, & Rice, 2007; Van Cleemput, 2010), South African research has suggested that MIM applications are used to increase social connections generally (Bosch, 2008).

In South Africa, MXit is the MIM application that dominated the digital social landscape for most of the past decade, and was the largest social network in the country until late-2013 (World Wide Worx & Fuseware, 2013). As of September 2014, over 60 million users are registered to use the service, 83.93% of whom are in South Africa. MXit is

⁴ Face-to-face communication, including face-to-face counselling, implies physical presence of both parties, at the same place, at the same time.

especially popular among teenagers and young adults, with 25% of the 7.4-million monthly active⁶ users aged 13-17 years, and 48% in the 18-24 years age range (Mxit, 2014).

Due in part to the limitation on SMS length, and manner in which words were constructed on earlier mobile phone models (Butgereit, Botha, & van den Heever, 2012), an abbreviated form of language-use has become prevalent in messages sent via SMS and MIM, which comprises particular abbreviations, contractions and syntax. This form of language used on Mxit has been called 'Mxit lingo' and is standard practise on the network (2012).

Cape Town-based MIM application, 2go, overtook Mxit as the most popular MIM in Africa in late-2013 (World Wide Worx & Fuseware, 2013), while in April 2014, WhatsApp hit 500-million international users, 72% of whom log in each day (WhatsApp Inc, 2014). Despite this, Mxit maintains a loyal user base in South Africa, has increased active users steadily since inception and members are spending longer on average on Mxit (van Zyl, 2014).

Since early-2008, volunteer counsellors at Reconstructed Living Labs (RLabs) in Athlone, Cape Town, have offered counselling via Mxit. Using specially-designed software, counsellors using Personal Computers (PCs), are able to send and receive instant messages with 'clients' using Mxit on their mobile phones. The back-and-forth exchange of instant messages is known as a 'chat'. The software allows counsellors to maintain chats with multiple clients concurrently, in separate 1-on-1 chat sessions. Clients are able to initiate chat sessions with counsellors during advertised service hours, in the same familiar manner with which they would initiate chat conversations with any other Mxit users, such a friends or family.

Since 2008, several other service providers have piloted Mxit-based counselling services, with most experiencing surprisingly high rates of demand (Childline South Africa, 2010a; Nembaware, Groll, De Tolly, Skinner, & Serufuri, 2011; Nitsckie & Parker, 2009). Some basic evaluation reports have been produced and usage statistics compiled, but little is known about the experience of using Mobile-Instant-Messenger counselling, including Mxit-based counselling.

⁶ Mxit defines a user as 'active' if they have been on the network in the past 30 days (World Wide Worx & Fuseware, 2013).

Aims of current study

At the 4th International Developmental Informatics Conference (IDIA) in Cape Town in 2010, Marlon Parker, founder of RLabs, presented a paper in which he called for further research to better understand ‘the use of mobile technology for counselling purposes’ (p. 10) especially to determine the needs and demographics of service users (Parker et al., 2010b). This research heeds that call, gathering the views of actual MXit-based counselling service users, through the use of an adaptive, MXit-based questionnaire. Qualitative and quantitative data were collected about the demography of service users and their experience of using the Mobile-Instant-Messenger (MIM) medium for counselling, as well as their experience of other popular modalities, telephone counselling and face-to-face (FtF) counselling. Data were also gathered about reasons for non-use of MIM and other counselling modalities.

Data analysis involved data cleaning, data organisation, response categorisation, statistical analysis, and thematic analysis using two coders. Where relevant, statistical properties were calculated to ensure data reliability and validity. Pertinent findings from the research have been discussed within the context of exiting literature on Online and MXit-based counselling, and where appropriate, demographic characteristics of service users has been compared with relevant population statistics. By reporting demographic information of respondents, the study hopes to understand the characteristics of the mobile counselling service user group for the sake of considering the scope and reach of the mobile-based counselling service. Demographic information might also be used by existing and potential service providers to more appropriately advertise and tailor their counselling services.

Both quantitative and qualitative data are collected about service users’ use of MIM-based counselling, as well as more established counselling modalities: face to face and telephone counselling. This allows for a comparison between respondent’s use and experience of various counselling modalities, and to confirm or clarify current understandings about the experience of online counselling, while adding to the literature information about the specific experience of receiving counselling via Mobile Instant Messenger.

If the medium can circumvent access barriers, thus allowing access to emotional information and support for hard-to-reach populations, this information may shed light on this as a present or future reality. Information is also collected about the reasons for non-use of the mobile-based counselling service (from a separate portion of the study population) to appreciate access barriers relevant to the medium. Taken together, information about the use

and non-use of the modalities can be used to improve the service and better facilitate access to emotional support.

Structure of dissertation

The literature review chapter follows, with an introduction to the global and local ‘treatment gap’ that exists in mental health, and the versatile use of mobile-based technology in addressing these and other issues. Previous research on online counselling and MXit-based counselling is considered, with a focus on aspects relevant to this research, namely the characteristics and experience of service users. The method chapter follows, and explains the methodological approach, data analysis and ethical issues. The results chapter reports on the findings of data collection and analysis, with regards to the demographics of MXit-based counselling service users, and the use of counselling modalities. Significant findings and aspects of the research are discussed in the context of previous literature in the discussion chapter, while the conclusion chapter covers strengths and limitations of the current research and offers suggestions for future research in this area of study.

Literature Review

Introduction

The literature review orientates to the current gap in mental health care, considering the various structural and personal barriers to service. A brief history of counselling in South Africa is followed by a report on telephone counselling, and a consideration of barriers in this regard. The field of online counselling is then explored, with a particular focus on aspects prominent in the literature, working alliance and ethics, and relevant to this research, the characteristics and experience of service users.

The emerging use of mobile phones for health (mHealth) is then reviewed, particularly with a focus its use in on mental health, and in South Africa. The use of mobile phones for the delivery of counselling is then introduced, and MXit, the dominant platform for mobile counselling is then considered and its use for social interventions, including counselling, is then described and existing literature on service user characteristics and experience is reported on. The limitations of previous research are considered before the chapter is concluded.

Mental Health Treatment Gap

According to the World Health Organisation, “there is no health without mental health.” (World Health Organisation, 2005, p. 24). Despite this declaration, the prevalence of mental illness is growing; Murray’s *Global Burden of Disease Study* (1996) projects (unipolar) depression to be the 2nd largest cause of Disability Adjusted Life Years (DALYs) by 2020, second only to ischaemic heart disease. By 2010, Major depressive disorder was ranked 11th in terms of Global DALYs ($n = 63\,239$, 95% CI: [47 894, 80 784]), up from 15th in 1990 ($n = 46177$, 95% CI: [34 524, 58 436]) (Murray & Lopez, 2013).

While there has been a call to more accurately calculate DALYs in South Africa (Lund et al., 2008), the lifetime prevalence of mental disorders has been reported as relatively high at 30.3% (Herman et al., 2009), with Williams et al. (2008) reporting that of the 16.5% of South African adults who had suffered with a mental disorder in a twelve-month period, only one in four reported having received treatment. Furthermore, this treatment was likely to come from the general health sector, not from the mental health sector. This led Petersen et al. (2009) to identify “a large ‘treatment gap’ for common mental disorders in South Africa” (p. 141).

Current resources to facilitate access to mental health care services in SA fall short of expectations for an upper-middle-income country (Petersen et al., 2009; The World Bank, 2014), especially with regards to the number of psychologists ($n = 0.32$ per 100 000) and psychiatrists ($n = 0.28$ per 100 000) in the public health sector (Flisher et al., 2007), the availability of care at a primary health care level (Mkhize & Kometsi, 2008), and the stunted implementation of a community-based care model (Petersen & Lund, 2011).

Other concerns from the literature of particular relevance to this research, include a shortfall in child and adolescent mental health care services (Lund, Boyce, Flisher, Kafaar, & Dawes, 2009), concerns about sufficient management of common mental disorders such as depression and anxiety (Petersen et al., 2009) and the neglect of the mental health needs of Black South Africans (Jones, 2009) who comprise the largest racial group in South Africa (80.2%) (Statistics South Africa, 2014).

Barriers to Services

Compounding the structural problems, shortfalls and obstacles (detailed above) are a range of well documented access barriers affecting prospective service users on an

individual- and community- level. These include (but are not limited to) stigma, discrimination, embarrassment (Ruane, 2010), a lack of knowledge about illnesses, medication, side-effects and healthcare providers (Pillay et al., 2009), as well as particular difficulties associated with physically accessing services related to location and (financial and time) cost, especially for people in rural areas (Petersen et al., 2009; Pillay et al., 2009). There was also a lack of belief in the efficacy of psychological services (Ruane, 2010), and a desire to recover on one's own (Seedat, Stein, Berk, & Wilson, 2002).

Counselling in South Africa

Historically, counselling in South Africa has been based on a career counselling movement coming out of the United States in the early 20th century, and developed alongside psychometric testing, which was used at a time in South Africa's history, whereby people were being divided according to their race and having resources unevenly distributed, based on that classification (Foxcroft & Roodt, 2009). As described by Maree and van der Westhuizen (2011), during apartheid counselling in Black schools was poor and often used to control black anger and mitigate against potential uprising. As a result, 'Blacks associated it with the inadequate guidance administered at school and consequently regarded it as inferior' (p. 106).

With this context in mind, there was a collective scepticism about counselling, especially in the Black majority, for whom the 'Western notion of a talking cure is alien' (Straker, 1988, p. 9, cited in Maree and van der Westhuizen, 2011). Freud used the term 'talking cure' in reference in traditional psychoanalysis, but the term is commonly used to describe a variety of psychotherapeutic approaches that involve talking between client and clinician (Mental Health Foundation, 2013). This scepticism may play some part in understanding why there are few Black psychologists; De la Rey and Ipser (2004) reported that just 18% of psychologists registered between 1994 and 2003 identified themselves as Black, inversely proportional to the most populous race group in South Africa, making up four fifths of the population (Statistics South Africa, 2014).

To address the high rates of HIV infection in South Africa (National Department of Health, 2008), the government established the Voluntary Counselling and Testing (VCT) and HIV Counselling and Testing (HCT) Campaigns, with the aim of encouraging HIV testing, and providing information and counselling before and after HIV tests (SANAC Secretariat, 2010). In addition to this, individual counselling by 'adherence counsellors' is an integral part

of the strategy to encourage adherence to antiretroviral (ARV) medication (Dewing et al., 2013).

This has potentially introduced the concept of counselling to a population that might otherwise not be exposed to the ‘Western’ notion of ‘talk-therapy’. Despite this opportunity for engagement and consideration of mental-health needs, there are difficulties which affect the impact of the programme, which remains inaccessible to young adults (Risenga, Davhana-Maselesele, & Obi, 2013). There also remains doubt about the proficiency of the ‘adherence counsellors’ (Dewing et al., 2013) involved in the VCT and HCT programmes. Clearly there is a need to consider how best counselling services can serve a wide variety of clients, of different backgrounds, beliefs and cultures.

Telephone Counselling

Non-government organisations (NGOs) and organisations from the not-for-profit (NFP) sector, have tried to fill gaps in mental health care provision, through the establishment of counselling facilities in metropolitan and rural communities. In addition to face to face services, many NGO/NFP service providers have followed international trends and added telephone counselling to their bouquet of services.

Telephone counselling has been offered in South Africa since 1968 (Lifeline, 2010) with general and specific focus areas, including domestic violence, HIV/AIDS, debt support, child abuse, depression, and drug abuse and addiction. Commonly, telephone counselling services are toll-free (free when called from a landline) and calls are answered by trained, lay-counsellors – usually unpaid volunteers.

In his analysis of calls made to the South African National AIDS Helpline (NAHL) between 2000 and 2003, Katz found that the helpline averages 201,476 calls per month. He also noted a steady increase of demands for counselling rather than information provision – the primarily conceived and advertised role of the helpline (2004). He also reported that the majority of callers fell in the range of 20 to 29 years of age, with 15 – 19 the second most prevalent age range.

Lifeline/Childline Western Cape revealed that just over forty-five thousand calls were answered by their crisis counselling helpline volunteers over the course of 2012 (Nompelo Dlodla, personal communication, 24 January, 2013). While these numbers are dwarfed by those reported by the NAHL, the recording processes seem to be different and a large

majority of calls placed to the NAHL do not necessarily result in ‘satisfactory contact’, as explained below.

Telephone counselling clearly navigates issues related to the physical access of service locations, including the stigma and embarrassment of being seen approaching service providers and the time and financial cost of accessing counselling locations. There is also the benefit of the immediacy and anonymity of telephone contact. Besides the ‘practical’ benefits of the medium, the effectiveness of telephone counselling to relieve emotional pain and the ability for a working alliance⁷ to be established across the medium has been established (King, Bambling, Reid, & Thomas, 2006; Reese, Condley, & Brossart, 2002).

Barriers affecting telephone counselling. While some of the barriers affecting the use of face to face counselling carry over to telephone counselling, a particular set of issues were found to be affecting telephone counselling provision by the NAHL. Firstly, because the NAHL service is toll-free to call from landlines, the service is prone to hoax callers (Nembaware et al., 2011); as many as 60% over a 6 month period (Katz, 2004), causing frustration and annoyance to counsellors. These hoax calls include children playing on the line, abusive callers, and callers who remain on the line in relative silence. The toll-free Childline service also receives frequent hoax calls, although counsellors are trained to understand these calls as a ‘test’ by the caller, who may call again in a time of genuine need (Nomphele Dlodla, personal communication, 23 January 2013).

Secondly, a lack of counsellors, and the time-intensiveness of 1-on-1 counselling via telephone means that many calls go unanswered, as many as 22.8% over a thirty month period of data analysis (Katz, 2004). Furthermore, there is a concern about the lack of privacy for many callers - as landline telephones are available in only 8.18% of South African households (International Telecommunication Union, 2012), public telephones are frequently used to access the service – in these instances, there are often people waiting to use the telephone standing within earshot of the caller, and calls are sometimes cut off prematurely (Nembaware et al., 2011). In the case of non-toll free services, the cost of a phone call is another potential barrier to service users, regardless of whether the call is placed via mobile phone or landline.

⁷ Working alliance relates to aspects of the therapeutic bond between therapist and client.

Online Counselling

Internet-based communication between ‘therapists’ and ‘clients’ has generally occurred via Personal Computers (PC) and been facilitated typically through email, instant-messaging or video-conference software, such as Skype. There are distinct differences between these methods. For example, while email and instant-messaging (IM) both involve the exchange of text, email is described as an ‘asynchronous’ form of communication, while IM is described as ‘synchronous’. Mallen, Jenkins, Vogel and Day (2011) explain synchronous chat as “the typing of messages back and forth in real time” (p. 221) - an exchange which continues until one party decides to leave the conversation.

Perhaps due to the instantaneous aspect of IM, it is used in a more colloquial and informal manner compared to email (Volda et al., 2002), and was adopted early by teenagers (Boneva, Quinn, Kraut, Kiesler, & Shklovski, 2006), young adults, and students (Kim et al., 2007), as a well-liked method of social communication. Generally, IM has been considered especially appropriate for maintaining close connections (friends and family), in a manner which includes sharing about one’s personal concerns and soliciting support (Boneva et al., 2006). The selection of various online methods (Email, IM, video-conference) for particular communications is complex and seems to depend on the interaction of individual, cultural and practical factors (Van Cleemput, 2010).

Internet-based communication was first used as a means for counselling in the mid-1990s (L. J. Murphy & Mitchell, 2009), with guidelines and standards for ‘online counselling’ being produced by relevant professional governing bodies in the United States and the United Kingdom in 1997 and 2001 respectively (Chester & Glass, 2006). Generally, initial literature reflected a common scepticism about the effectiveness of providing an emotionally supportive service without physical presence, while the ethical aspects of service delivery via the internet are the topic for a range of recent literature.

Working alliance in Online Counselling. While measuring the effectiveness of therapeutic interventions is complex (Allen, 2012), ‘working alliance’ has been identified as related to positive therapeutic outcomes (Martin, Garske, & Davis, 2000). The concept of working alliance is perhaps best conceptualised as “...interactive and collaborative elements of the relationship (i.e. therapist and client abilities to engage in the tasks of therapy and to agree on the targets of therapy) in the context of an affective bond or positive attachment” (Constantino, Castonguay, & Schut, 2002, p.86).

Some authors feel that the absence of verbal and visual cues (Barak, Hen, Boniel-Nissim, & Shapira, 2008), or lack of physical presence (Skinner & Latchford, 2006) is too big an obstacle in the way of establishing a strong working alliance between service provider and service user using internet-mediated mechanisms.

Many authors have examined and tried to measure working alliance using various methods, tools and scales (Cook & Doyle, 2002; Hanley & Reynolds, 2009; King et al., 2006; Leibert, Archer Jnr, & Munson, 2006; Lopresti, 2010; Mallen et al., 2011; Skinner & Latchford, 2006). Findings have been mixed; some papers have suggested that a working (or therapeutic) alliance in online counselling can be meaningful (Haberstroh, Duffy, Evans, Gee, & Trepal, 2007) or strong (Cook & Doyle, 2002), while others suggest it is weaker compared to the alliance achieved in telephone counselling (King et al., 2006).

Ethical concerns in Online Counselling. There have been concerns raised in the literature about ethical aspects of online counselling. These concerns have given attention to professional standards of the counselling service providers, provision of information for informed consent, issues relating to confidentiality and safekeeping information, boundaries, scope of practise, and screening of prospective clients (Baker & Ray, 2011; Kaplan, Wade, Conteh, & Martz, 2011; Ross, 2011; Shaw & Shaw, 2006).

As of August 2014, the Health Professional Council of South Africa (HPCSA)'s Health Professions Act (and Annexures) (Health Professions Council of South Africa, 1974) contain no reference to online counselling or guidance for potential service providers. An article on online counselling entitled 'A cautionary tale' (de Bruin, 2013) appeared in 'the Bulletin' - the online magazine of the HPCSA. The article quotes Professor Gertie Pretorius, Vice-Chairperson of the Professional Board for Psychology, as suggesting that the lack of online interventions in the act is "something that the Professional Board is well aware of and is working towards as a matter of priority." (p. 20). She also states that "the ethical code will also be revised." (p. 20), highlighting three principles which service providers should adhere to: informed consent, confidentiality and authenticity.

The principles that might potentially be stipulated by the HPCSA would most likely be intended for those registered as psychologists or counselling psychologists practising online counselling. The application of the ethical code to other online counselling service providers, including more 'informal' service providers, is considered below:

Informed consent. According to a government notice about the ethical conduct of practitioners registered under the Health Professions Act (South African Department of Health, 2006), informed consent requires the psychologist to provide the prospective client with information about “the nature and anticipated course of therapy, the fees, the involvement of third parties and confidentiality” (2006, p. 33) as early in the course of the therapeutic relationship as possible.

The notice goes on to cover “treatment in emerging areas in which generally recognised techniques and procedures have not been established” (South African Department of Health, 2006, p. 34), with the onus on the psychologist to inform the service user of the “developmental nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of the client’s participation” (p. 34). The HPCSA’s guidance on informed consent stipulates that consent can be indicated “orally or in writing” (Health Professions Council of South Africa, 2008b, p.10), in which case, digitally-transmitted consent may be gathered and is most applicable to MIM-counselling.

Confidentiality. The right to confidentiality relates to the privacy and protection of information shared in therapeutic relationship. Given that the online medium allows for easy retention and sharing of text, data protection issues are especially relevant in online counselling. In their consideration of practical aspects of online counselling, Mallen, Vogel and Rochlen (2005) encourage specific informed consent information for clients which covers risks involved with data storage, which includes future use of session transcripts for legal proceedings and methods of proper encryption and storage.

