

Chapter Three
Surveillance and Client-Centered Counseling

Introduction

Normative definitions of test counseling have evolved to reflect advances in HIV prevention research and changes in the epidemic. Beginning in 1993, counselor training curricula were revised to reflect the shift from an information-based education model to a more interactive and “client-centered” use of counseling skills. However, the institutional culture of the CT program has not been able to accommodate the new model of interaction. This chapter draws on recordings of 42 pre-test counseling sessions to show that normative models have limited relevance to locally defined practice. These sessions reveal the difficulties of applying an interactive, “client-centered” model of counseling within the constraints of a public health screening service.

At the BFC, as with other California publicly funded test sites, the structure and content of test counseling sessions are structured around a test counseling report form. This form, developed by the State Office of AIDS, must be completed for each client because it serves as an invoice that allows the clinic to be reimbursed for each test. Since 1990, the form has undergone four revisions. The data from each form is entered by the local health department onto a central database using software provided by the State Office of AIDS. With each change, the risk behavior questions have increased in complexity, requiring counselors to pay more attention to the form's database and surveillance logic and less to the client's individual narrative.

The increasing complexity of the form's questions are ironic because they were accompanied by new client-centered counseling guidelines that urged counselors to de-emphasize the form and generic AIDS information. Whereas previous training focused on filling clients with correct and presumably "neutral" information and advice, the new training pays more attention to listening skills. Under the new guidelines, counselors

should spend less time on providing information and instead help clients explore their feelings about their risk and devise a developmentally appropriate "risk reduction plan."

Counselor training curricula have embraced the new "client-centered" model. Yet normative understandings of counseling have little relevance for counselors if they fail to take into account how the practice of test counseling is institutionally structured by surveillance technologies such as the form. In this chapter, I examine how a particular institutional structure is effectively reproduced through the form. The form reveals the degree to which state power functions in a capillary fashion. In other words, state power is most efficient when it functions unnoticed, at the microscopic level of everyday practice. It is precisely these microscopic forms of power upon which institutions are built and continually reproduced through the most mundane forms of interaction. The form offers a perfect example of decentralized governmentality (Burchell, et al. 1991). The state's interest in behavioral risk at the population level results in the deployment of an army of roughly 1500 counselors with a warrant to discipline individual subjectivities according to a normative standard of safer sexuality. Even in the ostensibly progressive, and even sex-positive context of the Berkeley Free Clinic, the powerful effects of the form on the sessions are palpable. The form reflects the tensions between normative models of client-centered counseling and the state's need for surveillance data, all the while offering us a common reference point when analyzing the session transcripts.

The sessions

Despite the client-centered guidelines, evidence from the recorded sessions reveals how counselors dutifully serve the state's need for surveillance data at the expense of counseling. Far from being interactive, test "counseling" is essentially a data collection process. The client completes a survey in exchange for the test. In turn, the clinic

exchanges the completed survey for money from the state. The role of the counselor in facilitating this transaction of information for service is made very explicit in the introductory lecture of one counselor. (See appendix three for a key to transcript symbols.)

Counselor (C): Okay, so then this is your first (.) time coming into an ATS site to be tested? Alright let me explain a couple things. Number one you were told this test would be free.

Patient (P): Yeah.

C: And what the state means is there's going to be no money passing hands. But what we're going to do for about the next ten minutes is we're going to go over a demographic sheet...

Because the form serves as currency for a "free" service, test counseling is reduced to a formalized, bureaucratic transaction of information, not unlike renewing one's vehicle registration at the DMV.

The form offers a number of impediments for counselors in developing rapport with clients. The obscene nature of the form's questions creates a number of interactional problems. The questions are "obscene" (literally "off scene") in the sense that activities are removed from their highly charged emotional and social context in order to be examined under the cold and uncompromising light of moral and epidemiological discourses. Clients are interrogated and patronized while their sexuality is ripped out of context and plotted against a highly clinical grid of time, risk, and latex. It would be difficult to imagine a less "client-centered" form of interaction. Counselors employ a number of distancing strategies in order to mitigate the impact of the questions. Perhaps the most common strategy is to simply resort to the didactic model of counseling in which an expert provides information to a passive client. In this context, the bureaucratic and

impersonal format serves the interests of both client and counselor in speeding the process along with minimal friction.

