ABSTRACT

This paper explores the viability of offering an entry level HIV/AIDS related online counselling service in terms of design, utility and technological resources at the Durban University of Technology (DUT) situated in KwaZulu-Natal, South Africa. It examines the possibility of adapting learning management software viz. Blackboard/WebCT6 to facilitate online counselling that assures confidentiality and anonymity to staff and students at DUT. As a feasibility study, the findings have added credibility to the idea that providing a private discussion space with a qualified online counsellor, could contribute towards transformation and behaviour change with regard to sexual behaviour patterns amongst the staff and students at DUT. The need for privacy and convenience in requesting assistance on HIV/AIDS related concerns that are difficult to share in public for fear of rejection and stigma has been reiterated. An online counselling service that would address this need seems worth the investment in human and technological resources particularly when confronted by the enormity of the impact of the HIV/AIDS pandemic on higher education institutions.

INTRODUCTION

This paper looks at the theoretical and philosophical underpinnings in designing and offering an entry level HIV/AIDS related online counselling service that assures confidential and anonymous access. It explores the viability of such a project, in terms of design, utility and technological resources at the Durban University of Technology (DUT).

THE CONCEPT

The idea originated whilst discussing the various ways in which the online environment deals with the shortcomings of not having face-to-face contact between learners and educator. This ‘apparent shortcoming’ could be utilized to our benefit by answering the need for anonymity in first stage counselling for pre-HIV/AIDS testing.

Facilitating anonymity in the online environment would encourage people to participate in text-based online counselling regarding HIV/AIDS testing. This would provide an opportunity for discussion to take place regarding the fear of being tested, overcoming this fear through sharing of knowledge, information, experience and counselling done by counsellors trained to do counselling online.
Frank and reliable discussion may also assist in countering the HIV/AIDS-related stigma which affects self-esteem, mental health, access to care, providers’ willingness to treat people with HIV, violence, and HIV incidence. Interventions to reduce stigma are therefore crucial for improving care, quality of life, and emotional health for people living with HIV and AIDS (Klein, Karchner & O’Connell, 2002).

**THE HEAIDS STRATEGY**

It was at a presentation to the staff at the Centre for Higher Education Development by a member of DUT’s Student Counselling and Health Centre on the Higher Education HIV/AIDS (HEAIDS) strategy that I learned of the Higher Education sector being disproportionately more affected by the pandemic than other sectors of the community. This is because the majority of those studying and working within the Higher Education sector are in the age group with the highest prevalence of HIV infection.

More than 50% of the world’s 14,000 new infections every day occur among 15- to 24-year-olds. The risks for a Higher Education Institution (HEI) are also heightened by the liberal atmosphere that tends to be characteristic of HE campus cultures which may be open to activities and life-styles that facilitate HIV transmission (HESA: 2006).

At DUT, we have acknowledged:

- the fear of stigmatisation, rejection and isolation as the key obstacle in the provision of face-to-face (FtF) voluntary counselling to the DUT community
- the need for more information on HIV/AIDS, Voluntary Counselling and Testing, Anti Retro-Viral Therapy; particularly related to Higher Education Institutions (HEI)
- that there are few well utilized initiatives, e.g. face-to-face counselling, on campus to motivate behaviour change that is essential in the prevention of HIV/AIDS, particularly due to the fear of stigmatization and rejection
- that there is inadequate time on campus to attend to issues regarding personal health and well being. This is a common issue with academic and non-academic staff as well as students.

The online environment provides an opportunity for communication to take place without the need for identifying oneself. To avoid incurring additional costs related to the purchase of new software, it would be worth exploring whether it is possible to adapt a learning management programme, viz. Blackboard/WebCT 6 to create an online counselling facility that assures confidentiality and anonymity to staff and students at DUT seeking entry level HIV/AIDS related counselling online.

It is envisaged that the iSineke Project (a title for the proposed online counselling facility), would provide an opportunity for effective information sharing and counselling, and would be facilitated by the excitement with which online technology is embraced by this particular age group.