According to the (Health Professions Council of South Africa, 2008a), disclosure of confidential information is permitted in a situation whereby “the patient or other persons would be prone to harm as a result of risk related contact.” (p. 3). Childline South Africa’s online counsellors were particularly concerned about not being able to respond as they might in face to face contexts to expressed threats of risks, such as suicide or homicide, or disclosures of child or elder abuse, as required by law (Health Professions Council of South Africa, 1974) due to a lack of information about the service user (Childline South Africa, 2010a).

Some practitioners have suggested that the informed consent information require prospective service users to provide additional personal details to assist the service provider

to provide additional care if required. This might include details of an emergency contact (Rummell & Joyce, 2010), the service user's physical address (Shaw & Shaw, 2006), or details of a local health care provider (Mallen et al., 2005). The relevance of these suggestions to MIM-counselling is debated in the discussion chapter.

Authenticity. Though not elaborated upon in the article, the revision of the code by the HPCSA will likely require service providers to provide clear information about their professional identity, which might include details about relevant qualifications, professional board registrations, and contact details. Practicing psychologists are currently required to provide such information (and more) in accordance with relevant rules of the HPCSA (South African Department of Health, 2006). In the online medium, the lack of physical presence is an extra obstruction to clear identification of service provider, and has been identified in negative and positive terms by online counselling service users with regards to a sense of safety and containment (Cook & Doyle, 2002; King et al., 2006; Leibert et al., 2006).

Characteristics of online counselling service users. The demographic characteristics of online counselling service users have generally been collected as secondary to a main investigation; for example, when measuring the working alliance or attitudes to the online counselling medium. Other studies have used specific service user groups, controlling for demographic characteristics, such as age or area of concern, including eating disorders.

Two studies that have focused on the online counselling user group in particular, found that females outnumbered males with a ratio of at least 6 to 1, while no other significant demographic aspects were highlighted or noteworthy (DuBois, 2004; L. Murphy, Mitchell, & Hallett, 2011). These studies suffered from relatively small sample sizes, and in both cases, the 'online counselling' modality was almost exclusively e-mail.

Experience of online counselling service users. When it comes to examining the experience of online counselling, some research has simulated online counselling relationships – with psychology students playing the role of client (Haberstroh et al., 2007) – while other studies gathered experiential information from actual service users (Haberstroh, 2010; King et al., 2006; Leibert et al., 2006; Young, 2005). These studies used qualitative methodology, gathering data through the use of surveys (Leibert et al., 2006), focus group interviews (King et al., 2006), and from a combination of reflection journals, focus groups and sporadic interviews (Haberstroh et al., 2007).

Other research evaluated the experience and process of online counselling from the perspective of the counsellor (Bambling, King, Reid, & Wegner, 2008; Finn & Barak, 2010; Mallen et al., 2011). Overall, the literature shows that online counselling was generally experienced as favourable with specific advantages over telephone and face to face counselling.

One major advantage identified by online counselling service users in the literature has to do with the flexibility around the location of service use (Haberstroh et al., 2007). This was considered especially advantageous for individuals suffering with anxiety, or those who are unable or unwilling to access face-to-face services due to a lack of services in their community (Mallen & Vogel, 2005) or stigma (Vogel, Wade, & Hackler, 2007). The flexibility and convenience of the medium also extends to potential service providers who could offer services outside of regular hours, from the safety and comfort of a location of their choosing (Mallen & Vogel, 2005).

The privacy afforded by the medium generally lead respondents to a sense of safety, leaving clients feeling less emotionally exposed (King et al., 2006), and more able to express themselves freely (DuBois, 2004). Respondents to Leibert, Archer and Munson's exploratory survey (Leibert et al., 2006) named disinhibition ($n = 35$) and flexibility ($n = 24$) as advantages of online counselling. This is in line with comments from respondents ($n = 9$) of Cook and Doyle's study, who named a "sense of freedom to express themselves online without embarrassment or fear of judgment from therapists" (2002, p. 101).

There is also a suggestion that the activity of writing about one's emotional content can be cathartic in and of itself, while also allowing the client to re-read their words and reflect on what has been discussed (Pennebaker & Chung, 2011). According to Dunn (2012), the "time to think" (p. 322) offered by the email medium, was highly valued by respondents, alongside feelings of control and autonomy afforded by the lack of physical presence.

The lack of visual contact was cited as eliminating superficial differences between service users and counsellors, such as race, age, sex or gender (Mallen & Vogel, 2005) which might otherwise prejudice or negatively affect the therapeutic relationship. The lack of non-verbal cues was also the main complaint about online counselling in the literature, highlighting what Leibert, Archer Jnr and Munson (2006) described as a tension "between the desire for anonymity and the desire for personal contact with a therapist." (p. 78).

Technological obstacles and delayed responses from counsellors and insufficient times of service availability have also been fairly commonly reported (Haberstroh et al., 2007; King et al., 2006; Nembaware et al., 2011) which results in periods of misunderstanding (King et al., 2006) and seems to interfere with alliance between client and service providers (DuBois, 2004; Haberstroh et al., 2007).

Synchronous communication. There are a few studies that have examined counselling delivered via synchronous communication specifically, for the sake of comparing it to other counselling modalities, to examine the subtleties of interaction between counsellor and client, and to consider its effectiveness using particular measures linked to symptom relief.

Jenkins, Vogel and Day (2011) found that counsellors (who had been trained for face-to-face counselling) used more questions and messages of validation when delivering online counselling, and hypothesised that this might be to make up for a lack of physical information. Participants in their study reported an increase in their ability to form a therapeutic alliance - which surpassed their pre-conceived expectations.

Similarly, a focus group of twenty six trained counsellors, who had been offering synchronous counselling for over six months, explained that there were particular challenges faced by the medium, which they managed through adapting responses to avoid ambiguity and misunderstanding (Bambling et al., 2008). The research also found that while the speed of text exchange limited the breadth of material that could be covered in the hour sessions designated in the study, the emotional safety of the medium seemed to encourage the majority of clients to 'talk about their concerns from the first statement' (2008, p. 112).

Zabinski, Wilfley, Calfas, Winzelberg and Taylor (2004) examined the use of synchronous chat as the medium for an online support group, as an adjunct to a multi-intervention eating disorders treatment and found that "online interactions via synchronous communication appeared effective for improving behaviours and cognitions associated with eating disorder pathology." (p. 917).

mHealth

There has been a call for the greater use of communication technology to improve the efficiency and standard of care in general and mental health. The terms 'eHealth' (electronic-Health) and 'ICT4H' (Information Communication Technology for Health) have been used to

describe the use of technology in these fields. Within eHealth, the use of mobile devices (such as mobile phones and tablets) for health initiatives is called 'mHealth' (mobile-Health) (World Health Organisation, 2011). In fact, member states of the World Health Organisation, which includes South Africa, accepted resolution WHA58.28 in 2005 indicating their commitment to the adoption of eHealth (including mHealth) in their countries (2011).

Mobile penetration in Africa. South Africa has very high mobile phone penetration, with the International Telecommunications Union (2012) reporting that in 2011, approximately 90% of South Africans had access to a mobile phone, compared to just 8.18% with access to a landline (fixed-line) (down from 9.60% in 2006), while the number of mobile-cellular subscriptions per 100 inhabitants was 147.5 in 2013, compared to just 9.2 fixed-line subscriptions (International Telecommunication Union, 2014).

This move away from fixed-line telephones to mobile handsets has been a growing trend in the whole of Africa; between 2000 and 2011, the number of fixed-line telephones grew from 9.2-million to 12.1 million. In the same period, mobile phone subscriptions grew from 16.5-million to approximately 645-million, surpassing both the European Union and United States (The World Bank, The African Development Bank, & The African Union, 2012). Mobile phones have revolutionised communication in Africa, and are being used for access to the internet, to grow and sell services, to seek employment and for access to banking and government services (The World Bank et al., 2012).

mHealth in South Africa. Such high rates of mobile penetration and low levels of access to (strained and scarce) health services have been strong motivating factors for the integration of mobile technologies into the health care delivery system. A number of NGOs and companies operate in the mHealth field in South Africa, with operations mainly focused on mobile data collection, mass communications of health-related content and information sites via mobile-friendly websites. The topics most commonly addressed in low and middle income countries (by mHealth) have been HIV/AIDS and family planning/pregnancy (Gurman, Rubin, & Roess, 2012). Interventions mainly take the form of SMS as appointment and adherence reminders, or as informational and behaviour-change messaging campaigns. Mobile phones have also been used for data collection, intervention feedback and monitoring, and for the management of health services (Leon & Schneider, 2012).

mHealth and mental health care. Besides the delivery of static health care information, some mHealth interventions are now interactive and bi-directional, and some have been designed to address individuals' mental health. Many apps⁸ have been developed to allow individuals to monitor their mood and stress levels throughout a day, coach them through anxiety, and even screen for mental disorders (Landau, 2012). While these 'self-care' apps allow an individual to review and monitor their own well-being, other technology has facilitated therapeutic communications between 'therapists' (including psychologists, counsellors, social workers and other service providers) and 'clients' using the internet. The US-based National Board for Certified Counselors has defined this as 'technology-assisted distance counselling' or 'online counselling' (2005).

Mobile Instant Messenger

Mobile phones offer synchronous communication through Mobile Instant Messenger (MIM) applications, with typical conversations involving back-and-forth 'chats' between two or more users, as described earlier. In South Africa, MXit is the MIM application that has dominated the digital social landscape for most of the past decade, with over 50 million users registered to use the service in South Africa. While other MIM applications have grown in popularity, MXit has an established, loyal user base (van Zyl, 2014) who reportedly log on an average of 5 times per day, spending a total of 105 minutes on MXit every day (Mxit, 2014).

Use of MXit for social interventions. MXit has been used for social interventions in various fields including development, health, employment, and education (Butgereit, 2007; MXitReach, 2012). These interventions have come in the form of static textual information, interactive applications, and through MXit-based counselling. These interventions are accessible from the main MXit menu, under the heading of 'MXit Reach' with the goal to "provide tools on MXit enabling social upliftment" (MXitReach, 2012).

One such application, 'Dr Maths', was the first MXit-based tutoring programme, established as collaboration between the Council for Scientific and Industrial Research (CSIR) and the University of Pretoria (UP) (Butgereit, 2007). A content analysis of instant messages exchanged during sessions between 'Dr Math' tutors and high school students revealed "a need for MXit-based counselling services for young people" (Butgereit, 2007, p. 13).

⁸ 'App', an abbreviation of 'application software' is mobile-based software designed to perform specific tasks.

MXit-based Counselling

Various MXit-based counselling services have been piloted (and sustained) by a number of South African organisations. The first, Angel/Drug Advice Support (DAS), was set up in July 2008 by Reconstructed Living Lab (RLabs), based in Athlone, Cape Town (Parker et al., 2010b). By June 2010, there were over 57 000 subscribers to the DAS system (Parker, Wills, & Wills, 2013), with an average of 178 users making contact per counselling session (Nitsckie & Parker, 2009). At the time of data collection, counselling sessions had been run three days a week, on Mondays, Tuesdays and Wednesdays, from 3pm until 4pm. As of January 2014, counsellors were online on Mondays (2pm – 4pm) and Wednesdays (12pm – 2pm). On average, there are approximately 8 counsellors per shift.

DAS counsellors or ‘advisors’ are volunteers who have received counselling training from Lifeline, an established, national counselling service provider and training facility. Some of the advisors are previous drug-users and gang members, who approached one of RLabs’ partner organisations, Impact Direct, for reform and rehabilitation. This integration into the service-provision-side of the MIM-counselling service highlights one element of the larger impact of the DAS service on the community. It is not uncommon for reformed addicts to become effective addiction counsellors (Culbreth & Borders, 1998).

Another popular service, RedChatZone, was launched in 2009 by The South African National AIDS Helpline in collaboration with Cell-Life, a not-for-profit organisation specialising in mHealth innovations, and Lifeline, an established, nationally-operating, not-for-profit telephone and face to face counselling operator. RedChatZone was launched to test the viability of providing HIV counselling via MXit. Over the period 1 September, 2009 – 30 November, 2010, 4815 clients made contact with the service, with over 60% returning to use the service more than once (Nembaware et al., 2011).

Childline South Africa (Childline SA), a national non-profit organisation, has traditionally operated a telephone helpline, for the sake of protecting children (from violence and abuse) and children’s rights. In May 2009, following a peer-exchange trip to ISPCC Childline Ireland, Childline SA piloted and launched an eleven month trial of MXit-based counselling with trained volunteers available from Mondays to Saturdays, between 2pm and 6pm (Childline South Africa, 2010b). The response to the technology was “overwhelming” (p. 4) – over the eleven months of the trial, 1829 children received counselling – encouraging Childline SA to increase the number of available counsellors (Childline South Africa, 2010a).

A few South African universities have been involved with Mxit-based service provision. The University of Pretoria (UP), in collaboration with former deputy president Phumzile Mlambo-Ngcuka's Umlambo Foundation, launched a service in early-2010 called 'DrLOLS', offering Mxit-based counselling about Life Orientation and Life Skills (CSIR, 2010). The Nelson Mandela Metropolitan University (NMMU) received training to use Mxit-based counselling as part of their Student Counselling, Career and Development Centre (SCCDC). Plans to launch the service, named 'TXTM8', were halted in late-2013, although there is confidence that the service will be re-launched in earnest in the near future (M De Jager, personal communication, 12 August 2014).

NMMU were also involved in a pilot with FAMSA Port Elizabeth, to pilot counselling to primary school children. The University of the Western Cape (UWC) piloted an online support service between April and July 2010. The service could be accessed via computer, tablet or cell phone (Schreiber & Aartun, 2011). The user experience was not evaluated as part of the pilot. Another Mxit-based operator, MobieG, launched a Life Skills Helpline in July 2010 and a Career Guidance Helpline in March 2012 – with service users numbering more than 70 000 by March 2013 (LIVEJAM N.P.C., 2013). Both services continue to operate as of mid-2014 (Personal Communication, Stephnie Crouse, 10 August 2014). While a report was compiled describing age and gender of service users, there has been no investigation into the experience of using the service.

Internationally, a variety of organisations including The Kids Helpline (in Australia), Youthline (in New Zealand), Crisis Text Line (US) and Child Helpline (Internationally) offer online counselling by computer-to-computer Instant-Message (IM) chat, while a few organisations including Samaritans (in the United Kingdom), offer support via other online (but asynchronous⁹) methods such as SMS (text) and email counselling. Since 2013, there has been a surge of new synchronous counselling services around the world, offering counselling via WhatsApp, a popular MIM application. These include 'Oogachaga' (Singapore) and the University of Hong Kong who offer 'Youth Quitline' via WhatsApp to support students trying to quit smoking. These services have not published reports or undertaken analyses of their user base.

⁹ Asynchronous communication differs from synchronous communication in that communication does not have to occur in real time. Examples of asynchronous communication would be email, letter, postcard, SMS.

Literature on Mxit-based Counselling

Literature that deals specifically with Mobile-Instant-Messenger (MIM) counselling comes exclusively from the South African context and relates to the MIM of choice in South Africa, Mxit, which was likely chosen for service provision based on its dominance in the MIM market.

RedChatZone, offered by the South African National AIDS Helpline has been evaluated from a program-theory perspective, with a focus on service utilisation and service delivery (Nembaware, 2011). An assessment report has also been produced that has examined RedChatZone using three techniques: (a) analysis of usage statistics; (b) content analysis of counselling conversations; (c) interviews with counsellors (Nembaware et al., 2011).

The work done by RLabs, including the establishment, pilot and running of DAS has been reported on in different ways. Numerous conference papers have been presented on RLabs and DAS by Marlon Parker, founder of RLabs, in conjunction with other authors around South Africa (Dourando, Parker, & De la Harpe, 2007; Nitsckie & Parker, 2009; Parker et al., 2010b). In addition, Parker has co-authored two journal articles about RLabs, both of which draw attention to the DAS service (Parker, Wills, & Wills, 2010a; Parker et al., 2013).

This set of literature is exclusively descriptive, establishing an understanding of the (mainly substance-abuse related) issues affecting the Cape Flats area outside Cape Town that inspired the establishment of the DAS service, a description of the technology developed to address the problems, its launch, trial and use, and the perceived impact and consequences of the service (Nitsckie & Parker, 2009; Parker et al., 2010a; Parker et al., 2010b). Their research methods include interviews with advisors (counsellors) and supervisors, and some basic content analysis of conversations.

Childline South Africa (Childline SA) has produced basic, year-end statistical reports every year since 2010 (2011; 2012; 2013; 2014), reporting on logs completed by counsellors after each chat session with a client. These reports have categorical counts of conversation topics and user's sex and age. Unfortunately, a large amount of demographical data are categorised as 'unknown'.

Characteristics of MXit-based counselling service users. Data relating to MXit-based counselling service users' demographic characteristics comes from three sources: Childline (SA), RedChatZone and RLabs.

As previously stated, Childline (SA)'s reports (Childline South Africa, 2011; Childline South Africa, 2012; Childline South Africa, 2013; Childline South Africa, 2014), classify large proportions of service user gender data as 'unknown', between 41.51% (in 2010) and 55.76% (in 2012). When gender was known, female callers outnumbered male callers between 3.84:1 and 4.82:1. Again, statistics about the age of service users are affected by at least 25.97% (in 2013) and as much as 37.33% (in 2010) being recorded as 'unknown'. Of known ages, the 16-18 age group had the highest representation each year, between 44.56% and 48.36% of callers, with the wider range of 13 to 21 years of age representing 84.51% in 2010, 86.57% in 2011, 87.99% in 2012 and 88.57% in 2013.

A client survey carried out on the service users of RedChatZone (Nembaware et al., 2011) found that 74% were female, and the majority (51%) were aged between 20 and 24 years, 25% were aged 25 – 35 years, 20% were aged 15 – 19 years and the remaining 4% were either younger than 15, or older than 35 years.

An online article posted on the RLabs website in 2010, uses MXit registration details to categorise the 47663 subscribers of the Angel MXit service (at that point), to describe the demographics of the group (RLabs, 2010). Even though not all of these subscribers would have used the DAS MXit-based counselling service, it was exclusively advertised and accessible through the Angel service from its conception, until September 2012. The article highlights the fact that the vast majority of subscribers are youth (82% are younger than 25 years of age), and the gender split is fairly even (53% female, 47% male) (RLabs, 2010).

Experience of MXit-based counselling service users. The current literature offers little on the experience of using MXit-based counselling. Childline (SA)'s reports (2011; 2012; 2013; 2014), report only demography and conversation topics. An earlier presentation on a pilot of Childline MXit-based counselling (Childline South Africa, 2010a) reflected on a single aspect of user's experience, of having to wait to use the service:

Currently, in a four-hour shift, a counsellor speaks to an average of 4 to 6 people depending on the nature of the conversations. At any given time during the shift there are approximately 21 people waiting in a queue for each counsellor. (p. 11)

A client survey carried out on the service users of RedChatZone (Nembaware et al., 2011) found that respondents ($n = 127$) found the service ‘useful’ (80%), ‘cheap’ (83%), ‘helpful’ (51%), and worthy of reuse (96%) and recommendation (91%). There were concerns about the availability of the service, with 35% of users indicating that they desired a service offering more counselling time, while the speed of medium was also a concern for 41% of respondents (2011). The study reflects on constrained survey response options as a particular limitation, which may have influenced client responses reported above.

Limitations of Previous Research

Within the wider online counselling literature, there are methodological problems that limit the generalizability of results, including small sample sizes, data collection methods that invite bias (such as focus groups), and the absence of service users in the vast majority of study populations; with opinions coming from counsellors or simulated service users.

Though previous research has grappled with pertinent aspects of online counselling in general, the majority of the online counselling literature has considered the use of email, with research populations in first-world countries (USA, United Kingdom, Australia). There is a paucity of data that relates to the South African context.