The duration of the recorded sessions ranged from ten to forty minutes, with an average length of 16 minutes. While counselor styles varied to some extent, the dynamics created by the form gave the sessions a remarkable uniformity. Early in the sessions, counselors established a didactic or bureaucratic role format that facilitated an exchange of a pre-determined checklist of information. The form guided the content of the sessions, as each question served as a segue to epidemiological factoids and prevention messages, most of which was irrelevant to the clients' particular concerns. Counselors typically wrapped up the session with some variant of "That's all the information I need, and I think I covered everything, are there any questions?" Like any other formalized bureaucratic or clinical interaction, the role of the clients was to listen passively and answer succinctly so that their answers can be entered on the official form.

A key element of counseling is the open-ended question that is used to elicit a narrative from the clients and ultimately a discussion of their feelings. Counselors rarely asked open-ended questions beyond the standard introductory query, "What brings you in to be tested?" Quite often, this initial question was immediately followed by closed or multiple choice questions that guided the client's response (see chapter seven). The task of completing the form determined nearly all the interaction following a client's narrative of their reason for testing.

Clients spoke very little compared to the counselors. In the rare instances when the client expresses fear or anger concerning their situation, counselors either changed the topic, abruptly turning to the next question on the form, or provided vague reassurances (see chapter six). Based on the counselor's follow-up questions, the client's narrative appeared valuable to the counselor only to the extent that it provided information required

by the form. Rather than probe about their feelings, counselors followed up with factual questions: “how long ago was that?” or “and that was protected?” Counselors routinely repeated questions for which the client’s narrative has already provided an answer. When clients spoke, it most often using a formal, guarded tone in response to the implications of the counselors’ questions. The use of repeated formulas for each question, such as “Have you ever in your life...,” gives the sessions the forensic quality of a formal legal deposition.

In none of the recorded sessions did counselors explicitly discuss a risk reduction plan with their clients. Instead, counselors spent the bulk of the sessions explaining the testing process and completing the form and the related lab slips. Each counselor provides his or her own standard checklist of information that varied little, if any, between clients. Clients asked few questions, and the length of the sessions varied primarily according to the amount of information or advice the counselor typically presented.

The recorded sessions revealed a profound disconnect between normative models of test counseling – models with which these counselors are all too familiar - and the local norms that evolve in the practice of a "street-level" bureaucracy. Additional training is often advocated as a solution for counseling that diverges from expected standards. Certainly, more training and continuing education can only help. This chapter, however, examines the structural and institutional constraints that determine the quality of the interaction, regardless of the counselor's level of training or desire to embrace the client-centered model. The next section reviews the dialectic between counseling standards and the changes in the HIV prevention science, funding, treatment advances and surveillance policies. This is followed by a discussion of the State of California testing report form and the impact of specific questions on counselor practice.

The evolving models of CT

Test counseling is a unique and unprecedented behavioral intervention that is still in search of a standard of practice and transtheoretical model. Test counselors receive minimal training: a three day introductory training, a two day follow up at six months, and annual continuing education updates where available. To justify this low level of training, program administrators claim that counselors are “selected” rather than “trained.” Many counselors are volunteers, nurses, or medical assistants, and the vast majority lack professional training in counseling or behavioral research. Most test counseling occurs in clinical settings where time-intensive, mental health issues are generally given a low priority. In this context, counselors are more likely to be selected for their blood drawing skills than for their interpersonal skills.

Whatever communication skills counselors have learned through socialization and bring to their work, the skills needed to confront risky behaviors require counselors to act in ways that are somewhat "anti-social" (Beth Dillon, personal communication, 1999). Often, trained counselors employ various techniques to confront, challenge, or even empathize with clients in ways that depart significantly from normal conversational dynamics. For example, in chapter six I analyze the impact of the counselor's use of long silences in the session. Because it departs from ingrained social conventions, counseling requires a good deal of training and supervision. Evidence of the lack of supervision and training available to test counselors is the frequent misinterpretation of the client-centered guidelines as suggesting that the counselor allow the client to guide the focus of the session. In reaction to the "*laissez-faire*" approach, the recently developed training

materials from the CDC are more scripted and focused and use the term “client-centered” sparingly (CDC, 1998).

It is crucial for counselors to have a clear understanding of the standards and limitations of their role in primary prevention. In the next section I discuss how normative definitions of the counselor’s role have changed dramatically in parallel with scientific understanding of the epidemic and advances in treatment. A number of structural factors have also shaped the content of sessions and hampered efforts to shift from an information-based to a more interactive style. For example, as scientific understanding of the disease is disseminated through a growing array of print and electronic media, counselors have increasingly been asked by clients to help make sense of frightening and often contradictory information about transmission.