**THEORY**

Anderson & Goolishian (1992) describe counselling as the creation of a conversational safe space where there is a consensual domain. This is where the counsellor and client can share some meanings and realities around a problem. By comparison, online counselling, according to Mallen & Vogel (2005: 764) comprises ‘any delivery of mental and behavioural health services, including but not limited to therapy,

---

1 iSineke: a term borrowed from isiZulu meaning caring and patience.
consultation, and psycho education, by a licensed practitioner to a client in a non-FtF setting through distance communication technologies such as the telephone, asynchronous e-mail, synchronous chat, and videoconferencing.

Although controversy has emerged regarding the effective duplication of this personal interaction in a virtual environment, Ybarra, Kiwanuka, Emenyonu & Bunsberg (2006: 1) have shown the internet to be ‘a powerful, low cost method to deliver health intervention and prevention programmes to large numbers of young people across diverse geographic regions.’ In the light of the above and faced with the urgent need for HIV/AIDS related pre-test counselling one cannot ignore the opportunity presented by online counselling. Already, Uys and Magowe (2002), have introduced open discussion, information-sharing and entry-level counselling on HIV/AIDS by using public Web-based threaded message boards as anonymous Q&A forums for an expert to answer questions posed by staff and students on HIV/AIDS at the University of Botswana. Their findings support the use of electronic media as an effective mode of information dissemination on HIV/AIDS, particularly when contextualised within the culture of the people using these facilities.

Mbananga & Becker (2002) in a study on the use of technology in reproductive health information designed for communities in South Africa, identified a fundamental problem which underlies the development of Reproductive Health Information (RHI). They found that vision and cognitive processes are separated from the cultural, environmental and socio-economic status of the individuals targeted by this type of information. Hence, they caution the need to develop a close relationship between the developers of visual materials and the consumers of such material for them to be meaningful. These findings reinforce the supplemental need for online one-on-one communication allowing clarification and questioning between counsellor and client.

Although the planned intervention proposed in this paper is one of providing the DUT community with a private space online to discuss HIV/AIDS related concerns, it is believed that there is a need for both open and private dialogue. The provision of a separate and safe space to enable both to occur would be advantageous. The wider aim of the iSineke project is to provide an online space for both private and public discussion and information sharing on HIV/AIDS. In doing so, it acknowledges the role of both the public and the private space.

The debate regarding open versus private online dialogue is informed by existing theory. The contrast is between, on the one hand, the ‘public sphere’ (Habermas, 1989; Fraser, 1990) where one is interacting with others and with society at large and on the other hand, the ‘private sphere’ (Gorner, 2007; Vincent, 2004; Keller, 1999) where one can be one’s authentic self and realize the importance of the self. The self’s relation to the world is grounded in self-reflection and introspection, as explained in Kierkegaard’s existentialist philosophy (McDonald, 2004).

Postmodernists view knowledge and learning from the perspective of power and emancipation. Mallen & Vogel (2005) suggest that clients may find voluntary participation in online counselling empowering. By comparison, Inglis (1997) asserts that empowerment and emancipation are two different things. Empowerment means that people find strategies to ‘exist within the existing system and structures of power’, whereas emancipation involves ‘resisting and challenging structures of power’. Heeding this, the iSineke project proposes to empower by providing a space for impersonal information sharing on HIV/AIDS related issues, using the public online space. The online private space, by assuring user anonymity, would allow for personal and sensitive sharing between qualified online counsellor and client.

With reference to current research on HIV/AIDS Education, Elbaz (1997), also a postmodernist, believes that learning happens when people deconstruct knowledge. His first approach is focused on the individual,
testing the ability to learn from scientific material and to apply this knowledge with resulting behaviour transformation that prevents HIV infection. His second approach adopts a social orientation by looking at economic and cultural variables that may facilitate or block the individual from understanding the mechanics of HIV transmission and thus may affect their capacity to prevent HIV transmission. Elbaz promotes an HIV/AIDS programme that functions at a multisystem level, which includes both the ‘identity’ focused paradigm as well as ‘resource’ focused, social, familial and education processes.