While a presentation by Childline SA (2010a) and the report on RedChatZone (Nembaware et al., 2011) offer opinion on the experience of South African MIM service users, both reports suffer from methodological problems which affect the validity of findings. The Childline presentation (2010a) offers no further detail about the service and the user experience is unclear. The report on RedChatZone (2011), while gathering actual service user opinion, used a questionnaire which invited social desirability bias through non-neutral questions and unbalanced fixed-choice responses. For example, the question “*Is RedChatZone friendly*”, had the following as options: (a) “put off” ; (b) “I coped” ; (c) “just right” ; (d) “too friendly”.

Conclusion

While the authors of the initial literature on Online Counselling was skeptical about its effectiveness, various examinations of working alliance suggest that despite physical distance between counsellors and clients, an effective working alliance is possible, although findings are mixed and the concern is perhaps not completely unwarranted. Ethically, a lack

of guidance and legislation from professional bodies in South Africa means that online counselling activities are unregulated and as a result, there are potential risks to service users.

Previous literature has examined different aspects of online counselling, though perhaps due to the relative novelty of the medium for counselling provision, research has generally been descriptive and considered over-arching aspects of the medium. In trying to understand the demographics and experience of online counselling, a combination of qualitative methods have generally been used to gather data from actual and simulated service users, and from counsellors. While the studies identified and described particular qualities of online counselling, the validity and reliability of findings (especially for the South African context) comes into question. This is due to small sample sizes, and potential bias in sampling and data collection methods, with sample populations gathered from first world populaces, while the online counselling modality examined, was very frequently limited to email.

While online counselling has received attention in the literature, there has been little said about counselling facilitated specifically via Mobile-Instant-Messenger. In South Africa, MXit-based counselling has been provided by charitable organisations, NGOs, NPOs and university student support services for 8 years. Despite this, existing research on the medium has been generally limited to descriptions of the context of service provision and reports on statistical details of service use, in rather basic terms.

The characteristics of MXit-based counselling service users has been reported on by Childline, RedChatZone and DAS, with the youthfulness of service users prominent across all three services, and females outnumbering male service users quite considerably. Statistics reported by DAS and Childline shed light on high service user numbers, although there are worrying gaps in the data, with as much as 55.76% of gender data 'unknown' in a particular report.

RedChatZone, the MXit-based counselling service of the National AIDS Helpline, has been assessed using data gathered from interviews with counsellors, analysis of counselling conversations, a client survey, and examination of usage statistics. While gathering actual service user opinion, the questionnaire featured biased fixed-choice responses which affected the validity of its findings.

Despite some methodological issues, both the international online counselling literature and South African MXit-based counselling literature posit a number of advantages which may very well address the access barriers identified in the literature on mental health provision in South Africa. These include the flexibility of use (in terms of cost, access, hours and location) and the resulting privacy afforded by the anonymity of the medium, which seems to encourage emotional disinhibition.

The main complaints in the literature had to do with the lack of physical presence of the counsellor, a contradiction of the advantage of privacy, which highlights the contrasting experiences of online counselling use. Technical problems such as breaks in the service or inexplicable delays were also commonly reported, which caused frustration to both counsellors and service users of RedChatZone due to interference with service delivery.

From the literature, there is good reason to believe that the field of mHealth holds a lot of potential solutions to the problem of a ‘treatment gap’ in mental health care services in low and middle income countries. While some initial strides have been made into understanding counselling delivered via mobile phone (MIM-counselling), the full promise of the medium requires an accurate understanding of the user base, and their experience of using the service. As yet, these data are missing from the literature and this study aims to take up that opportunity.

In particular, the demography of users demands more details reporting than just gender and age statistics. This study examines employment and student status, race, language and location, to get a fuller sense of the user base. While investigating the positive and negative aspects of using MIM-counselling, this study also queries experiences of using telephone and face to face counselling, to get a sense of the use of different modalities and to understand the reasons for use of MIM-counselling in particular.

Method

Research aims

The current research aims to better understand the characteristics and experience of Mobile-Instant-Messenger (MIM)-based counselling service users, by analysing qualitative and quantitative data captured through a questionnaire. The questionnaire was advertised (alongside MXit-based counselling), in the menu of services and information offered by a MXit-based counselling service provider. Questionnaire items gathered demographic information, as well as information about the use and experience of face to face, telephone and MXit-based counselling. Reasons for non-use of these services were also requested. The ultimate outcome is to contribute to the very limited literature on this subject, with the hope that a more accurate understanding of users and their experience will allow for the provision of a more effective and appropriate service.

Context of the research

As stated previously, MXit is a Mobile-Instant-Messenger (MIM) application that runs on a variety of cellphones, and allows users to send and receive text and multimedia messages in private one-on-one ‘chats’ and in public ‘chatzones’. Mxit users can also add a ‘Mxit Service’ which is a directory of links to pages of information, mobi-sites¹⁰ and other MXit Services.

MXit-based counselling has been offered by a few service providers, all based in South Africa. The first to do so was Reconstructed Living Labs (RLabs), based in Athlone, Cape Town. Since 2008, RLabs has offered counselling through a MXit-contact known as ‘DAS’ - which stands for ‘Drug Advice Support’. The ‘DAS’ contact has been advertised through a MXit Service called Angel, self-described as a “24 hour support and information service”. Angel also contains links to information about Substance Abuse, Depression, Human Trafficking, Debt and other general counselling (telephone) help lines and is updated from time to time with additional links and information.

Since the beginning of the DAS service, interested service users have been required to manually add the ‘DAS’ contact, following instructions provided. This process of adding a new ‘chat contact’ is familiar to MXit users (Chigona, Chigona, Ngqokelela, & Mpofu,

¹⁰ Mobi-sites are versions of websites that are specifically designed for optimal browsing on a mobile-device.

2009). The DAS contact then appears in the user's list of MXit contacts. In the hours of operation, the DAS contact appears online and service users are able to initiate a chat with a counsellor, and then send messages back and forth to one another.

In September 2012, the process of accessing a DAS counsellor changed. Although the method detailed above still worked for existing service users, it was no longer necessary to add a new MXit contact to access the service. Interested service users could simply initiate a new chat with a live counsellor through the Angel menu by selecting the "LIVE Counselling (NEW)" option (see Figure 1).



Figure 1 - Angel service menu (screenshot¹¹ from MXit)

DAS counsellors are able to hold private conversations with multiple service users at once, by making use of a software application called JamiiX¹², which is run from their computer. This one-to-many relationship, as facilitated by JamiiX is illustrated in Figure 2 below. Holding multiple concurrent chat conversations is standard practise in instant-

¹¹ A screenshot is an image of the display on a digital device (e.g. computer, mobile phone)

¹² JamiiX, also known as JamiiX Social Exchange is a cloud based tool providing organizations a platform to manage multiple conversations from different Social Media and Instant Messaging applications (JamiiX, 2012)

messaging chat (Nardi et al., 2000). The potential downside of counsellors being able to maintain multiple counselling conversations at once is explored in the discussion chapter of this paper.

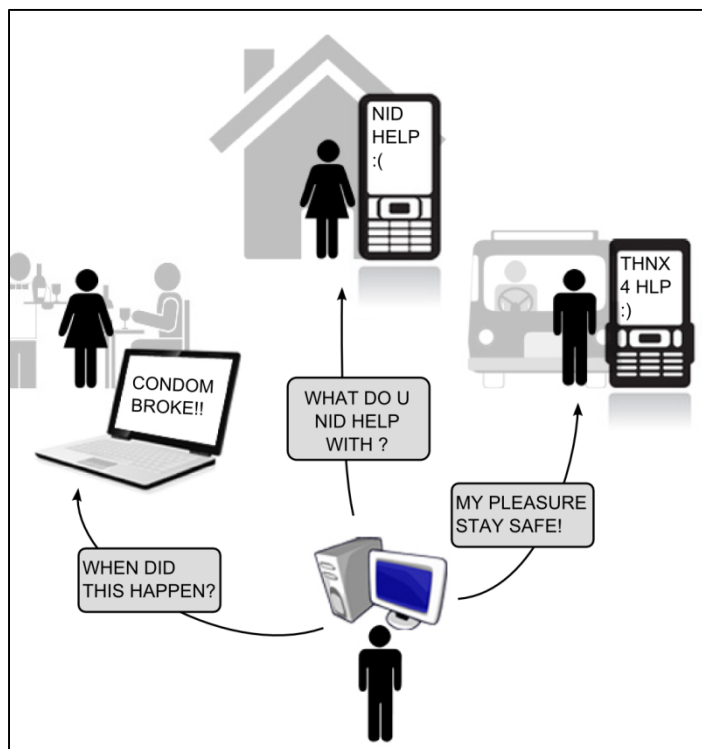


Figure 2 - A DAS counsellor can hold multiple private conversations¹³

Study design

This is a descriptive study that used an adaptive, MXit-based questionnaire for data collection, and qualitative and quantitative methods of data analysis, including thematic analysis with multiple coders. Sampling was non-probabilistic, and representativeness was checked for in data analysis. Recruitment was incentivised by entry into a prize draw, to win an airtime voucher to the value of R50.

Sample

The sample comprised 2977 men and woman, who responded to the MXit-based questionnaire between 18 June 2012 and 31 July 2012. Of the final sample (2977 respondents), 124 were excluded due to their being under 15 years of age. Of the 2853 remaining individuals aged 15 years of age and older, 568 identified themselves as having had counselling on MXit.

¹³ Image adapted from Nitsckie & Parker, 2009

Research participants were recruited through a link in the Angel menu. Once selected, a link, advertised as “Survey (NEW) **prizes to be won” led to consent information and an invitation to ‘Proceed’ or go ‘Back to Angel’ (see Appendix A).

Data Collection

Questionnaire. Following four exploratory interviews with counselling service users, a pilot version of a MXit-based questionnaire was trialled over a 72-hour period, in which 306 responses were received. Examination of these responses highlighted misinterpretation of a few questions. A revised version of the Questionnaire was designed, to try to minimise the effects of misinterpretation and more accurately answer the research questions.

The questions were formulated around collecting demographic information about respondents, as well as information about their use and experience of various counselling modalities, as well as reasons for non-use of modalities. The revised version of the Questionnaire contained a mix of fixed-choice and open-ended questions and was adaptive in nature. In other words, the questionnaire would follow a dynamic path based on responses to fixed-choice questions. For example, based on their response to “*Have you ever had counselling in person (face to face)?*” the next question would either be “*Who did you speak to (for face to face counselling)?*” or “*Why have you not had face to face counselling before?*” The questionnaire was either seventeen or eighteen questions in length, depending on the path. The questionnaire is attached as Appendix A.

The first six questions gathered demographic information about: (a) age ; (b) sex ; (c) location ; (d) race ; (e) first language ; (f) employment or student status. An additional question followed, asking respondents whether they owned or shared a cell phone. Previous research has shown that young people are using each other’s cell phones (Kreutzer, 2009), which may result in access to confidential or private counselling conversations. The question was included to gauge how much of an issue this is for study participants.

The next section of questions asked about the use of face to face, MXit and telephone counselling. Depending on responses, respondents were asked about their experience of using each service, or their reason for having not done so. Respondents who indicated that they had had counselling on MXit were asked what they liked and didn’t like about doing so.

Following this section, two open-ended questions gathered information for the sake of better understanding the use of the service. The first asked “Where are you using MXit from

right now?” In the pilot version of the questionnaire, example answers were provided as part of the question and analysis revealed that the large majority of responses were selected from these examples, as if it was a fixed-choice question. The question was thus revised and appeared in the final version of the questionnaire without examples. The question was motivated by a suggested benefit of mobile-based counselling, that it can be accessed from various locations (Haberstroh et al., 2007; Nembaware et al., 2011).

The second additional question - “*My biggest worry in life right now is...*” - was included as an attempt at assessing the counselling needs of service users, as expressed in their own words rather than requiring them to select from a multitude of confined options. Finally, two questions asked the respondent which cellular network they were using and for their cell number, which were required for payment of the potential prize, a R50 airtime voucher.

Data Analysis

Data cleaning. Erroneous and incorrectly formatted responses were either transformed to a more suitable format for analysis, or, failing that, marked as erroneous. For example, to the question, “*What is your age?*” a response of “I am nineteen” was corrected to “19”, to allow statistical calculations to be performed. In addition, misspelled words were corrected and responses in ‘Mxit lingo’ or abbreviated were translated, for the sake of automatic tallying. For example, as responses to the question of the respondent’s race, ‘Clrd’ and ‘Coulerd’ were transformed to ‘Coloured’. Location responses were transformed into an address format that could be located automatically on Google Maps. E.g. ‘KZN DURBAN’ was transformed to ‘Durban, South Africa’. Each location was checked to ensure accuracy of plotting.

Univariate analysis. The only purely numerical data field was ‘age’ for which the mean and standard deviation were calculated. For the sake of highlighting the distribution of values, the minimum and maximum values, and the lower and upper quartiles were also calculated. Age data are also represented categorically, for the sake of comparison with data from other sources, which appears in age category format.

Simple response categorisation. Following transformation, responses to the open-ended questions about race and language were categorised according to classifications appearing in the most recent South African National Census (Statistics South Africa, 2012c),

for the sake of comparison. Certain responses were combined, to align with these. For example, on the question of race, 'Xhosa', 'Zulu', 'Black African', 'Black', 'Ndebele', 'Pedi', 'Tswana' were combined as 'Black'. Responses that fell outside the categories of the census were grouped together as 'Other'. The coded responses to these two questions and responses to all fixed-choice questions were tallied up and frequency percentages calculated.

Identifying recognised service providers. Two questions were included to better understand the use of telephone and face to face counselling services by those who reported using these respective services. These questions were "*Which helpline(s) did you call?*" and "*Who did you speak to (for face to face counselling)?*", and a wide range of responses were received. Responses were coded (by the primary coder), into commonly-appearing categories. For example, responses to the question: "*Who did you speak to (for face to face counselling)?*" were coded as 'doctor', 'psychologist', 'friend', 'family', etc. Responses to the question about telephone counselling were coded as 'Childline', 'loveLife', 'drug abuse line', 'police'. While some of these categories represented professionals or recognised providers of relevant services (e.g. 'doctor', 'psychologist', 'Childline'), others did not (e.g. 'family', 'police', 'ambulance', 'Cell C customer care line').

Analysis of sample representativeness. As part of understanding the characteristics of the sample making use of MXit-based counselling, goodness of fit chi-squared analysis was used to assess similarity of the sample with the general South African population. A standard p-value of 0.05 was used as a cut-off between significant and non-significant results.

Thematic analysis. There were five sets of responses that underwent a more thorough process of thematic analysis. The questions that produced these responses were: (a) "*Why have you not had face to face counselling before?*"; (b) "*What did you LIKE about counselling on MXit?*"; (c) "*What did you NOT like about counselling on MXit?*"; (d) "*Why have you not used MXit counselling before?*"; (e) "*Why have you not called a helpline before?*"

The process had three stages. First, I immersed myself in the data to establish a set of codes, for the purpose of categorically representing the data, to establish the main themes. Then, a second coder, trained by me, independently coded a random sample of approximately 10% of the data. Finally, the primary researcher coded the same sample before calculating the inter-rater reliability of the two sets of codes. If a satisfactory level of agreement was reached

about the codes, I proceeded to code the remaining 90% of the data. As Braun and Clarke (2006) suggest stating, I want to make it clear that the thematic analysis was carried out from a realist theoretical orientation, for the sake of reporting the experience of participants.

The main phase of thematic analysis was coding, for the sake of representing the data categorically, to establish the main themes. Codes were generated inductively, as seen in the data, rather than being based on any existing theory or prior knowledge. This seemed most appropriate due to the relative paucity of existing research and the investigatory nature of this research (Hsieh & Shannon, 2005). As suggested by Braun and Clarke (2006), a rich description of all aspects of the data set seemed most appropriate, given that this is an unexplored area of research.

The inductive process involved the primary researcher reading and re-reading the full set of responses several times to allow for immersion in the data, to get an overall grasp of embedded themes. Through this process, the researcher identified and listed key themes that appeared across responses. Single word labels were composed to represent each of these key themes and responses were read over once more. This time, the researcher assigned one or more labels to each response, selecting labels that best represented what was expressed in the response. On occasion that a response could not be adequately labelled, the response was marked as unclassified. Once all responses in the set had been passed over and labels applied, unclassified responses were examined collectively and additional descriptive themes were identified.

Label frequencies were counted up and sparsely populated categories were absorbed by other categories or combined to form new, inclusive labels. Responses marked with oft-occurring labels were re-examined and sub-themes identified. In these case(s), appropriate new labels were constructed and applied to add complexity to these common themes.

A document was put together listing each theme (and corresponding label), the distinguishing features of responses within this theme, and a few examples of typical responses. This document was then presented to a second coder along with a stratified sample of approximately 2% of the responses. Following a read-through of the document and an opportunity for clarification, the second coder (without guidance from the primary coder) applied the labels to the sample responses to test her understanding of the labels. If the

primary coder was satisfied with the labelling test, a larger, random sample of approximately 10% of responses was given to the second coder for labelling.

The primary coder independently labelled the same random sample and Cohen's Kappa was calculated to determine the inter-rater reliability between the two coders. Hruschka (2004) points out that though there are several categorisation arrangements, "...the criteria for identifying 'excellent' or 'almost perfect' agreement tend to be similar" (p. 313). Taking several proposed criteria into account (Hruschka et al., 2004; Landis & Koch, 1977), a cut-off value of 0.80 was established as a significant level of agreement between the two researchers. If this level of agreement was reached about the coding of the responses, the primary researcher proceeded to code the remaining 90% of the data.

Excluded from analysis. Responses to two additional open-ended questions, "*Where are you using MXit from right now?*" and "*My biggest worry in life right now...*" were not analysed due to a high number of responses that suggested misinterpretation of the question and a vastly heterogeneous set of responses respectively. The questions about cellular networks and numbers were simply for the sake of allocating a prize to the winner of the advertised incentive: a random draw to win an airtime voucher to the value of 50 South African Rands.

Ethical Considerations

The research proposal was submitted to the UCT Department of Psychology Research Ethics Committee with a request for waiver of handwritten consent, and a request for waiver of parental consent for minors. The reasons for these requests are detailed below, as are the consequent recommendations and actions taken. The potential risks and benefits to participants are also considered below.

Risks and benefits. The rights of the research participants was considered in the study by addressing the following basic principles which guide ethical research:

Autonomy. Research participants were free to leave the study at any point while still being entered into the incentivised contest, and were informed of this right at the outset. The confidentiality and anonymity of the participant was respected: their unique MXit handle¹⁴ is not contained in the data, nor are any personally identifiable details. Cell phone numbers

¹⁴ A 'handle' refers to a self-assigned online nickname.

were requested for payment of the incentivised reward, but these were deleted from the final dataset before analysis.

Nonmaleficence. Though a lack of non-verbal cues may have made it difficult to ensure indirectly if a participant was being harmed by the research, the research focuses on process and motivations of online counselling, not on the emotional content of counselling conversations or topics. I believe that the risk of harm to research participants was very small.

Beneficence. I am hoping that the results of the research will be used to improve the MIM-counselling process and the DAS service in particular.

Justice. This benefit also speaks of the justice of the research – the research participants were drawn from the population who stand to benefit directly as a result of the research.

Waiver of handwritten consent. Given the setting of the research, the process involved with gaining handwritten consent for the research might have severely jeopardised the study, as it would be a break from the setting of the online chat and would have required confidential information about the participants (name and postal address) to be revealed. The request was granted by the UCT Department of Psychology Research Ethics Committee, with the suggestion that consent be received through the acceptance of pre-questionnaire consent information (see Appendix A).

Waiver of parental consent for minors. For the sake of validity, it was important to include minors in the study population, as they make up a large component of the MXit user base (MXit Lifestyle, 2012; MXit Lifestyle, 2013). The National Health Act of 2004 (Republic of South Africa, 2004) specifies the requirement of consent from a parent or legal guardian, as well as the requirement for ministerial consent for non-therapeutic research involving minors. At the time of proposing and undertaking this research, there was uncertainty about whether and how to include minors in research in general, this study included.

This issue is complicated further by the research environment. The anonymous nature of the medium is thought to be a central aspect of the use of online counselling, including MXit-based counselling (Haberstroh et al., 2007; Leibert et al., 2006). Requesting more

personal information from minors such as contact details for one's parent or legal guardian, would have compromised that aspect of an individual's use of the service.

This problem was considered by the UCT Health Science Faculty Human Research Ethics Committee and chair of the UCT Ethics Research committee who suggested that opinions be canvassed from an appropriately representative group of parents as to their views on letting adolescents decide unassisted whether to participate in such research.

It proved to be impractical to recruit parents of MXit-based counselling service users specifically, so the researcher recruited parents (with children of any age) to complete a brief Parents Poll (Appendix B). This poll was available as an online survey and was widely advertised on parenting forums, websites and various social media streams. The poll was completed by twenty six parents from around South Africa. A paper version was also available and was completed by five parents from different areas of Cape Town.

Of the thirty one responses gathered, 81% of parents responded to *"If you had adolescent children, would you want them to be able to access counselling services via MXit without your consent?"* in the affirmative. The responses to *"If they WERE accessing counselling services via their mobile phone, would you allow your adolescent children to decide for themselves if they wished to participate in research?"* were 71% positive.

Tabulated results of the Parents Questionnaire can be found in Appendix C. It is worth noting that of the seven negative responses to the second question, four of those respondents showed opposition to the idea of online counselling for adolescents in their responses to the first question.

Based on the '(less than) minimal risk' to participants (A. Pope, personal communication, 4 May 2012) and the results of the Parents Questionnaire, the chair of the UCT Ethics Research committee decided that there was adequate factual evidence to support the decision to allow adolescent participants to choose to participate without parental permission. The requirement of parental consent for minors aged between 15 and 17 years of age was therefore waived, while it was recommended that participants aged 14 years (and under) be excluded from the research population altogether.

Results

Of the study population following exclusion of under-age participants ($N = 2853$), there was a sample of 568 who responded positively to “*Have you ever had counselling on MXit?*” representing 19.91% of the total study population. This group, hereafter referred to as MXit-based Counselling Service Users (abbreviated to MBCSUs), is the main focus of the results chapter. What follows below is a description of the demographic characteristics of this group, including Age, Sex, Race, First Language and details about Employment or Student status.

Where relevant, demographic characteristics of MBCSUs have been compared to the general population statistics of South Africa, according to “Mid-year population estimates, 2011” (Statistics South Africa, 2012c). Language statistics come from “Census 2011 – Census in brief” (Statistics South Africa, 2012a). Unemployment statistics were from “Quarterly Labour Force Survey: Quarter 2 (April to June), 2012: Press Statement” (Statistics South Africa, 2012).

Following this, is a report of MBCSU’s use (and non-use) of telephone and face-to-face counselling, including reasons for non-use, as well as their positive and negative comments about MXit-based counselling. The reasons for non-use of MXit-based counselling by the remainder of the study population is also reported on.

Where relevant, results are discussed in terms of association with relevant findings from existing literature, while further consideration of particularly noteworthy aspects of the results can be found in the discussion chapter.

Demographic Characteristics of MXit-Based Counselling Service Users

Age. The histogram below (Figure 3), highlights the centrality of the data around the mean age of 20.17 ($sd = 4.97$). The 25% and 75% quartiles are 17.75 and 21 respectively, and the minimum and maximum values are 15 and 65, although there were just six respondents aged 40 or older. The most frequently reported age was 18 years.

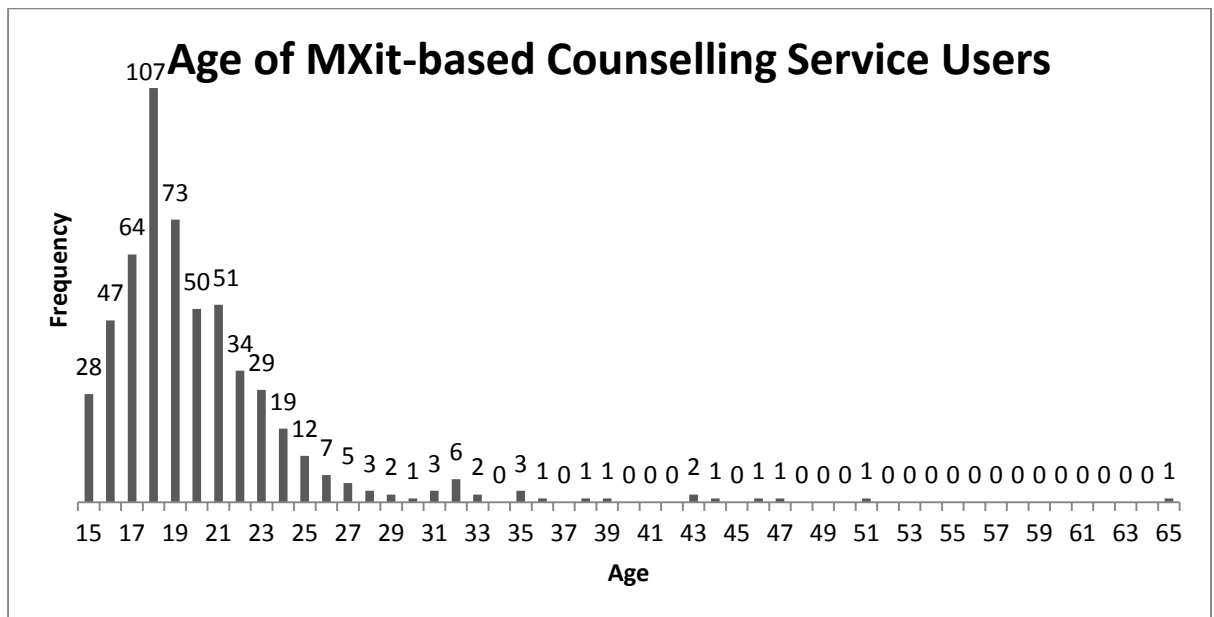


Figure 3 – Age distribution of MXit-based counselling service users

The ages of MBCSUs are grouped in sectors and shown side-by-side with data from the Mid-year Population Estimates from July 2011 (Statistics South Africa, 2012c) in Figure 4 below:

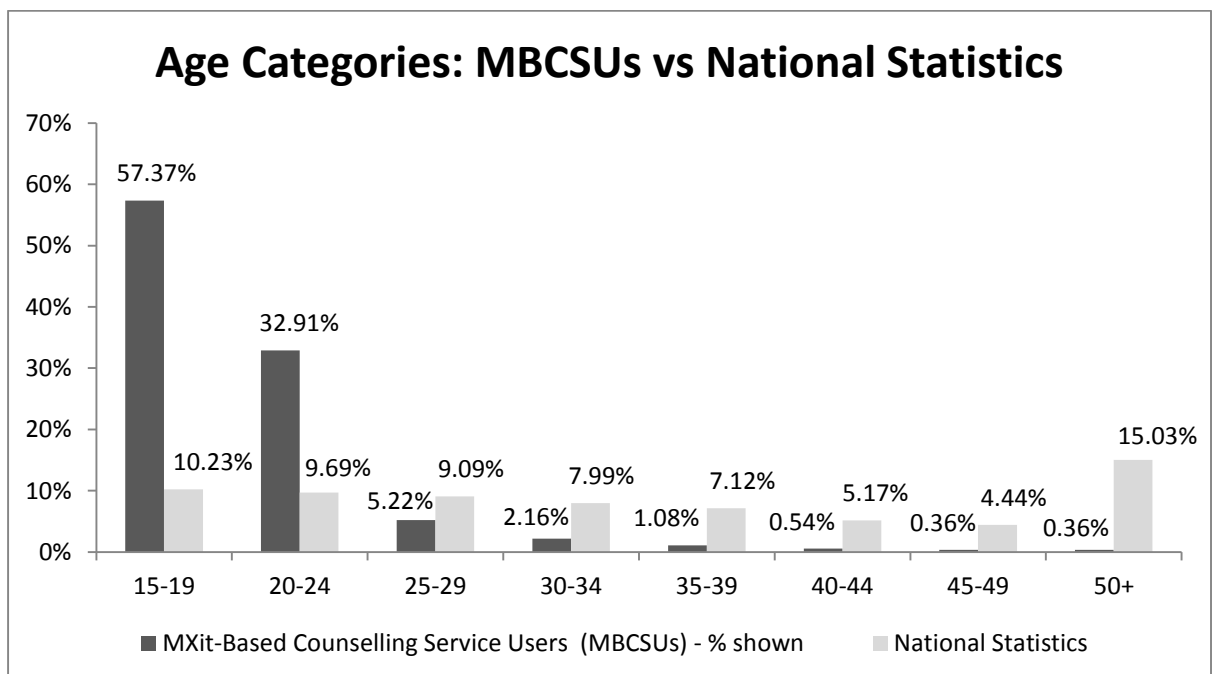


Figure 4 – Age categories: MXit-based counselling service users vs. national statistics

As can be seen, most MBCSUs were in the category of 15-19 years old (57.37%), followed by 20 – 24 years old (32.91%), in significantly different proportions to the National

Statistics, χ^2 (7, N = 556) = 1115.83, $p < .001$. The youthfulness of MBCSUs is considered in the discussion chapter below.

Sex. Females accounted for 305 (53.79%) of the 567 MBCSUs with males making up the remaining 262 responses (46.21%). The Mid-year Population Estimates from July 2011 (Statistics South Africa, 2012c), denote 52.42% of the population female and 47.58% male. The goodness of fit was found to be significant, χ^2 (1, N = 567) = .43, $p = .51$. This central split is similar to the split in all MXit-users in South Africa (Mxit, 2014), while previous research (when gender was measured) reports females as the majority of MXit-based counselling service users (Childline South Africa, 2011; Childline South Africa, 2012; Nembaware et al., 2011; RLabs, 2010) and online counselling clients (DuBois, 2004; L. Murphy et al., 2011), although the latter studies are somewhat limited by small sample sizes.

Location. The 546 non-erroneous responses to the question of location were transformed to a recognisable address format and automatically plotted to a map of South Africa using Google Fusion Tables to show the spread of MBCSUs around the country. As can be seen from Figure 5 below, there was a concentration of service users around South Africa's major urban hubs of Cape Town, Durban and the Gauteng province. Just two responses placed service users outside of South Africa; in India and Zimbabwe. See Appendix D for a larger map of MBCSU locations.

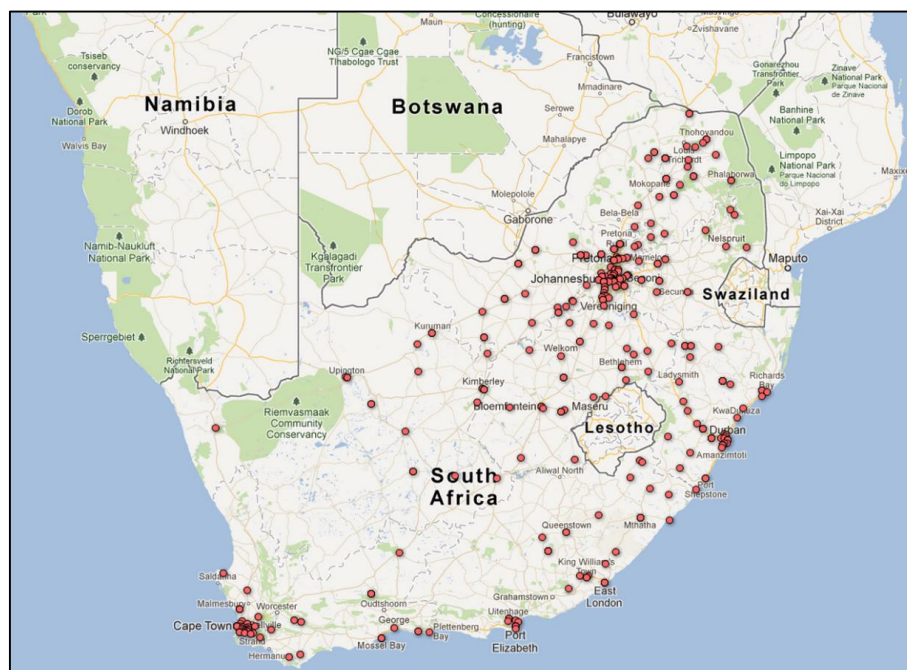


Figure 5 – Locations of MXit-based counselling service users

Race. There were 61 responses that were uninterpretable leaving 507 responses to the question of race. Racial representations are shown in Figure 6 below, alongside data from the 2011 Mid-year Population Estimates (Statistics South Africa, 2012c), which did not feature an ‘other’ category. The goodness of fit was calculated with the ‘other’ values excluded, and was found to be non-significant, $\chi^2 (3, N = 492) = 47.41, p < .001$.

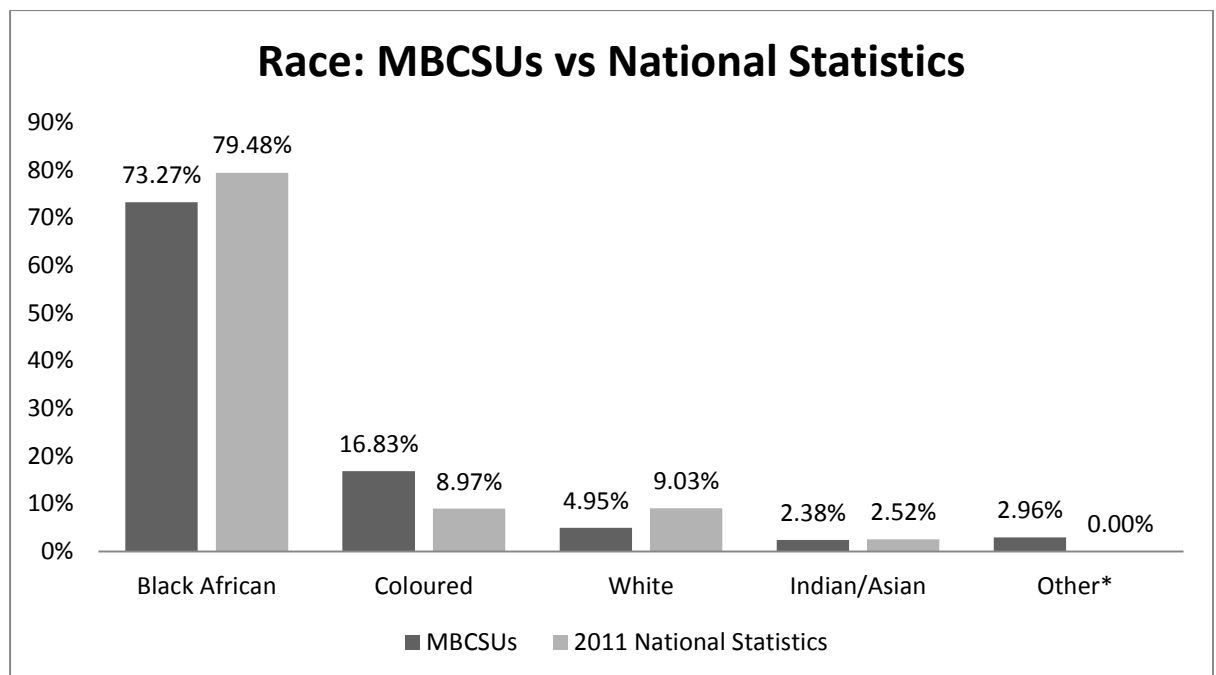


Figure 6 – Race: MXit-based counselling service users vs. national statistics

First language. Languages were categorised according to the eleven official languages of South Africa, with the addition of another category for other languages. The official languages were represented in 98.82% of responses. The distribution is illustrated in Figure 7 below, alongside language statistics from “Census 2011 – Census in brief” (Statistics South Africa, 2012a).

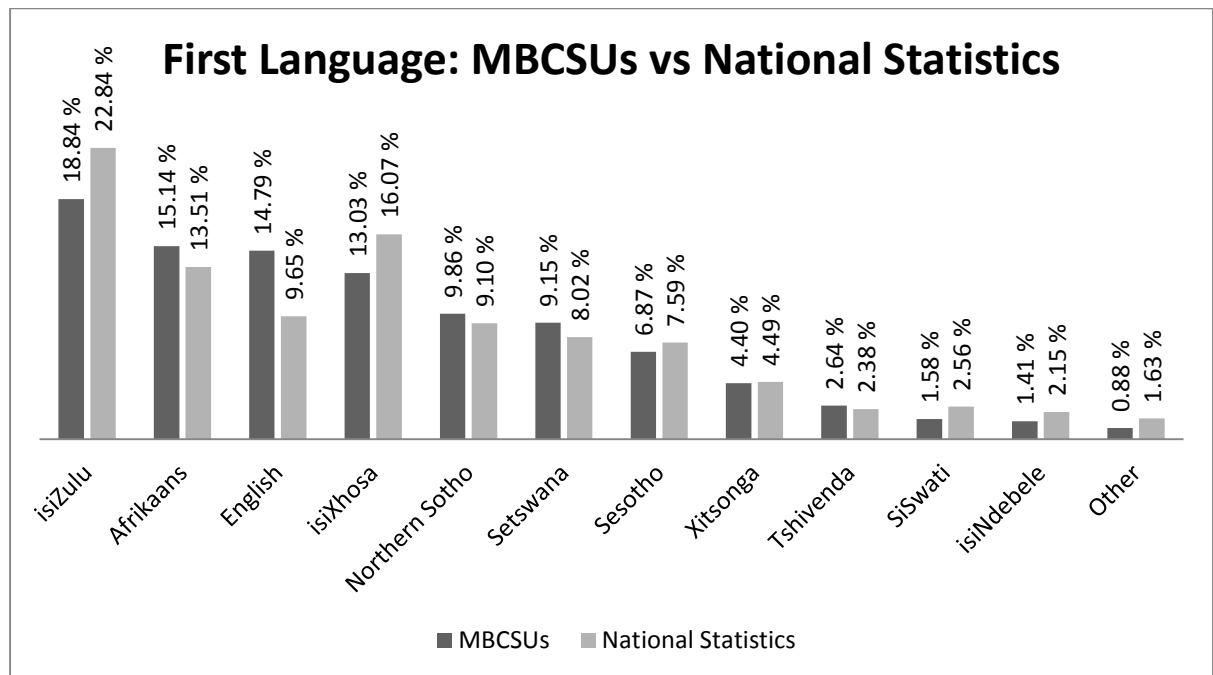


Figure 7 - First language: MXit-based counselling service users vs. national statistics

As can be seen from the distribution in Figure 7 above, isiZulu and isiXhosa are underrepresented while English and Afrikaans are overrepresented. The goodness of fit statistic, $\chi^2 (11, N = 560) = 31.64, p < .001$, indicates significant difference between the language distributions of the MBCSUs and national language statistics. The fact that counselling is offered almost exclusively in English is reflected upon in the discussion section below.

Employment or student status. The fixed-choice question about current employment or student status had six options. The distribution of responses for the MXit-based Counselling Service Users ($n = 568$) is illustrated in the pie chart below, labelled Figure 8.