By comparison, constructivists like Mezirow (2000), Cranton (1994) and Baumgartner (2002) believe that learning is a search for meaning. Knowledge is not simply ‘out there’ to be attained; it is constructed by the learner. Learning is achieved through assimilation and accommodation. People assimilate information when they add it to an existing cognitive structure, whereas accommodation is the process of reframing one’s mental representation of the external world to fit new experiences.

Although Mezirow’s cognitive approach to transformative learning has been criticized for an over reliance on the individual experience without looking at the influence of societal structures in the transformative learning process, it emphasizes the effect of critically reflecting on beliefs and engaging in ‘reflective discourse’ in order to arrive at a perspective transformation or change in world view. He proposes that individual transformation leads to social transformation.

Using Mezirow’s 10 step transformational learning process (2000), the diagnosis of seropositivity could be the first step, the ‘disorienting dilemma’, which could lead to feelings of fear, anger, guilt and shame. This would then be followed by a critical assessment of the assumptions one holds about life and the world. The next stage is the discovery that others have gone through what they themselves are feeling. This may be a result of sharing with others (online or face-to-face) and leads to the re-determining of roles, reviewing action plans, seeking new and related information. This would lead to the adoption of a new role and the reintegration and acceptance of the reality that is their own. Mezirow believes that accommodation requires that the cognitive structure needs to be created anew or completely reorganized. Mezirow’s Perspective Transformation and transformational learning is characterized by ‘a shift of consciousness that dramatically and permanently alters our way of being in the world’ (Morrell & O’Connor, 2002: xvii). Through exploring the transformation of behaviour patterns amongst young adults at DUT, it may be possible to use online counselling and information sharing to foster change, beyond entrenched patterns of thought regarding HIV infection.

The following questions emerged whilst reflecting on the assumptions made regarding the provision of online counselling at DUT. Would it be fair to assume that the users of online counselling have access to technology, are comfortable with online communication (Giannini-Gachago, Molelu & Uys 2005; Masters & Oberprieler, 2003), and are able to express their feelings and ideas in text format and are not intimidated by the online interaction? This concern is one of the classic ‘digital divide’, a term that describes the differential access to the internet and related to technologies because of financial and socio-economic issues (Hoffman, Novak & Schlosser, 2001).

Similar issues were explored in a qualitative study with five research participants on their experiences of online counselling (Haberstroh, Duffy, Evans, Gee, & Trepal, 2007). In particular, the effectiveness of online counselling in relation to the degree to which individuals were comfortable with the use of technology and communicating via e-mail and chat rooms was examined. From the findings of Haberstroh et al. (2007), and Wright & Chung (2001), it was encouraging to note that interacting online alleviated pressures to respond quickly and served as a less threatening outlet for sharing embarrassing topics. This factor would be most beneficial in addressing sensitive issues in entry level HIV/AIDS related pre-test counselling. In addition, Haberstroh et al. (2007) and Patrick (2004) show that online counselling offers
a unique forum for written interaction between a professional and client that can focus on the cognitive and emotional qualities of clinical issues. This would be a critical factor in consolidating the ‘therapeutic alliance’ (Mallen & Vogel, 2005) between therapist and client in computer mediated counselling (CMC). It must be noted, however, that in examining the dynamics of the online relationship some participants found the missing interpersonal cues limited their self expression and level of trust. For some the slower pace of the sessions seemed to encourage deeper reflection whilst for others the slower pace appeared tedious and hampered self disclosure.

Although the online intervention proposed in this paper assures anonymity of the client, information regarding the identity, education, certification and contact details of the online counsellor/s would be available to the client as required by ethical considerations of the practice of online counselling. The International Society for Mental Health Online (ISMHO, 2000, online) specifies ‘The client should be informed before he or she consents to receive online mental health services. In particular, the client should be informed about the process, the counsellor, the potential risks and benefits of those services, safeguards against those risks, and alternatives to those services.’ Hence, as part of the counselling orientation process, the counsellor would explain to the client the procedures for contacting the counsellor when he or she is off-line and how often e-mail messages will be checked by the counsellor. In addition, the counsellor would be required to discuss alternative modes of communication in the event of technology failure, e.g., provision of the local crisis hotline telephone number.