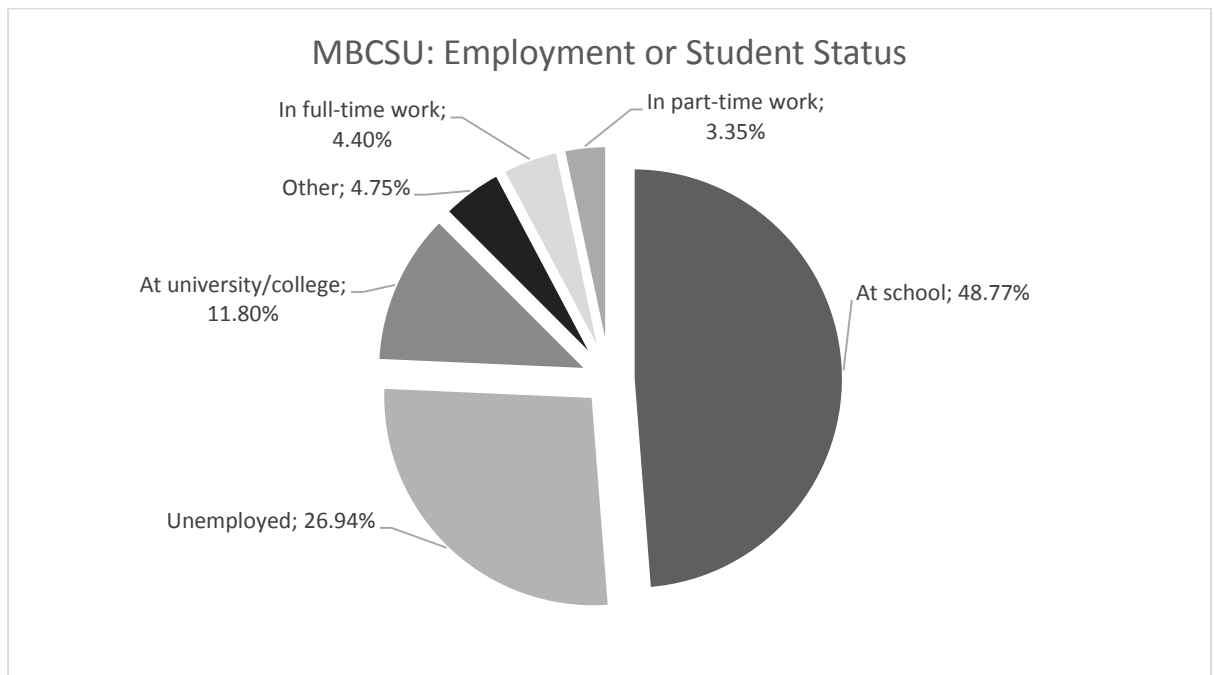


Figure 8 - Employment or student status: MXit-based counselling service users

School-going age vs non-school going age. Due to fact that such a large majority of the sample were of a school-going age, it was decided to divide the sample to get a better understanding of the unemployment levels of respondents aged 19 years and over (denoted as '18+') ($n = 310$), and the school-going levels of respondents aged 15-18 ($n = 246$). These are illustrated in Figure 9 and Figure 10 below:

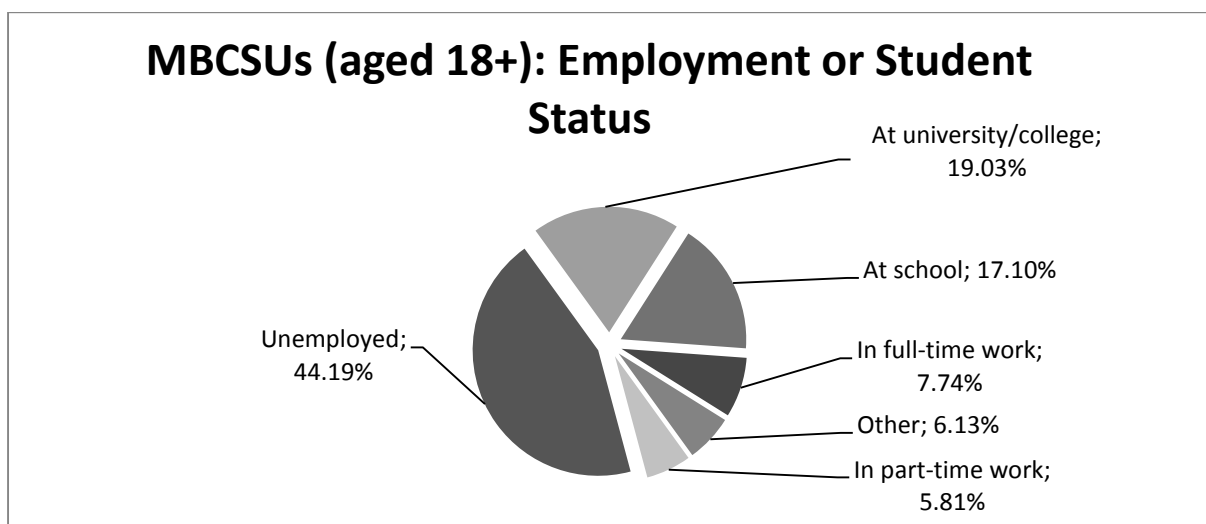


Figure 9 - Employment or student status: MXit-based counselling service users (aged 18+)

This rate of unemployment (44.19%) reported by MBCSUs aged 19 years and over is higher than the expanded unemployment rate (37.80%) reported by Statistics South Africa

(Statistics South Africa, 2012b), which includes discouraged workers. The fact that such a vast number of unemployed individuals are able to access MXit-based counselling, speaks of an important positive aspect of the medium, its affordability. The capacity of the medium to circumvent this and other treatment barriers is expanded upon in the discussion section of the paper.

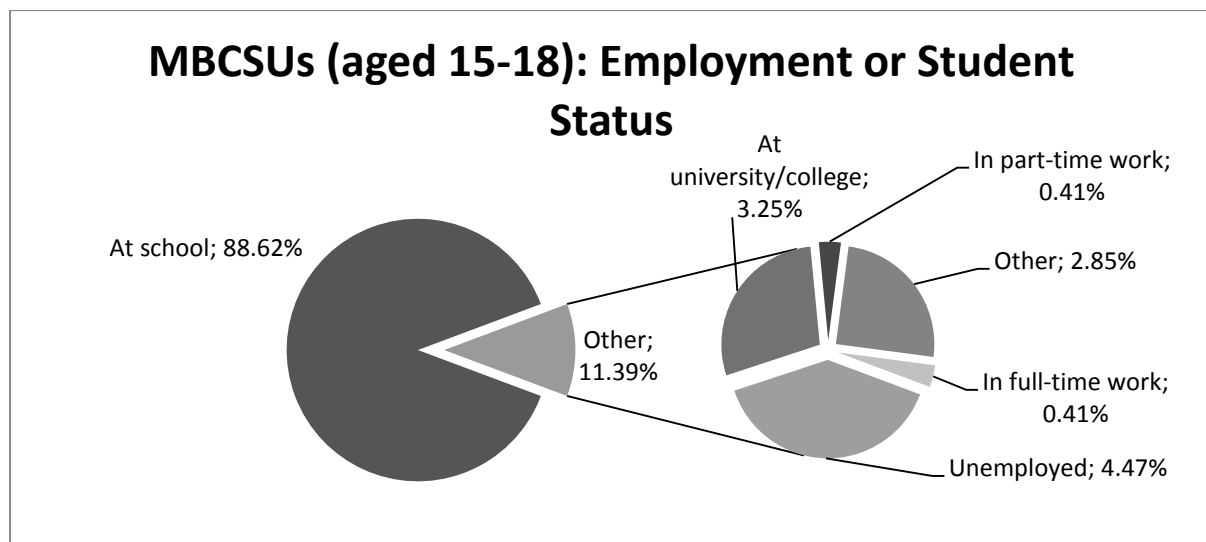


Figure 10 - Employment or student status: MXit-based counselling service users (aged 15 – 18)

There is no obvious manner in which to interpret the statistics of *employment or student status* as reported by MBCSUs aged between 15 and 18 years old (inclusive). It is possible that an individual can be ‘at school’ AND ‘in part-time work’, or ‘at school’ AND ‘unemployed’, yet the questionnaire limited responses to a single option. Previous research has found that approximately a fifth of 17-year old South Africans are not attending any type of educational institution whatsoever (Kreutzer, 2009). In comparison with that statistic, it appears that MXit-based counselling service users are more likely to be receiving an education.

Use of Counselling Modalities

Usage statistics of different counselling modalities are based on the questions: (a) “Have you ever had counselling on MXit?” ; (b) “Have you ever had counselling in person (face to face)?” ; (c) “Have you ever phoned a helpline?”. Positive responses to the latter two questions were followed-up with additional questions to understand which service providers or individuals provided counselling. These responses were then coded to differentiate between recognised ‘paraprofessionals’ and family members, friends and other

unspecified individuals. For further details, see ‘Coding of paraprofessionals’ in the data analysis section. A discussion of analysis about the use (and non-use) of these three counselling modalities are detailed below. Where appropriate, figures are used to illustrate findings.

Use of telephone counselling. What follows is a description of usage statistics relating to the use (and non-use) of telephone counselling for Mxit-based Counselling Service Users (MBCSUs) as well as the reasons for non-use.

Usage statistics. Of the 538 responses from MBCSUs, 161 (29.93%) specified that they phoned a helpline, 377 (70.07%) said that they had not. Of the affirmative responses, 101 (68.71%) of the non-blank responses to the follow-up question specified a telephone counselling service provider, such as loveLife, Childline, the National HIV/AIDS Helpline or the type of provider, i.e. “drug abuse helpline”. Six participants mentioned more than one service provider. The remaining 54 (31.07%) responses covered calls made for practical assistance (eg; police, cellular phone networks or family) rather than emotional support or counselling, or were not interpretable. For example: (a) “cell c helpline” ; (b) “ambulance” ; (c) “my 4rnd”[my friend]¹⁵; (d) “1”. The misinterpretation of the question may be due in part to the use of the term helpline, which is commonly used by the cellular phone networks to advertise their customer assistance support services.

Taking the responses to the follow-up question into account, it is more appropriate to say that of the 538 responses from MBC-SUS, 101 (18.77%) suggest use of telephone counselling provided by a service provider. This is illustrated in Figure 11 below:

¹⁵ The response has been translated from Mxit-lingo for the reader’s convenience

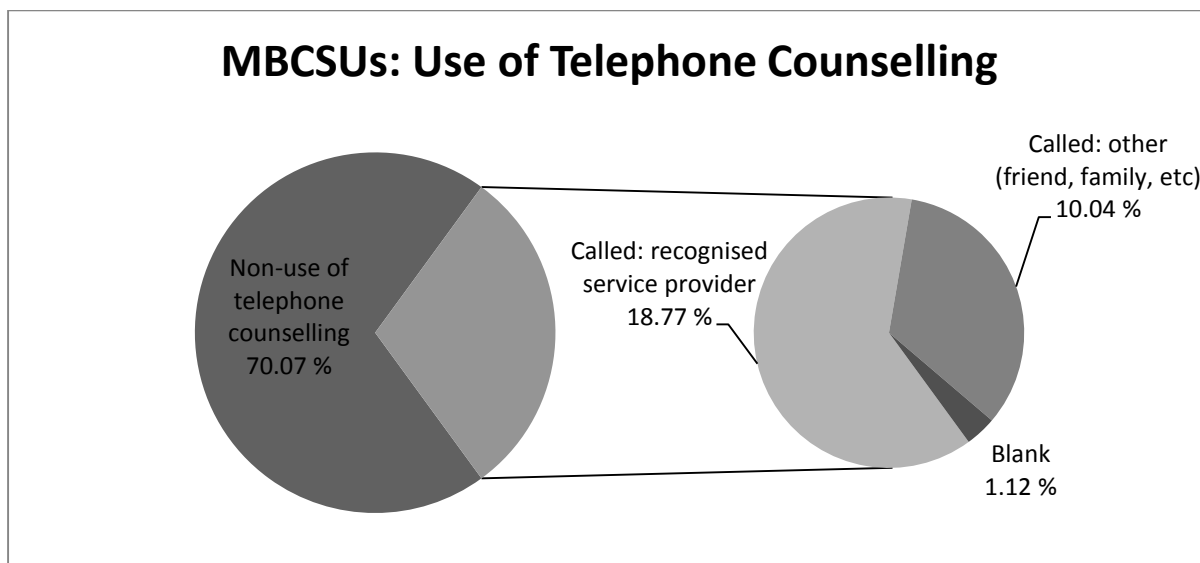


Figure 11 – Use of telephone counselling: MXit-based counselling service users

Use of recognised telephone counselling service providers. Of the 107 total indications of recognised telephone counselling service provider, the three most mentioned were Childline (43 mentions, 40.19%), the National HIV/AIDS Helpline (14, 13.08%) and ‘thethaJunction’, the loveLife National Helpline (16, 14.95%). Other service providers mentioned were SADAG (South African Depression & Anxiety Group) and SANCA (South African National Council on Alcoholism and Drug Dependence).

Reasons for non-use of telephone counselling. There were 308 interpretable responses to the question “*Why have you not called a helpline before?*” (after 19 blank and 40 erroneous responses were excluded). Of these, 172 participants (55.84%) indicated that they had no need for telephone counselling. Within this group, 16 (9.30% of the responses to this question) added that their needs were being adequately met by MXit-based counselling.

Another large set of responses related to barriers to accessing telephone counselling, making up 63 (20.45%) of total responses to this question. Within this theme of ‘access barriers’, a lack of airtime (26 responses, 41.28%) and a lack of contact numbers for telephone helplines (24, 38.1%) comprised the vast majority of responses, and there was also a mention of not having a landline.

Another major response set (54 responses, 17.53%) includes responses that relate more directly to personal or emotional aspects of the respondent. These include feelings of

insecurity, fear, pride or shame. Of these feelings, a (mainly unspecified) fear made up the majority of this response set with 28 mentions (51.85%).

The remaining responses (not classified in these three major groups) related to an unspecified dislike of the medium, concern about being overheard and the lack of time to make the call. These reasons are displayed in Figure 12 below. A second coder was involved in the process of thematic analysis and the inter-rater reliability, as measured by Cohen's Kappa was .89 ($p < .001$, 95% CI: [.78, .99], $k_{\max} = .89$) indicating "almost perfect agreement" (Landis & Koch, 1977, p.165) (Landis, J.R. 1977).

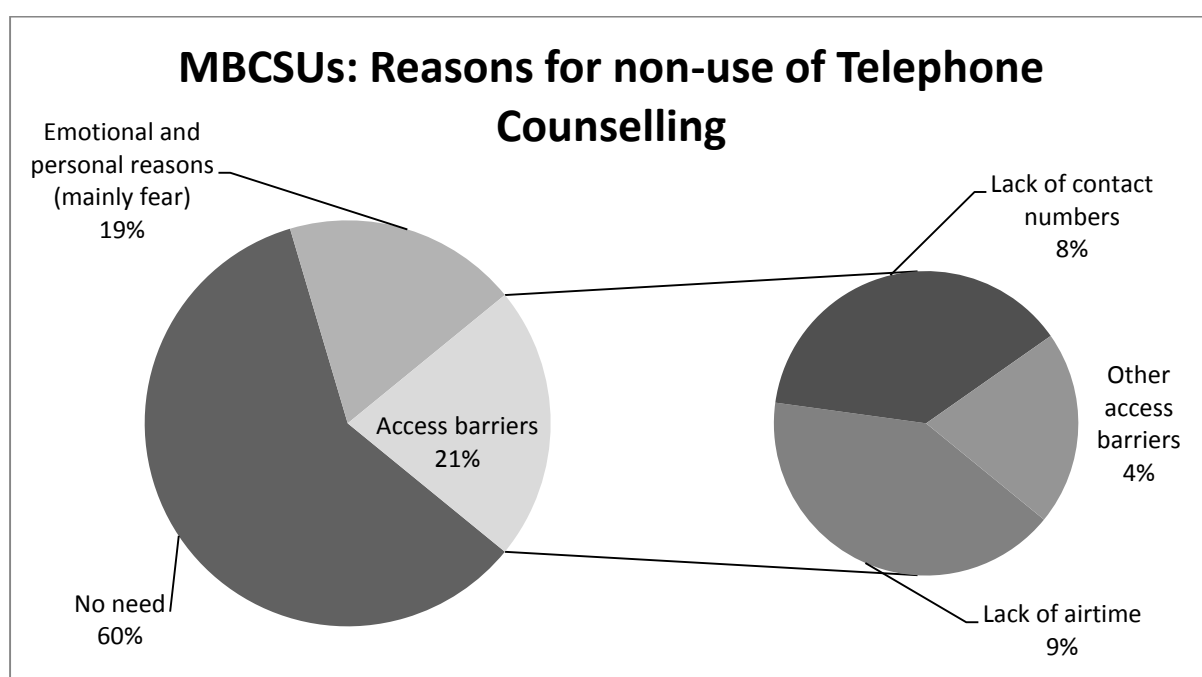


Figure 12 - Reasons for non-use of telephone counselling: MXit-based counselling service users

Use of face to face counselling. What follows is a description of usage statistics relating to the use (and non-use) of face to face counselling for MXit-based Counselling Service Users (MBCSUs) as well as the reasons for non-use.

Usage statistics. Based on responses to the dichotomous-choice question, "Have you ever had counselling in person (face to face)?" 206 (36.27%) MBCSUs identified themselves as having had face to face counselling, and 362 (63.73%) said that they had not. The next question for the 206 that responded in the affirmative was "Who did you speak to (for face to face counselling)?" which generated a wide range of responses. These were coded, to

separate trained ‘para-professionals’ and recognised service providers from less recognised sources of face to face (FtF) help such as friends, family, teachers and colleagues.

Analysis shows that for 83 (40.29%) of the 206 participants who responded positively, counselling was in fact provided by recognised service providers and ‘paraprofessionals’. Family, friends or teachers were represented 41 times (19.90%), unknown individuals, (e.g. “Mr Ndlovu”), 39 times (18.93%) and the remaining 43 responses (20.86%) were uninterpretable, erroneous or blank. This is illustrated in Figure 13 below:

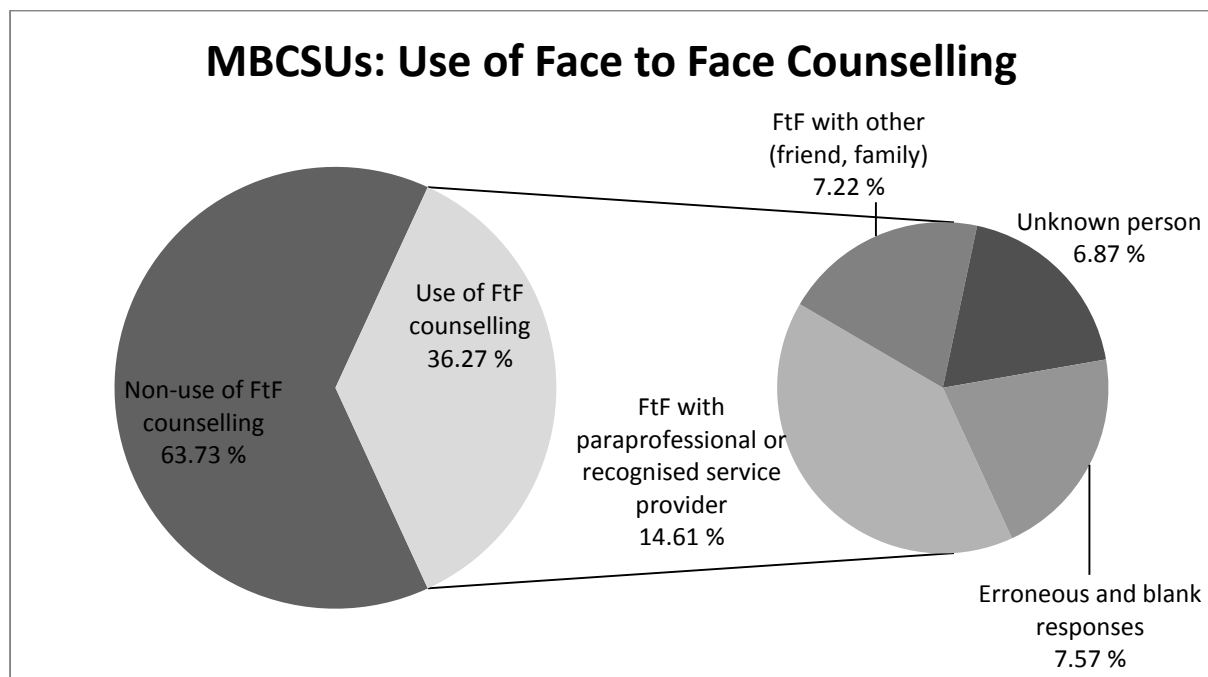


Figure 13 – Use of face to face counselling: MXit-based counselling service users

So, this second question helped identify that just 83 of 538, (just 14.61%) of respondents had in fact had face to face counselling with a recognised service provider or ‘paraprofessional’. It is worth adding that 39 responses refer to an unknown person, who may or may not be considered a ‘paraprofessional’. This reflects a potential 6.87% difference, if these responses were better understood.