**METHOD**

For this study, action research, particularly participatory action research, is the method of choice because the research is done with and for the community of DUT, where the research is done in partnership with the community to achieve the change in behaviour and attitude toward HIV/AIDS.

According to Seymour-Rolls & Hughes (1995) Participatory Action Research (PAR) is a method of research where creating a positive social change is the predominant driving force. Research using PAR as its method will happen in the four moments of action research, namely reflection, planning, action and observation. These research moments exist interdependently and follow each other in a spiral or cycle.
McTaggart (1989) holds that participatory action research is collaborative: those responsible for action are involved in improving it. It starts small by working on minor changes which individuals can manage and control, and works towards more extensive patterns of change. Guided by this, the first action research cycle was done with six academic staff members at DUT who were familiar with the online environment. Data were collected from them regarding ease of access and the facilitation of anonymity online. Reflecting on this cycle, the need for meticulously planned and precise instructions that were easy to understand and follow became clear.

Adjustments were made for the second cycle, and six participants who were unfamiliar with the online environment were included in this process. The data collected revealed further shortcomings and supporting visuals were added to the instructions to facilitate ease of access.

Through the cycles of action research it has become evident that action and reflection are indissolubly united. This experience has reaffirmed Freire’s (1972: 41) concept of praxis, ‘reflection without action is sheer verbalism or armchair revolution and action without reflection is pure activism or action for action’s sake’. Reflection and action can be done with a planned purpose that is linked to transformation.

This is reaffirmed by McTaggart (1989) in his 16 Tenets of Action Research, who refers to participatory action research as a systematic learning process in which people act deliberately through remaining open to surprise and responsive to opportunities. It is a process of using critical intelligence to inform action, and developing it so that social action becomes praxis (critically informed, committed action).

**REFLECTING ON THE PROCESS AND PROCEDURE**

The first intervention was to establish an online counselling space adapting the Blackboard Learning Management System to accommodate online counselling. The course, titled ‘iSineke’, was registered with the system administrator. The helpdesk administrator was required to be particularly mindful of the process to ensure anonymity. (The task of facilitating anonymity online was an intriguing challenge.)

The larger hurdle was that of establishing initial contact without necessitating identification, especially for the process of enrolment. The first suggestion, from an online facilitator at DUT was that of adjusting the WebCT6 software programme, with scripting using application protocol interface. This was considered unfeasible from the perspective of complexity and cost.

The second suggestion was to station a box in a suitable place in which the ‘student’-cum-client could place a secret password (which would serve as the username). This would facilitate registration into the ‘short course’ serving as online counselling space. However, this suggestion had the same inherent flaw as the FtF counselling, i.e. it did not address the fear of being recognised to be requesting HIV/AIDS related counselling.

The making available of a cellular telephone number to the DUT community to send their secret username/ password to the helpdesk administrator via the Short Message Service (SMS), proved to be the ideal solution ensuring the anonymity of the client from the first encounter. The procedure which assured anonymity was explained to the prospective client in the marketing campaign. A simple and clear set of instructions was developed to facilitate registration and online accessing, in two stages (Annexure 1).

The Discussion tool in WebCT 6 (Annexure 2A) using the Journal topic provides the ‘student’-cum-client with an individual space for his/her own writing. The Learning Management System offers the option to allow the client to keep his/her journal private between the client and the ‘section instructor’-cum-client. This proved to be useful, as the online counsellor had a record of the counselling interaction that took place.
via the journal entries (identified by the pseudonym), thus ensuring the anonymity whilst simultaneously being able to maintain a sequenced counselling interaction (Annexure 2B, printed with permission of ‘pseudo’ client).

**OBTAINING FEEDBACK FROM RESPONDENTS**

The first phase of data collection was done using a questionnaire within a week of online interaction. The questionnaire (Annexure 3) was designed to be administered on paper to prevent an inherent bias in favour of those familiar with the online environment. Of the 12 members of the sample, mixed in age and gender, six were unfamiliar with, and four were conversant with the online environment. The evaluation was done on two levels. The first section in the evaluation sheet focused on the measurement of the ease with which the client was able to access the online counselling service and establish communication. The second section measured their individual reactions to online communication.