Face to face counselling provision. Of the 124 non-erroneous responses that didn’t refer to an unknown person, the most frequent response (33 responses, 26.61%) indicated that face to face counselling took place with a counsellor. Other popular responses were friends (24, 19.35%) and family (12, 9.68%). Otherwise, doctors and social workers proved to be equally as likely to have provided face to face counselling with 12 responses (9.68%) each.

Psychologists (8, 6.45%), psychiatrists (4, 3.23%), religious leaders (5, 4.03%), nurses (6, 4.84%) and teachers (5, 4.03%) make up the rest of the responses along with just three mentions (2.42%) of organisations that provide face to face counselling.

Reasons for non-use of face to face counselling. There were 362 negative answers to the question “*Have you ever had counselling in person (face to face)?*” which prompted the question “*Why have you not had face to face counselling before?*” This question produced 47 (12.98%) erroneous and blank responses, leaving 315 responses to be coded, which was done with “almost perfect” (Landis & Koch, 1977) inter-rater reliability ($K = .81$, $p < .001$, 95% CI: [.65, .96], $k_{\max} = .89$).

Of these, 95 participants (30.16%) indicated that they had no need for face to face counselling. A variety of personal and emotional reasons account for 92 (29.21%) explanations for the non-use of face to face counselling. Within this theme, unspecified fear is mentioned in just less than half of the responses (43, 46.74%) with shyness and embarrassment also highly represented. When a reason was specified, common responses include a fear of emotional vulnerability in front of a stranger, a fear of judgement, and low self-esteem. Other responses in this category include concerns about anonymity and the difficulty in keeping a visit to the counsellor secret. E.g.; “Because when you talk to people face to face people here are gossiping” (Respondent ID 2068).

Another popular theme that appeared in 76 responses (24.13%) relate to various barriers in accessing face to face counselling. These barriers include prohibitive cost, inaccessible locations and a lack of opportunity, knowledge or time. E.g.; “My parent are not working so i didn't get money to go ther” (Respondent ID 825).

Use of MXit-based counselling. What follows is a description of usage statistics and experiences relating to the use (and non-use) of MXit-based counselling, as well as the reasons for non-use of the service.

Usage statistics. Of the study population following exclusion of under-age participants ($N = 2853$), there was a sample of 568 who responded positively to “*Have you ever had counselling on MXit?*” representing 19.91% of the total study population. There were 242 blank responses to this question. Because this question offered a dichotomous-choice response set, it indicates that the 242 respondents (representing 8.48% of the sample population) had exited the questionnaire before this question. This group of MXit-based

counselling service users (MBCSUs) were asked what they liked and didn't like about counselling on MXit. The group that indicated that they had not had counselling on MXit ($n = 2285$), were asked for reasons for their non-use of MXit-based counselling.

Positive aspects of MXit-based counselling. The open-ended question “*What do you LIKE about counselling on MXit?*” asked about the benefits of MXit-based counselling and produced a set of qualitative responses which was analysed thematically by two raters. The inter-rater reliability, as measured by Cohen's Kappa was .83 ($p < .001$, 95% CI: [.73, .93], $k_{\max} = .87$) indicating “almost perfect agreement” (Landis & Koch, 1977). Theme counts are displayed in Table 1 below.

Table 1			
<i>Positive Aspects of MXit-based Counselling ($n_{\text{themes}} = 509$)</i>			
Theme	Sub-theme	Count	Percentage
<u>Safety</u>			
	Anonymity	55	10.81%
	Not face to face	50	9.82%
	Private	21	4.13%
	Confidential	16	3.14%
	Comfortable	15	2.95%
	Non-judgmental	13	2.55%
	Trustworthy	5	0.98%
	Safe	5	0.98%
	Secure	2	0.39%
Total		155	30.45%
<u>Disinhibition</u>			
	Can be open	92	18.07%
	Can be honest	5	0.98%
Total		97	19.05%
<u>Convenience</u>			
	Easy to use	21	4.13%
	Affordable	13	2.55%
	Fast	9	1.77%

Convenient	7	1.38%
Timely	7	1.38%
Easy to access	4	0.79%
Comfort with the medium	4	0.79%
Total	65	12.77%
<u>Supportive</u>		
Helpful	30	5.89%
Informative	19	3.73%
Advisory	37	7.37%
Total	48	9.43%
<u>Other</u>		
Positive appraisal	51	10.02%
Negative appraisal	14	2.75%
Everything	14	2.75%
Total	79	15.52%

Table 1 - Positive Aspects of MXit-based Counselling

As can be seen from Table 1, the theme of ‘safety’ was especially prevalent, with more than a quarter of respondents (155, 30.45%) including a reference to this theme. Mentioned in this category were responses that referred to the anonymity, privacy or confidentiality offered by the medium, and the resulting feelings of trust, comfort, security and/or safety. For example

- “You get to talk to someone who is not in front of you and you don't get nervous or scared cause it's a stranger you don't even see” (Respondent ID 3021),
- “Your parents won't know” (Respondent ID 1226), and
- “It is discreet, i feel safe and comfortable. And i mention each and everything that bothers me without hiding anything” (Respondent ID 882)

As can be seen in the response from Respondent ID 3021 above, numerous responses make specific reference to the fact that Mxit-based counselling is NOT face to face counselling. As shown below, this was also mentioned as a negative aspect of MXit-based counselling. This complementary view is explored further in the discussion section of this paper.

The responses in this section often overlapped with another popular category, one which made reference to the benefit of being able to be open, honest and forthcoming about one's situation or feelings. There were 97 responses that carried this theme, accounting for 19.05% of responses, such as: "It because u say everythings that hurt you deeply inside" (Respondent ID 684). This ability to be more open over the internet has been described by Suler (2004) as 'the online disinhibition effect' (p. 321) and has various aspects, which are discussed in the discussion section.

A large set of responses (65, 12.77%) spoke of the convenience and ease in accessing counselling via MXit. Included in this theme were responses that mention the familiarity of the medium, the low cost of using the service, the convenience of the medium, and the portability of the service. For example

- "It doesn't cost 2 much,u dnt dnt have 2 take a walk or go sumwer 4 counsellin u get direct help" [It doesn't cost too much, you don't have to take a walk or go somewhere for counselling you get direct help] (Respondent ID 1224),
- "I can cry and write at the same time" (Respondent ID 1510), and
- "I cn tel sme1 my problems at hme" [I can tell someone my problems at home] (Respondent ID 1575)

Several responses indicated that what was liked about MXit-based counselling was the provision of information and advice, for example: "I liked the way they made me understand about depression n stress n how to deal with it,since im going through those signs myself i have handled it perfectly" (Respondent ID 4194)

A slightly smaller category of responses spoke of the positive emotional benefits of MXit-based counselling, including renewed feelings of confidence, hope, happiness and courage, and the amelioration of stress. For example: "It made a person to feel better and encourages,give strengh when u feel down" (Respondent ID 1449)

Finally, a collection of responses referred to various aspects of the counsellors' positive behaviour such as professionalism, helpfulness, patience, understanding and friendliness.

Negative aspects of Mxit-based counselling. After excluding blank and problem entries, there were 362 labels applied to responses to the question "*What do you NOT LIKE*

about counselling on MXit? ” The label frequencies and themes are displayed in Table 2 below:

Table 2			
<i>Negative Aspects of MXit-based Counselling ($n_{\text{themes}} = 362$)</i>			
Theme	Sub-theme	Count	Percentage
<u>Actually Positive</u>			
	Nothing	169	46.69%
	Enjoyable	22	6.08%
Total		191	52.76%
<u>Unsafe</u>			
	Anonymity of counsellors	22	6.08%
	Concerns about confidentiality	16	4.42%
	Dishonesty	11	3.04%
	Feeling judged	9	2.49%
Total		58	16.02%
<u>Service related</u>			
	Limited service times	27	7.46%
	Slow service	22	6.08%
	Network problems	4	1.10%
	Secure	2	0.39%
Total		55	15.19%
<u>Specific Aspects</u>			
	It's not face to face	36	9.94%
	Too many questions	9	2.49%
	Different counsellors each time	4	3.14%
	Lack of professionalism	3	0.83%
Total		52	14.36%

<u>Other</u>		
Unsure	5	1.38%
Everything	3	0.83%
Total	8	2.21%

Table 2 - Negative Aspects of Mxit-based Counselling

More than half of the responses (191, 52.76%) suggested that there was nothing that was not liked about counselling on Mxit, and that it was in fact, a solely positive experience. There was a fairly wide assortment of responses from the rest of the respondents, which fell under are four main themes, neither of which is especially dominant:

Roughly 10% (of total responses) mention the lack of face to face interaction as a shortcoming of Mxit-based counselling. Though most responses are no more specific than this, the following drawbacks are mentioned:

- the inability for communication via visual cues
- a lack of potential for an offer of physical comfort
- a difficulty in (emotional) expression through purely written channels

This concept was succinctly captured in the response: “Because a person who you are speakn to can not see how r facial expression's are for example whn you're sad or crying tht person cannot see how emotional you are” [Because a person who you are speaking to cannot see how your facial expressions are. For example, when you're sad or crying, that person cannot see how emotional you are] (Respondent ID 3898).

Related to the lack of face to face contact, another theme covered expressions of doubt about the trustworthiness of the counsellor and counselling service. Responses labelled with this theme mention a perceived lack of safety about sharing personal details about one's life, a fear of judgement and an insecurity about not knowing who the person on the other end of the chat actually is. For example: “I dont like being counselled on mxit because sometimes i wonder who is actually the counsellor and i dont seem to get an answer.” (Respondent ID 3381).

A further theme covers responses that detail problems that impede access to the service, including: (a) network problems; (b) limited hours of availability; (c) slow response times. For example: “At this point we need a counselour 24/7, and my problems dont have a

calender or watch” (Respondent ID 1510). Within this theme, the limited times of availability and slow response times were particularly dominant in responses.

Questionable counselling style and method made up another set of responses. With the view offered that counsellors asked too many questions or offered confusing advice or responses. For example: “When u want 2 knw sumthng n they give u these details dat u dnt even undastand” [When you want to know something and they give you these details that you don’t even understand] (Respondent ID 3824).

All of these themes are discussed further in the discussion section, in relation to previous online counselling research and relevant literature. The inter-rater reliability for this set of codes was indicative of “almost perfect agreement” (Landis & Koch, 1977). The Kappa value was .90 ($p < .001$, 95% CI: [.81, .98], $k_{\max} = .96$).

Reasons for non-use of Mxit-based counselling. A total of 2285 respondents (who had indicated that they had not used MXit-based counselling) were asked “*Why have you not used MXit counselling before?*” The vast majority (1052, 64.98%) indicated that they were not aware that MXit-based counselling was available. An additional 280 responses, representing 17.29%, indicated that they had never had a need for it.

Though no other themes were represented particularly well in terms of quantity, there were a few distinct tracts covered. A particular theme expressed worry about safety. Included in this were concerns about being judged or gossiped about, fear about one’s privacy and confidentiality being breached, and other, less specific expressions of mistrust and fear.

Another set of responses expressed doubt about the effectiveness of the usefulness of MXit-based counselling and/or a preference for face to face counselling. “I prefer speaking to someone who will listen and at least look as if they care not a social networking counselor who might not even give me full answers” (Respondent ID 3887).

A small set of responses show the individual to feel too shy, nervous, ashamed or embarrassed. In many cases, the response suggested that this feeling would also limit their use of other counselling modalities. For example, “*I am a very quiet person an im used to keep things inside an for myself*” [I am a very quiet person and I’m used to keeping things inside and for myself] (Respondent ID 1546).

The Kappa value was .81 ($p < .001$, 95% CI: [.73, .89], $k_{\max} = .89$) for this coding process, falling within the range considered by Landis and Koch (1977) to indicate “almost perfect agreement”.

Use of multiple counselling modalities. After limiting face to face and telephone counselling use to interactions with paraprofessionals and recognised service providers, Table 3 (below) indicates the use of different counselling modalities by the group of MXit-based Counselling Service Users (MBCSUs) and Non-MXit-based Counselling Service Users (non-MBCSUs).

Table 3 <i>Use of Counselling Modalities: MXit-based Counselling Service Users (MBCSUs) vs. Non-MXit-based Counselling Service Users (Non-MBCSUs)</i>					
Groups	No counselling	MXit-based Counselling	Telephone Counselling	Face to Face Counselling	Telephone Counselling AND Face to Face Counselling
Non-MBCSUs (n = 2225)	879 (42.57%)	0 (0.00%)	315 (15.25%)	377 (18.26%)	86 (4.16%)
MBCSUs (n = 538)	0 (0.00%)	538 (100%)	101 (18.77%)	83 (14.61%)	27 (5.02%)

Note: Blank responses to fixed-choice questions represented an incomplete questionnaire. These were removed from the dataset for these calculations; hence sample sizes are reduced.

Table 3 - Use of Counselling Modalities: MXit-based Counselling Service Users (MBCSUs) vs. Non-MXit-based Counselling Service Users (Non-MBCSUs)

From the data displayed in Table 3, MBSCUs can be seen to be more likely to have accessed telephone counselling than non-MBCSUs, but not face-to-face counselling. The difference between MBCSUs and Non-MBCSUs when comparing their usage of other modalities (and both other modalities) is significant, $\chi^2 (2, N = 538) = 13.97$, $p < .005$.

Additional Findings

Mobile phone ownership. Amongst the MBCSU ($n = 567$, 1 blank response), 524 (92.42%) responded as owning a phone, with the other 43 (7.58%) said that they share a phone. Previous research by Tino Kreutzer has explored the notion of phone ‘owners’ and ‘co-users’, with ‘co-users’ defined as individuals who do not own a mobile phone themselves (Kreutzer, 2009). In his research with 411 grade 11 students at different schools in low-income areas around Cape Town, 77% of his respondents said that they owned a phone, 18% were ‘co-users’, 4% said that used someone else’s phone but had their own SIM card, and 1% said that they had recently had their phone stolen or didn’t use a mobile phone. Kreutzer (2009) also found that the most striking difference between the ‘owners’ and ‘co-users’ groups was in their personal communication, with ‘co-users’ using instant messaging 42% less than phone owners.

Rates of phone ownership and co-usage have implications for the privacy of counselling conversations, and rates of potential access to counselling. Kreutzer (2009) has found that while ownership of a mobile phone is associated with more frequent and more sophisticated usage, the understanding, especially in a school-environment, that mobile phones are not for solely ‘personal’ use, means that ‘co-users’ still enjoy plentiful access to mobile phones. This is corroborated in part by the fact that 43 (7.58%) MBCSUs reported themselves as sharing a phone.

Despite privacy concerns introduced by co-usage, Gurman’s systematic review of mHealth interventions in developing countries (2012) highlights that “voice calls provide a greater bugger of privacy for those sharing phones than SMS.” (Gurman et al., 2012, p. 100). This assertion can surely be extended to the medium of Mobile Instant Messenger, whereby conversation records cannot be accessed easily as an SMS (MXit accounts require a password) and the synchronous method of communication requires the service user to be ‘in use’ of the phone for the duration of the conversation, thus other co-users are less likely to be exposed to the conversation thread.

Use of Angel/DAS for drug-related counselling. Historically, the setting for this research – Angel/DAS (Drug Advice Support) – has been advertised as offering information, advice and support related to drug addiction and drug-related problems. Though I have been assured that there is a wide range of topics covered in counselling and various reasons for accessing the service (Marlon Parker, personal communication, 16 February 2012), Parker,

Mills and Mills (2010b) found that drug-related queries made up 61.8% of the total number of conversations between Angel/DAS counsellors and service users.

An item was included in the questionnaire to gather information about the main topic that might be discussed in MXit-based counselling. It was worded in such a way as to be appropriate for users and non-users of MXit-based counselling: “*My biggest worry in life right now is...*”. Even though detailed analysis of this item was not undertaken due to a greatly diverse set of responses, a word-search through the dataset of MXit-based counselling service users’ responses finds that just 19 out of 568 responses (3.35%) refer to drugs, alcohol or addiction.

Conclusion

This research set out to understand the characteristics of those individuals who have accessed counselling via their mobile phone, using Mobile Instant Messenger (MIM), as well as their experiences of doing so. This population of MXit-Based Counselling Service Users (MBCSUs) was found to be generally young ($n = 568$, $\text{Mean} = 20.17$, $\text{sd} = 4.97$), equally split along gender lines ($n = 567$, 53.79% female, 46.21% male), and situated around South Africa; although there appeared to be more respondents around urban centres of Cape Town, Durban and Gauteng.

In terms of Race ($n = 507$), MBCSUs were mostly 'Black African' (73.27%) and 'Coloured' (16.83%). First languages ($n = 507$) varied across all 11 official South African languages, although isiZulu (18.84%) and isiXhosa (13.03%) were underrepresented while English and Afrikaans were overrepresented (compared to national statistics). The employment or student status of the MBCSU group was considered in two distinct age groups, with 88.62% of respondents aged 15-18 ($n = 246$) attending school, and 44.19% of respondents aged 19 years and over ($n = 310$) identifying themselves as unemployed.

In terms of counselling modality use, 18.77% of MBCSUs ($n = 568$) had phoned a recognised telephone counselling service, with Childline (40.19%) the most frequently cited, while face to face counselling ($n = 568$) with a recognised service provider or ‘paraprofessional’ (e.g. psychologist, social worker) had taken place for 14.61% of MBCSUs. Overall, 5.02% of MBCSUs had used all three mediums.

Qualitative data about the experience of using MIM-counselling and reasons for non-use of various mediums was analysed using thematic analysis with two coders, with the

Cohen's Kappa measurement statistic indicating a significant level of interrater agreement ($\kappa > .80$) across all 4 categorical datasets.

Reasons for non-use of telephone counselling ($n = 308$) included 20.45% of responses relating to access barriers (including a lack of airtime or contact numbers), and 17.53% which related to feelings of insecurity, pride, shame and fear. The majority of responses however, relayed 'having no need' for counselling (55.85%), despite having accessed counselling via MXit.

A dominant reason for non-use of face-to-face counselling ($n = 362$), was a series of responses indicating personal or emotional reasons including an unspecified fear, shyness and embarrassment (29.21%). A number of these reasons involved the presence of another person - for example, fear of judgment. Access barriers and 'having no need' represented the majority of other reasons.

Reasons for non-use of telephone and face to face counselling are in line with expectations from the literature, with regards to limited access to mental health care provision, concerns about embarrassment and judgement and fear of emotional vulnerability.

The MIM-counselling experience was described positively as safe (28.03% of responses) which encouraged openness. This is in line with the literature, which discusses the willingness of online counselling service users to share quickly and deeply. The medium was also reported by respondents as being accessible - in terms of convenience and familiarity. Negative opinions of MIM-counselling were based on in terms of practical concerns related to service access times, and specific shortfalls related to the quality of counselling provision. While the lack of physical presence of a counsellor featured as a positive aspect, it was also mentioned negatively.

Reasons for non-use of MIM-counselling ($n = 2285$) were explored, with most respondents (64.98%) indicating that they did not know how to access MXit-based counselling, and 17.29% suggesting that they had no need for it. Additionally, 92.42% of total respondents ($n = 2285$) owned a mobile phone, with the rest reporting that they shared a phone. Finally, a word search of responses to the question "My biggest worry in life right now is..." investigated the hypothesis that DAS is used primarily for drug and or addiction related counselling, which was effectively disproved due to a small incidence of related terms.

Discussion

Summary of major findings

What follows below is a discussion of significant findings from the research. Where relevant, findings are considered against the existing literature and general issues relevant to online counselling and mental health care provision. The first section covers results related to the demographic characteristics of MXit-based Counselling Service Users (MBCSUs), including their youthfulness, variety of first languages, and the use of the service by Black South Africans. Following this, the experience of using MXit-based counselling is considered, including the myriad effects of the physical distance between counsellors and service users, practical issues which interfere with satisfactory service delivery, the ability of the medium to overcome common access barriers, and ethical factors. Finally, the best potential role of MXit-based counselling is considered.

Majority of service users are young adults. The demographic characteristics of the MXit-based Counselling Service Users (MBCSUs), as detailed in the results section, indicate a population which is fairly representative of the national population in terms of language, race and location. The main departure is in terms of the youthfulness of service users, with the vast majority (90.28%) falling in the age range of 15 – 25 years. This is consistent with what is known about MBCSUs from previous research and reports (Childline South Africa, 2011; Nembaware et al., 2011; RLabs, 2010) and MXit-users in general (MXit Lifestyle, 2013).

A severe deficit in existing child and adolescent mental health services in South Africa has been identified by Petersen and Lund (2011). One particular strength of the MXit application is access to this young population, in a medium that is so familiar that it is considered an integral 'part of their lives' (Chigona et al., 2009, p. 7). The ability to address suicide rates in young (particularly male) individuals was one reason that motivated the UK's largest emotional-support charity, Samaritans, to venture into online counselling (Wright, 2003).

Black South Africans are accessing emotional support via MXit. Not only are the service users of MXit-based counselling young, almost two-thirds of them identify as Black African. As has been stated previously, the literature points to a scepticism and stigma attached to the concept of a 'talking cure' for emotional problems among Black South

Africans (Straker, 1988, p. 9, cited in Maree and van der Westhuizen, 2011). It has been thought that Black South Africans are more likely to consult with a traditional healer instead of, or at least before and/or during consultation with a representative of the mental health system (Jones, 2009; Petersen & Lund, 2011), or resolve concerns within the family (Ruane, 2010). According to Jones (2009), the mental health needs of Black South Africans have not been adequately met.

This research offers some contrasting evidence to this notion and demonstrates that certain Black South Africans are prepared to access mental health support in the form of counselling via MXit chat. While the potential reasons for this is beyond the scope of this paper, the young generation of Black MXit users encountered by this research may highlight a generation with less traditional views of the mechanisms and procedures by which emotional support is garnered. To that end, the privacy of the medium may play a part in hiding the individual's use of the service from fellow family and community members, thus avoiding criticism and/or shame due to stigma.

First language of service users is not only English. The DAS counsellors are men and women from the Cape Town metropolitan area, mainly speaking English as their first language, and Afrikaans as their second language. Though previously it was estimated that approximately 75% of DAS service users are English-speaking (personal communication, Marlon Parker, 13 April 2012), questionnaire responses showed that just 14.79% of MXit-based counselling service users language (and 19.85% of all survey respondents) reported English as their first language. The first language distribution amongst study participants is wide, and covers South Africa's full set of eleven national languages - although isiZulu and isiXhosa are underrepresented while English and Afrikaans are overrepresented in the MBCSU population, in comparison with national statistics.

The report on RedChatZone (Nembaware et al., 2011) explains that though some clients are keen to communicate in Xhosa, Zulu, Sotho or Afrikaans, the predominant language of conversations between counsellors and clients is English. The report describes a form of abbreviated language (used on MXit) which is used to reduce the number of characters and time required to convey a word, expression or feeling. These abbreviations exist across (and combine) various languages, and are very commonly used across all areas of MXit. The RedChatZone report (2011) indicates that though some counsellors found the adoption and understanding of the abbreviated language a challenge, they found it an

important ability to master, for the sake of meeting clients on their own level: *“they feel like they are chatting to a friend...”* (p. 20).

Butgereit’s report on ‘Dr Math’ (2007) also found that students making use of their tutoring services were keen to receive counselling in a variety of languages, including Afrikaans, Zulu and Tswana. Butgereit (2007) comments on the impossibility of offering multi-lingual tutoring, as there were not enough tutors who could speak those languages to extend the service. She also points out that understanding and using the abbreviated ‘Mxit-lingo’ form when trying to relate in one’s second language *“could be extremely difficult”* for tutors and counsellors (p.10).

As much as this could be a problem for tutors and counsellors, the same must surely apply for service users of Mxit-based services, including counselling service users. Second-language English speakers may have particular difficulty conveying profound, multi-faceted emotional content sufficiently (Faubert & Gonzalez, 2008), or may use the fact that they are not comfortable in the language of counselling to avoid highly charged emotional content (Oquendo, 1996) while their inability to communicate openly may be misinterpreted by the counsellor as resistance (Faubert & Gonzalez, 2008). Though it was not a particular focus of this research, we can hypothesise that the lack of English as a first language accounts for some service users’ experiences of confusion – reported fairly frequently as a negative aspect of Mxit-based counselling.

Maree and van der Westhuizen (2011) identify ‘three broad principles, which collectively address the pivotal role of diversity [in counselling interventions]’ (p. 109), namely: (a) Equity; (b) Access; (c) Redress. The first two principles speak of the need for counselling to be freely available to clients regardless of their race, gender, language or socioeconomic standing. The principle of ‘redress’ speaks of the need for counsellors to ‘find ways to effect redress given the historical imbalances still prevalent in South Africa’ (p. 109). Though it could be said that Maree and van der Westhuizen’s (2011) principles are well addressed by Mxit-based counselling, it is important to consider the implications of the lack of first language counsellors on the service user experience of Mxit-based counselling.

Disinhibition of the medium. Emotional freedom and disinhibition was one of the most common themes that emerged amongst the benefits of Mxit-based counselling, and as a reason for non-use of face-to-face counselling.

This has been seen before in online counselling and MXit-based counselling: This ‘disinhibition effect’ of an online medium has been apparent in other studies of online counselling with participants reportedly feeling greater ease at disclosing (Leibert et al., 2006), more safe and less emotionally exposed (King et al., 2006), and that one can be more explicit and honest about certain issues that would be difficult to discuss face to face (Cook & Doyle, 2002; DuBois, 2004). The report on RedChatZone (Nembaware et al., 2011), described clients who were upfront and unafraid to discuss information which might otherwise be considered taboo, included risky sexual behaviour, sexual abuse, and rape. In some cases, clients disclosed their HIV-positive status for the first time ever, to the RedChatZone counsellor.

This tendency to be ‘open’ over the internet has been described by Suler (2004) as ‘the online disinhibition effect’ (p. 321) - the result of a number of factors, many of which are relevant to the experience of a service user of online counselling (including MIM counselling). A particularly central factor, described by Suler (2004) as “dissociative anonymity” (p. 322) is a feeling of anonymity which allows for the presentation of an aspect of oneself which is not readily associated with the ‘rest of their lives’ (p. 322). Both adults and children have the tendency to disclose personal information faster, or as readily, through online mediums as in face to face communication (Joinson, 2000). Online relationships have also been shown to be equal to ‘offline’ relationships in terms of ‘depth’ and ‘breadth’, which relate to the comfort in disclosure and variety of topics covered, respectively (Parks & Roberts, 1998).

Lack of physical presence. While disinhibition and emotional freedom can be understood as a positive feature of the medium, the lack of physical presence, between service users and service providers was mentioned both as positive and negative aspect by respondents.

As a positive aspect, respondents reported that a lack of physical presence meant that they felt free of shyness or fear and could be more emotionally expressive, without concern that somebody could see them, know who they were, or see their tears. This was also reflected under the theme of ‘fear’ in using face-to-face counselling; that shyness and embarrassment dissuade potential service users. A similar sentiment was captured by the title of the paper by Beattie, Cunningham, Jones and Zelenko (2006), “*I use online so the*

counsellors can't hear me crying": *Creating design solutions for online counselling*, which explored synchronous online counselling as offered by The Kids Helpline in Australia.

Another central element of a purely text-based counselling relationship is the lack of voice, which has obvious drawbacks; there is valuable information embedded in the pitch, tone and pace of speech and the absence of these may make it more difficult for clients and counsellors to express and assess emotions (Beattie et al., 2006). Suler (2004) has hypothesised that the 'hearing' of the counsellor's response in one's own mind (solipsistic introjection), can function to 'unleash many powerful psychological issues' (p. 323), by involving the service user's own projections and transferential needs and desires. While this could be seen as an advantage of text-based counselling, the risk to service users of 'unleashed emotional issues' might deserve consideration as an ethical risk. This and other ethical aspects are discussed later in this chapter.

Aside from voice, respondents also mentioned that the lack of visual information meant that counsellor and client would be unable to read each other's facial expressions and cues, thus losing out on additional information. While the question of security represented the greatest number of responses to the question of positive aspects of the MXit-based medium, it was also represented in the reasons for non-use of the service. It appears that this is another doubled-sided issue closely related to the issue of the lack of face-to-face; that clients feel both safer and less safe without the physical presence of a counsellor.

Other aspects mentioned by respondents in connection with the lack of physical presence include the inability for physical comfort, in the form of having a hand placed on one's own, or a hug. While there seems to be an ambiguity around the ethics of using touch in therapy, it is generally considered inappropriate in most counselling and psychotherapeutic schools of thought (Karbelnig, 2000). There may be a role in the mere **potential** for contact, as experienced by the client, which is lost without the presence of the caring other.

Working alliance in online counselling. As explained in the literature review chapter, working alliance has been a central concern of the online counselling literature, which has used various measures to investigate the construct, with mixed outcomes. While the assessment of working alliance was not a particular outcome of this research (and a full examination of the construct is beyond the scope of this paper), the experience of service

users may contribute to the discussion about working alliance in online counselling, and MIM-counselling specifically.

The central argument that online counselling may interfere with the establishment or maintenance of a working alliance is based around the lack of physical presence (Skinner & Latchford, 2006), and the resulting loss of verbal and visual cues and information (Barak et al., 2008; Cook & Doyle, 2002). While closeness or distance in the relationship with counsellors was not specifically evident as a theme, it is interesting to note that the lack of physical presence was noted as both a positive and negative aspect of MXit-based counselling by respondents.

Despite this, there was a clear opinion that the medium (especially the fact that it precluded the physical presence of counsellor) resulted in more spontaneous and open communication. The nature of the medium, might not invite or require the same therapeutic methods or process. In fact, working alliance may not hold the key to effectiveness that it might for face-to-face counselling, and thus new methods of assessment may be required to measure the effectiveness of the counselling practised via the online medium.

Inefficiencies of text-based communication. There were some common complaints about the actual counselling being delivered by DAS counsellors which have also been reported by users of RedChatZone (Nembaware et al., 2011). Specifically, participants detail difficulty in asking questions, having to field too many questions from counsellors, and confusing or limited advice.

It has been suggested that the process of text-based counselling is compromised due to certain 'inefficiencies' in communication (Bambling et al., 2008). These inefficiencies relate to breaks in the flow of conversation that frequently occur in text-based chat when waiting for a response from the other party. The break often prompts the user waiting for a reply to rephrase their previous message, add extra detail, or change the focus of the chat completely. When a reply does come back, its relevance and order in the chat can lead to the inefficiencies detailed above (Haberstroh et al., 2007). Bambling, King, Reid and Wegner (2008) found that the inefficiencies lead to 'a focus on problem clarification and possible solutions without sufficient exploration of client goals' (p. 110).

Counsellors offering instant-messenger-based online counselling to Kids Helpline service users found that questions had to be asked one at a time, to avoid confusion. They

found that a significant amount of time was required to gather just the basic details required to get a grasp of the individual's situation (Bambling et al., 2008). The client experience of the Kids Helpline online counselling service tells us that the one hour counselling session times were often experienced as too short to be productive; the concern was raised in all five of the online focus groups used to gather reports service users' experiences (King et al., 2006).

With the variety of online counselling modalities, service hours and methods of accessing services, a more thorough investigation might be able to establish **exactly** what aspects of accessing the service might hamstrung more efficient communication and more satisfactory contact between client and service provider.

Time-related issues in MXit-based counselling. Time-related issues were particularly dominant in the negative aspects reported by respondents. These related to limited hours of operation¹⁶, delayed responses from counsellors and the disappointing speed of communication via the medium. These complaints have been noted by previous research (Haberstroh et al., 2007; King et al., 2006; Nembaware et al., 2011).

In many instances, it appears that service users were unaware of the actual hours of operation of the counselling line and were thus frustrated by a lack of response, when the service was in fact offline. The same problem was found in the report on RedChatZone (Nembaware et al., 2011), in which analysis of conversation content found many instances of clients asking "*R u there?*" at various times outside of those advertised. While service users had at least added the DAS contact (even if contact was attempted at incorrect times), almost two thirds of the 2285 non-service users gave the reason for their non-use of MXit-based counselling as a lack of information about the service.

Portions of the RedChatZone report (Nembaware et al., 2011) recount interviews with MXit-based counsellors in which they admit that several counselling conversation requests from clients go unanswered, mainly due to there being too many conversations on the go at once. Though holding multiple concurrent chat conversations is standard practise in instant-messaging chat (Nardi et al., 2000), it is clear from the counsellor's testimonies that it can negatively affect the experience of service users, who, as MIM-users, are likely to have

¹⁶ DAS service hours for respondents were Monday, Tuesday and Wednesday, 2 - 4pm.

expectations of immediacy (Church & de Oliveira, 2013). Though it is difficult to know exactly what was responsible for time delays experienced by service users in this research, it is safe to assume that the strain of handling multiple concurrent conversations on counsellors played some part.

Time-related issues as benefit. For participants in the study by Haberstroh, Duffy, Evans, Gee and Trepal (2007), the space between responses was a double-edged sword. While some participants found it irritating and forced them to shorten their responses, others found it to be a useful prompter of self-reflection. Respondents in another study (King et al., 2006) reported the time delay as a beneficial aspect of online counselling, because it offered a chance to consider one's response and make corrections before sending the message. This was also mentioned in research by Cook and Doyle (2002) in which respondents lauded the ability to re-read conversations, and reflect on the content of therapeutic sessions.

In addition, there is known and hypothesized benefit in counselling by written (or typed) word, regardless of the promptness or existence (!) of a reply from a counselor. Research has shown that there can be emotional, social and even physical benefits from writing about one's feelings, known as 'expressive writing' (Baikie & Wilhelm, 2005), although Pennebaker and Chung (2011) warn that the effect size of these benefits has been 'modest at best' (p. 433). It's possible that combining therapeutic writing with the supportive environment of an online counselling session might increase the benefit of expressive writing alone, separate from the lack of an expected reply in the case of an absent counsellor.

MIM-based Counselling can overcome practical access barriers. Though the online counselling literature discusses the benefits of various modalities, there are certain reported positive features of MIM-based counselling particularly relevant to the South African context. These are features with the benefit of circumventing common barriers which otherwise limit access to mental health care.

The fact that this form of online counselling is offered directly to the service user's mobile phone suggests that potential access is possible anywhere with a cellular signal. This particular convenience factor deals directly with issues related to the lack of local facilities, and the financial costs (and time costs) involved with accessing services.

Another benefit of the portability of the medium, is the enhancement of privacy and confidentiality. With no voice to be overheard, the medium can be used by someone when

physical privacy is impossible, and stigma discourages them from accessing physical services, for fear of being seen. The theme of security was most prominent among positive aspects of MXit-based Counselling in the data, but was also represented as a concern for users who mentioned trusting an invisible counsellor as a particular challenge.

With 44% of the MXit-based Counselling service user respondent group identifying themselves as unemployed, the fact that no service providers charge for access to their services via this medium, is a major benefit. This speaks directly to a common barrier to mental health services, that of cost. This was relevant in the responses about the lack of use of face to face counselling and telephone counselling with the lack of airtime representing one aspect of this.

Ethical issues of MIM-based Counselling. As discussed in the literature review chapter, ethical aspects of online counselling have featured heavily in the literature, with particular concerns about the professional standards of the counselling service providers, provision of information for informed consent about confidentiality, boundaries, scope of practise, safekeeping of information and screening of prospective clients before administration of particular counselling services (Baker & Ray, 2011; Kaplan et al., 2011; Ross, 2011; Shaw & Shaw, 2006). These topics are considered below with regards to the remit of MIM-based Counselling.

Regulation of service providers. As mentioned in the literature review chapter, the Health Professional Council of South Africa (HPCSA) currently provides no official documentation relating to online counselling, including MIM-counselling. As a result, there are no licenses required by service providers before offering services, no defined standards for MIM-counselling service providers to adhere to, and no guidance about implementing important aspects of ethical counselling, such as informed consent, client screening and other affairs relating to the protection of service users and legal protection of service providers alike.

This lack of regulation of MIM-counselling service providers may relate to one aspect of responses in this study which spoke about doubt about the trustworthiness of the counsellor and counselling service. A more clearly defined role of qualified MIM-counsellor or ratified service provider agency may have assuaged insecurities about the identity of the counsellor, and reduced anxiety about engaging in a therapeutic process with them.

Additionally, another concern from respondents relating the quality of counselling style and method might be mitigated by requirements for particular training or regulation of training for MIM-counsellors.

Informed consent. Neither DAS/Angel nor other MXit-based counselling services currently gather informed consent from potential service users or provide any pre-counselling information. Only MobieG displays pre-counselling information, with a reference to the anonymity of the service in the line: “MobieG provides free anonymous help”, visible on the MobieG MXit service menu from where ‘Live Chat Life Helpline’ is accessed.

The establishment of norms or boundaries for the therapeutic relationship is known as setting ‘the frame’, and is considered vital for the establishment of trust and a sense of safety, and ultimately, for therapeutic change (Milton, 1993). The absence of comprehensive pre-counselling text may represent a failure to establish a suitable ‘frame’ for prospective and actual service users and contribute to the theme of ‘feeling unsafe and insecure’ amongst responses to the question of negative aspects of MXit-based Counselling, and reasons for non-use of MXit-based Counselling.

Screening of clients. Aside from a lack of pre-counselling information, pre-counselling screening of particularly vulnerable clients is absent from the current MXit-based counselling process. This becomes relevant when considering that adolescents and young adults (popular users of the medium) bring particular risk factors to counselling (Moran et al., 2012). This potential problem is complicated further by the physical distance between counsellors and clients which removes the ability to physically intervene in the event of a crisis, for example, if the client starts engaging in self-injurious behaviour is otherwise emotionally uncontained.

One suggestion from the literature is to include a request for particulars from clients as part of gathering informed consent, for the sake of providing additional safety mechanisms in the event that they may be required, for example, emergency contact details (Rummell & Joyce, 2010), or details of the physical location of the client (Rummell & Joyce, 2010), in the case of needing to call an ambulance for a suicidal service user, or details of a local doctor or other emergency services (Mallen et al., 2005). To some degree, this request for identifying information may counteract a prime advantage of the medium as identified by respondents: that of safety as offered by the anonymity of the service.

The best role for MIM-based Counselling. While there may be standalone benefits to MIM-based counselling for anybody, there are particular circumstances whereby MIM-based Counselling might be particularly beneficial or appropriate.

Certain population groups. As highlighted previously in this chapter, the majority of MXit-based Counselling service users are young adults, a population generally at ease with mobile technology while remaining underserved by mental health services. Besides youth, there are other population groups for whom online counselling (and mobile-based counselling in particular) may be particularly appropriate.

As was raised by the parent of a deaf child completing the parents' poll (see method section), there are people with certain disabilities for whom receiving counselling face to face or over the telephone is less possible or in fact, not at all. This has been previously discussed by Chester & Glass (2006), who suggested the suitability of online counselling for "...those with a disability, the terminally ill, elderly and other groups unable to leave home" (p. 148). Previous research has highlighted the use of online counselling particularly for individuals with social phobias and anxieties, eating disorders, posttraumatic stress disorder and problems about self-image (Cook & Doyle, 2002; Leibert et al., 2006; Moessner & Bauer, 2012).