**FINDINGS**

The participants found it easy to send the password via SMS. However, the second set of instructions to access the online journal required attention to detail and three participants did not remember to use the original password as their username when asked to log in again after being prompted to change their password.

One participant did not feel comfortable with the written assurance regarding the privacy and anonymity of the communication. Three participants were pleased that they could communicate online to a counsellor without having to make an appointment. It has been noted that five of the six participants were dissatisfied with the asynchronous communication and found the 24 hour wait too long.

It was reassuring to note that only one participant felt unsafe to discuss his/her concerns online. Two participants were unsure whether they preferred the anonymous online space to FtF counselling. Four participants preferred to communicate anonymously online rather than discuss their concerns on the telephone. Two participants found it difficult to communicate in text.

The second phase consisted of an interview with two participants. The questions dealt with:

(a) technical obstacles
(b) reflections on the counselling process
(c) relating in a nonverbal environment
(d) having to wait for a reply
(e) the convenience of online counselling.

The first participant, unfamiliar with the online environment, mentioned that it was ‘frustrating’ and ‘tedious’ to log in and not succeed ‘time and time again’. He suggested that ‘It would be good to arrange with the counsellor to be online at the same time’. He did mention that he ‘like(d) the idea of being able to ask potentially embarrassing questions without feeling exposed’, although he believed that ‘the dialogue would be affected by the lack of verbal and visual feedback’.

The second participant, familiar with the online space, said ‘I found it easier to express myself clearly as I could read my reply and add to it or change it, but how do I know that I can trust this online counsellor?’ She also suggested that it would be ‘advisable to include an emergency contact number’.

Both interview participants mentioned that although they appreciated the convenience of being able to post an online message at any time of the day, they did not like to wait (‘too long’) for the reply.
The findings of this study are limited to the design and viability of the provision of an online service to discuss HIV/AIDS related issues, one-on-one between anonymous client and online counsellor. Based on the findings of the current feasibility study it has become evident that further investigation into DUT staff and student reactions from a randomized and larger sample would be essential to extrapolate on current findings. Further research, perhaps a ‘before and after trial’, would also be necessary to confirm reliability, validity and effectiveness of an online counselling service for the DUT community.

The data collected from the questionnaire and the interviews indicate that it would be erroneous to assume that

- the majority of the DUT community would be at ease with text based online communication on HIV/AIDS related matters
- the asynchronous delayed communication would not be a serious deterrent
- most people are not reliant on visual and verbal cues to facilitate communication
- people would automatically trust the online counsellor.

Hence, for the next round of implementation, (i) with regard to ease of access and technical obstacles:

- It would be imperative to supplement the short message service (SMS) based information provided to possible clients to gain access to the online counselling space. This could be done concurrently with the marketing of the online counselling service, with relevant information included in paper fliers, e.g., instructions to log in, with recognisable graphics.
- The instructions would be amended to include written instructions supported by visual cues like ‘REMEMBER to use your original password as your username’. It was found that this particular step was frequently not followed and led to log in failure.

(ii) With regard to improving familiarity and comfort with text based communication, the following should be considered:

- Additional opportunities for online text based communication with non-threatening issues that can be shared in the iSineke online counselling service (for example, using the chat tool), should be included to improve levels of familiarity and comfort with text based communication.
- Encouraging academic staff to increase computer based instruction and coursework delivery via blended learning, as well as student-to-student online interaction via e-mail and other text based communication networks.

(iii) With regard to the ethics of online counselling and the establishment of a trust based online counselling relationship, it is suggested that

- Detailed explanation on the online counselling process and procedure is provided.
- Information on the qualification and certification of online counsellor/s is made available.
- The risks and benefits of the online counselling process is explained and ways of protecting oneself against these potential risks are provided.
- An existing emergency contact number, with a helpline (e.g. Lifeline), should online contact be unavailable, is provided. This may be included in the marketing of the online counselling service.
Media facilities available at the DUT campus are used, e.g. The Conduit (a biweekly campus newspaper) and the DUT website to introduce the online counsellors and thereby facilitate trust building between client and online counsellor/s.

(iv) With regard to enhancing the convenience of online counselling and specifically the ‘wait period’ in asynchronous online counselling:

Information needs to be provided with regard to the likely ‘wait period’ between online counsellor and client communication would be essential. The possibility of arranging specific times for synchronous communication via the online journal could be suggested to the online counsellors as an option.

The first two cycles of the study have been focused on the design and technological facilitation of the online counselling service. Thus far it has been an online adventure, a journey of discovery exploring uncharted territory. The use of action research has revealed the possible strengths and weaknesses in the design with new cycles to be commenced with refined attempts to improve the design and implementation. The responses from the ‘clients’ have added credibly to the idea of providing a private discussion space with a qualified online counsellor to facilitate transformation and behaviour change with regard to sexual behaviour patterns. The need for privacy and convenience in requesting assistance on HIV/AIDS concerns that are difficult to share in public for fear of rejection and stigma is undeniable. The opportunity provided by an online counselling service assuring the user anonymity is encouraging, especially when confronted by the enormity of the impact of the HIV/AIDS pandemic on higher education institutions.

REFERENCES


**ANNEXURE 1**

Instructions provided using the Short Message Service (SMS) to gain access to the online counselling service.

The first stage for the client would be to SMS a secret password to the helpdesk administrator. The username would also serve as the initial password. The process for accessing the online counselling space would then follow as a reply to the client via the SMS facility, and would also be included on the DUT website, which would allow for images to support the instructions e.g.

**step one** : after 24 hours, go to http://edtech.dut.ac.za

**step two** : Click on My Blackboard

**step three** : to log in use your the same password that you have sent to me via SMS as both your password and username.

**step four** : you will be requested to change your password.

**step five** : you will then be requested to log in again.

**step six** : Remember to use your original password as your username and type in your new password to log in.

**step seven** : In My Blackboard, in the Course List, click into the iSineke course

**step eight** : In the Course Tools drop down menu, click the discussion tool

**step nine** : In the discussion window, click on VCT

**step ten** : In the VCT window, click on the create new entry button to create your new entry in My Journal.
ANNEXURE 2A

The VCT window with instructions to create a new entry in My Journal

ANNEXURE 2B

An example of an online interaction

Subject:
December is AIDS AWARENESS MONTH

Date: 20 November 2007 13:49

Knowing that December 1 is a World Aids Day and the whole month is dedicated to Aids awareness, my question is how is government going to convince people to use condoms after what happened when millions of condom had to be returned?

What if a person has been using those condoms thinking that S/HE is protected only to find that s/he was the same as the person who was not using protection?

How can we be sure that, the condoms that government is distributing now are safe to be used?

Just a concern !!!

Kayb30
Comments

**Subject:** December is AIDS AWARENESS MONTH

1. **Author:** Gitanjali Mistri  
   **Date:** 20 November 2007 14:30  
   Hi kayb30  
   I too am concerned about the reliability of the condoms. I have read in the press that the damaged condoms (government provided) have been recalled but it has already done untold damage to the prevention drive.

2. **Author:** kayb30  
   **Date:** 20 November 2007 14:39  
   But still prevention is better than cure, so I can just hope that the commercial condoms are the way to go. in fact **abstinence is the cure**

3. **Author:** Gitanjali Mistri  
   **Date:** 21 November 2007 14:28  
   Yup! I agree. One partner relationships should be promoted as well, don’t you think?
### Section 1: Access

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Don’t know</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The online counselling facility was well advertised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The anonymity and privacy of the online interaction was clear and easy to understand.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was easy to send my password via SMS and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was easy to follow the SMS instructions to access the online journal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The fact that the online counsellor would post an online reply to me within 24 hours was well explained.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It’s convenient to communicate online without having to make an appointment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional comments:**

### Section 2: Communication Preferences

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Don’t know</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel safe in the online space to discuss my concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I prefer to meet with a counsellor face to face</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I prefer to discuss my concerns with a counsellor on the telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I prefer to send an e-mail to the counsellor who would know my name and identity.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I prefer to remain anonymous and communicate in text</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t like having to wait for a reply</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Comments:**