Dynamic access to health information. As highlighted by respondents, MXit-based counselling is useful for accessing information about health. This addresses another common access barrier, of there being a lack of knowledge about illnesses, medication, side-effects and healthcare providers. The service might also assist in increasing access to other mental health resources – a reason offered by participants in this study for the non-use of Telephone Counselling was a lack of knowledge of services.

Adjunct or introduction to other services. Though research by Young (2005) suffers from a small sample size, she found that for 85% of her respondents, online counselling had been their first time receiving any form of any therapy. Professor Jean Greyling of Nelson Mandela Metropolitan University has suggested that MXit-based counselling may just be the first step for service users in receiving help from mental health service providers (NMMU Computing Sciences, 2011). His view reflects the fact that there are multiple ways in which online counselling has been conceptualised in relation to traditional therapeutic and counselling modalities and methods.

Online counselling has been used previously in varying degrees to supplement psychotherapy, to offer short-term, repeated counselling, and as an ‘emergency-care’ service, to be used as frequently or infrequently as desired, even for once-off support (Chester & Glass, 2006; Mallen, Vogel, Rochlen, & Day, 2005). Petersen et al. (2009) commented on the fact that decentralized mental health care in South Africa was focused on primarily on ongoing psychopharmacological care of patients with chronic psychiatric conditions and management of psychiatric emergencies. There was a distinct lack of follow-up psychosocial support – this is just one of many spaces in which MIM-based Counselling can adjunct existing services.

The incorporation of multiple modalities is not uncommon in the provision of mental health care: Mallen et al. (2005) highlight the fact that 24-hour telephone crisis interventions are often relied upon by counselling psychologists, as a means of service provision which is available when others are not. In the report on RedChatZone (MXit-based counselling provided by the NAHL), Nembaware et al. (2011) found that in at least 5% of counselling conversations, NAHL MXit counsellors referred service providers to a wide range of telephone helplines, including the NAHL telephone counselling line, particularly if the MXit counselling session was soon to come to an end. Similarly, several participants in the research carried out by King et al. (2006), with one exclaiming “*What’s the point in having online counselling if the counsellor asks you to call?*” (p. 172). Clearly the manner in which counselling modalities dovetail is important, to maintain respect and continuity for the service and service users.

Conclusion

Though the burden of mental illness continues to rise (Murray & Lopez, 2013), a range of barriers have limited access to mental health care for many South Africans suffering with a mental illness, with only 1 in 4 receiving treatment in a twelve month period (Williams et al, 2008). Practically, stigma discourages help-seeking behaviour (Ruane, 2010), while accessing services is often an expensive and inconvenient task (Petersen et al., 2009).

The widespread adoption of mobile phones, even in under resourced populations, has created an opportunity for a creative approach to health promotion and service provision. For 8 years, counselling has been provided via MXit, with only simplistic reports and ‘logs’ produced by service providers, and basic reviews of the experience using interviews with counsellors and a methodologically flawed user survey.

This research examined the demographics and experience of MIM-counselling service users through the use of an adaptive, mobile-based questionnaire, which was advertised on MXit, alongside the access point of MXit-based counselling provided by Angel/DAS. By gathering a range of demographic and service use information from MXit-based counselling service users, the research performed a more thorough investigation of service user experience than ever before conducted. Reasons for non-use of various counselling mediums, including MXit-based counselling were also queried, as well as some details about mobile phone ownership.

Findings corroborate some pertinent aspects from the literature. For example, the reasons for non-use of telephone and face to face counselling (by MXit-based counselling service users) are in line with expectations, with regards to limited access due to location, cost and a lack of knowledge, as well as concerns about embarrassment and judgement. Another reason given, a fear of emotional vulnerability emphasises the aspect of privacy afforded by the medium, which was frequently mentioned as a particular advantage of the MIM medium.

Previously considered problems with the medium were also mentioned by respondents, in terms of technical issues which caused broken connections between counsellor and clients, limited service times, and poor quality service provision. Clearly, there is a need for service providers to address these aspects of service provision which exist

separately from the question of whether or not an effective counselling relationship has been established.

Despite issues, findings suggest that working alliance, a focus for discussion in the literature on online counselling, is possible via the MIM medium, although detailed unpacking of the construct was beyond the scope of this paper. The current delivery of MIM-counselling clearly falls short of ethical standards for counselling, and there are some minor changes to current service provision which seem especially urgent for the sake of protection of client and counsellor alike.

Despite the main concerns facing MXit-based counselling, it is evident from the experience and reports of service users, that the established access barriers to mental health can be circumvented by utilising MXit-based counselling, if not as a complete solution, then at least as a first-stop on the road to treatment, information and recovery. Regardless, there is a clear deficit in the current provision of service which may be addressed by current and prospective service providers, and it is my hope that this research can play some role in guiding the future development of services which provide ethical, and effective care.

Strengths of current research

The current research has succeeded in gathering data from actual service users, in the space in which they have accessed MXit-based counselling services. The adaptive format of the questionnaire allowed for each question to be relevant for each respondent, while, following learnings from a pilot questionnaire, the language used in questions was carefully considered and adapted to try minimise misinterpretations of questions.

The questionnaire gathered a vast dataset of over 2800 responses, with a completion rate of 82.83%. The qualitative nature of questions about the users' experience of MXit-based counselling was appropriate given the paucity of research on the topic and facilitated an investigatory orientation to the data. This philosophy was continued with the use of inductive code generation for thematic analysis, while the use of a second coder, and the calculation of interrater reliability, added to the validity of the thematic analysis process.

On the whole, the research was able to respond to a need for a better understanding of the demographic characteristics of MXit-based counselling service users, and the experience of using 'mobile technology for counselling purposes' (Parker et al., 2010, p.10), as called for by the literature.

Limitations of current research

A prime goal of qualitative, descriptive research is to strive for strong external validity – in the case of this research, I would define the target population as South African MIM-based-counselling users. Obviously we are drawing a sample from just one of the handful of MIM-based-counselling users - if I had been able to distribute the MXit-based questionnaire to service users of some of the other South African MXit-based counselling service providers, such as Childline and MobieG, it would have increased understanding of the wider target population.

Though the adaptive path of the questionnaire was a strong feature of the questionnaire, it was only realised during data analysis that open-field responses were limited to 150 characters. Any responses longer than 150 characters were cut-off. Due to the nature of the medium, which invites short responses, this only affected a very small number of responses, estimated at less than 1%.

It also became clear from data analysis, that certain respondents were completing the questionnaire twice, causing the duplication of responses. This is likely in an effort on the part of respondents to better their chances of winning the incentivised prize of R50 airtime, by completing the questionnaire twice (or perhaps three times), once for each SIM card in their possession - each of which has a different cellphone number – which was used as a unique identifier to try eliminate duplicate responses. This eventuality was not considered by the researcher or his technical consultants prior or during the pilot of the questionnaire. It proved difficult to quantify the effect of this on the dataset, but should be noted as a limitation.

Recommendations for future research

A deeper level of understanding of certain issues could be achieved through different data collection methods. In particular, unstructured interviews would allow the interviewer to probe non-specific (yet very common) responses in the hope of forming a more nuanced understanding of certain issues. For example, a common reason for having not had face-to-face counselling (approximately 29% of responses) or telephone counselling (approximately 18%) is an unspecified fear. A follow-up question by an interviewer could explore this further and clarify the source of the fear; if it is fear of having to discuss a past trauma or fear of being gossiped about in the community, there is very different meaning to that individual's experience.

Secondly, future research might include a Likert or some other rating scale, to gauge how strongly respondents feel about particular aspects of MIM-based counselling (and other modalities) and allow for more easily comparable results. Finally, the fact that a record remains of MXit-based Counselling transcripts automatically (without the need for recording, transcription or other costly processes), invites further research into aspects of the discourse between counsellors and service users. For example, transcript analysis of counselling sessions would allow for a better understanding of the in-session processes involved with MIM-based counselling to further understand the use of the medium.

Takeaways for potential service providers. A goal of this research was to gain an understanding that could ultimately be used to improve service provision. With this in mind, there are several key findings from this research which might be considered important to potential service providers, who want to establish or improve a MIM-based counselling service.

Flexibility. As discussed in the literature review section, MXit's long-standing popularity in South Africa has recently been firmly challenged, and despite steadily growing numbers and a loyal user base, other applications such as 2go and WhatsApp are growing in popularity. With this in mind, there is a clear need for an 'agnostic' system which has the functionality to interface with a variety of Mobile-Instant-Messenger applications, including MXit and WhatsApp, with a flexible design that allows for adaptation to shifting consumer trends and the dynamic nature of the mobile industry. Another aspect of flexibility, extends to the language of service provision. As motivated for in the discussion chapter, service providers would do well to recruit a group of counsellors who speak multiple South African languages between them, so that clients could converse with a counsellor in their first language.

Clarity. A range of practical concerns could be addressed through fairly straightforward additions to current service provision. For example, clearly advertised hours of operation and automatic 'out-of-hours' messages would most likely reduce the frustration experienced by many service users in trying to access MIM counselling outside of service hours.

Safety. As highlighted previously, there are legitimate ethical concerns about current online counselling service provision which extends to counselling being delivered via Mobile

Instant Messenger. A well designed and written piece of pre-counselling text (suitably adapted for mobile devices) should include information about confidentiality, storage of chat transcripts, and consideration of relevant risk, as well as clear information about the service provider's credentials. Ultimately, this carefully considered text should conclude with an agreement of informed consent. A template of this nature appears as an Appendix in *The Practical Aspects of Online Counselling: Ethics, Training, Technology, and Competency* (Mallen et al., 2005).

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APPENDIX A

Angel Survey Questionnaire

The MXit-based questionnaire was completed on the respondents' cellphones. An example of the MXit interface (with a fixed choice response) can be seen in Figure A1 below:

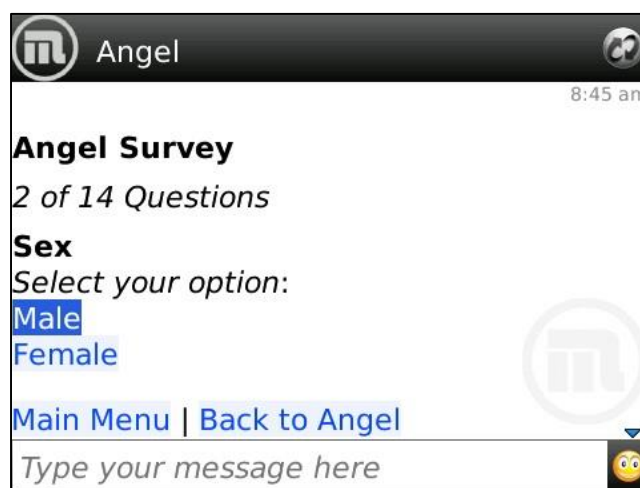


Figure A1 - Example Angel Questionnaire question (screenshot from MXit)

In the representation below, fixed-choice responses are indicated by square brackets. Otherwise, responses were open-ended and indicated by 'Open-ended response'.

Pre-questionnaire text:

A researcher from the University of Cape Town would like you to take 5 minutes to answer some questions about counselling on MXit. Your answers are anonymous - you will not be asked for your name or MXit nick. If you enter your cell number and network at the end you will be entered into a random draw to win R5000 but these details will not be used for anything else. Competition closes end of August 2012.

[Proceed]
[Back to Angel]

If respondent selected 'Proceed':

Angel Survey
1 of 14 Questions
What is your age?

Open-ended response.

Angel Survey
2 of 14 Questions
What is your sex?
Select your option:

[Male]
[Female]

Angel Survey
3 of 14 Questions
What is your location?

Open-ended response.

Angel Survey
4 of 14 Questions
What is your race?

Open-ended response.

Angel Survey
5 of 14 Questions
What is your first language?

Open-ended response.

Angel Survey
6 of 14 Questions
I am...

Select your option:

[at school]
[at university/college]
[in full-time work]
[in part-time work]
[unemployed]
[other]

Angel Survey
7 of 14 Questions
I...

Select your option:

[own a cellphone]
[share a cellphone]

Angel Survey
8 of 14 Questions
Have you ever had counselling in person (face to face)?
Select your option:

[Yes]
[No]

The next question depended on the response (Yes / No):

If respondent selected 'Yes':

Angel Survey
8 of 14 Questions
Who did you speak to?

Open-ended response.

If respondent selected 'No':

Angel Survey

8 of 14 Questions

Why have you not had face to face counselling before?

Open-ended response.

The next question followed for both sets of respondents:

Angel Survey

9 of 14 Questions

Have you ever had counselling on MXit?

Select your option:

[Yes]

[No]

The next question depended on the response (Yes / No):

If respondent selected 'Yes':

Angel Survey

9 of 14 Questions

What did you LIKE about counselling on MXit?

Open-ended response.

AND

Angel Survey

9 of 14 Questions

What did you NOT like about counselling on MXit?

Open-ended response.

If respondent selected 'No':

Angel Survey

9 of 14 Questions

Why have you not used MXit counselling before?

Open-ended response.

The next question followed for both sets of respondents:

Angel Survey

10 of 14 Questions

Have you ever called a counselling helpline?

Select your option:

[Yes]

[No]

The next question depended on the response (Yes / No):

If respondent selected 'Yes':

Angel Survey

10 of 14 Questions

Which helpline(s) did you call?

Open-ended response.

If respondent selected 'No':

Angel Survey

10 of 14 Questions

Why have you not had called a helpline before?

Open-ended response.

The next question followed for both sets of respondents:

Angel Survey

11 of 14 Questions

Where are you using MXit from right now?

Open-ended response.

Angel Survey

12 of 14 Questions

My biggest worry in life right now is...

Open-ended response.

Angel Survey

13 of 14 Questions

Cell number (for competition)

Open-ended response.

Angel Survey

14 of 14 Questions

Cell network (for competition)

Select your option:

[8ta]

[Cell C]

[MTN]

[Vodacom]

[Virgin Mobile]

[Other]

Post-questionnaire text:

Thank you for completing the survey. If you want to ask the researcher any questions, or want to be told the results of the survey in January 2013, email nickgroll@gmail.com or add NickGGG on Mxit. To add a Mxit counselling service, choose 'Add contact', select 'Google ID' and invite das@jamiix.im as a contact, nickname: DAS. DAS Mxit counsellors are available Mon to Wed between 3pm and 4pm.

APPENDIX B**Parents Poll****Parenting Poll - Adolescent use of MXit-based counselling**

Since 2008, people of all ages, including adolescents, have been able to access counselling services via MXit (a mobile-phone based chat program). The counselling is delivered by supervised volunteers, who have been trained by Lifeline/Childline Western Cape. The client remains anonymous and conversations are confidential.

If you had adolescent children, would you want them to be able to access counselling services via MXit without your consent?

Yes ☐

No ☐

Other: _____

Please explain your response below (optional):

Parenting Poll - Research with adolescents

I am interested in understanding the client's experience of using this service and would like to conduct research with them, in the form of a survey and interviews. I do not believe that my proposed research poses any risk to participants, and they will remain anonymous throughout. They will be free to leave the interview at any stage. and can be transferred back to a counsellor immediately, if so requested. As with all psychological research, the survey and interview questions would be verified by an appropriate UCT Research Ethics Committee.

If they WERE accessing counselling services via their mobile phone, would you allow your adolescent children to decide for themselves if they wished to participate in research? *

Yes ☐

No ☐

Other: _____

Please explain your response below (optional):

Do you have any further comments?

Thank you for participating.

APPENDIX C

Parents Poll Results

Table C1		
<i>Parents Poll Results</i>		
Responses	If you had adolescent children, would you want them to be able to access counselling services via MXit without your consent? (n = 31)	If they WERE accessing counselling services via their mobile phone, would you allow your adolescent children to decide for themselves if they wished to participate in research? (n = 31)
‘Yes’	25 (80.6%)	22 (71.0%)
‘No’	5 (16.1%)	7 (22.6%)
‘Other’	1 (3.2%)	2 (6.5%)

Table C1 - Parents Poll Results

APPENDIX D

MXit-based Counselling Service Users Locations

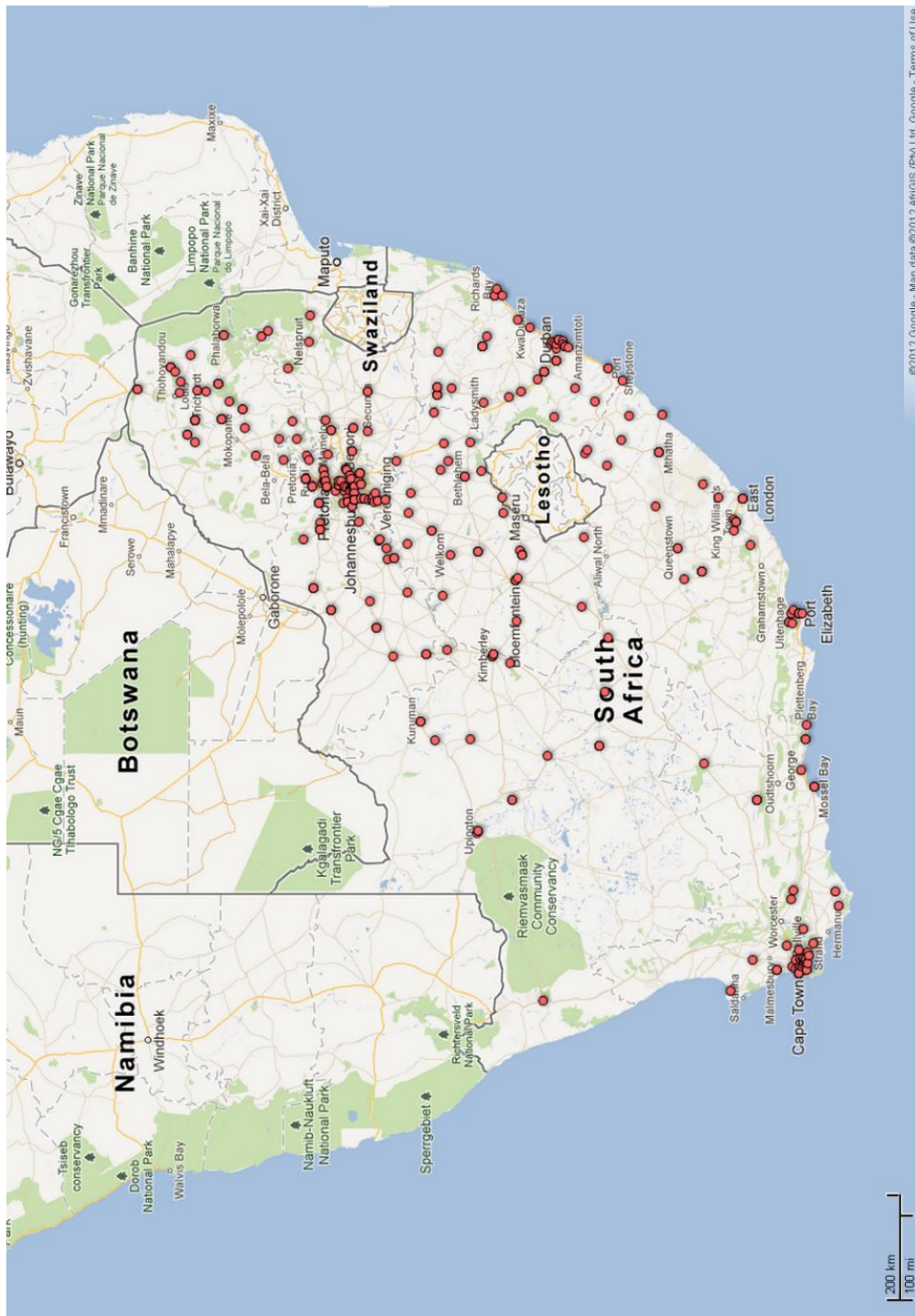


Figure D1 - MXit-based counselling service user locations