As testing became more routine for clients and the volume of clients grew, counselors adjusted to an increasingly routinized and bureaucratic workflow. As the volume of clients grew, so did the proportion of low-risk clients increased. Funding streams remained flat during a period of rapidly rising health care costs. These structural factors contributed to the routinization of test counseling. Although test counseling was originally meant to serve as an referral point to other more intensive prevention services, these costly prevention services have, for the most part, never been funded and implemented. The result has been that some high-risk clients repeatedly use testing for lack of other more appropriate and effective counseling services. The phenomenon of repeat testers raises important questions concerning the limits of test counselors' role in primary prevention.

The Crisis Years: 1985-1987

During the initial phase of the CT program, from 1985-1987, HIV testing was originally conceived as a way to protect the blood supply by diverting high-risk clients away from blood donation centers and into “Alternative Test Sites” (ATS). During these years, test counseling was mainly conceived in terms of crisis management for the large numbers of HIV positive clients. In San Francisco in 1987, the proportion of positives was 20% (Thompson, personal communication, 1997). Counseling was provided at the post-test, and groups of clients watched a video in lieu of a pre-test. One veteran counselor who began working at the San Francisco AIDS Health Project in 1986 described the earliest test counseling protocol.

We did group health education ... about 10 people every half-hour.... A lot of it focused on the test results more really than kind of a risk assessment or any primary prevention....So it was all very crisis-y and no referrals and just you know condoms, condoms, condoms. There definitely was education but it was much more simple and instructive, you know these are the safe sex guidelines, this is how you have safe sex, there was no sense of flexibility about that or even the idea that somebody might have a hard time with that at all. This is an emergency, this is what you do. See ya.

During this period, the primary counseling concern was the degree to which positive results could lead to suicidal thoughts (Marzuk, 1988; Kizer, 1988; Cote, 1992). No treatments existed, and scientific understanding of transmission and prognosis of HIV infection was rudimentary.

Routinization of Testing: 1988-1992

During the second phase of the CT program, from 1988 to 1992, the testing program grew very rapidly. As the percentage of positive results declined from double digits to between one and two percent, test counseling was conceived less as a crisis intervention and more in terms of an opportunity for primary prevention. Alternative Test Sites were renamed “Counseling and Testing Sites” to reflect the programs change in

focus. During this period, counseling served primarily to disseminate basic information about HIV and AIDS and safer sex guidelines. Unlike the early years, the role of the counselor was primarily didactic, providing each client with a standard body of information about the test, the availability of new treatments, and ways to reduce their risk.

As Table 3.1 illustrates, the number of low-risk testers doubled while the proportion of high-risk testers began to decline, as reflected in the declining percent of positives.

Table 3.1: HIV Testing in Publicly-Funded Sites, United States, 1990-1992

Year	Tests	Seropositive (%)	Funds
1990	1,491,715	56,064 (3.8)	\$100,849,173
1991	2,090,635	57,879 (2.8)	\$102,751,773
1992	2,689,056	55,024 (2.0)	\$102,742,506

(CDC, 1994b)

Despite the rising costs of providing individualized counseling, funding remained essentially flat for the period. For example, in California, clinics received the same level of reimbursement from 1985 until 1997. Since clinics were reimbursed according to the number of tests provided, and reimbursements did not keep up with inflation, there was no incentive to improve or even maintain current levels of quality or duration of prevention counseling. In 1990, the state of California began collecting client demographic information using client profile forms (Appendix 1). This marked the beginning of a trend toward bureaucratization of CT services. Because no other primary prevention services existed in most jurisdictions, and testing budgets appeared bottomless, it became a routine practice to encourage clients to test regularly. Over half

of all people testing in publicly-funded clinics were low or no-risk clients. Still more people tested regularly at private doctors offices where prevention counseling was generally non-existent.

In the aftermath of Magic Johnson's announcement, testing centers were flooded by low-risk clients in late 1991 and early 1992 (Benson, 1993; Sims, 1991; Truax, 1996). Routine testing is an expensive intervention. Annually, over 100 million dollars is spent directly by the CDC for testing in the public health system. Overall, approximately 650 million dollars on testing by the US health care system (Coates, 1998). After Magic Johnson's announcement, questions arose over the cost-effectiveness of the testing program. Justifications for the testing program have evolved along with changes in treatment and politics. Holtgrave et al.'s (1993) cost-benefit analysis of testing found that the average cost per infection averted, nearly \$26,000, was less than the social and economic costs of treating an infected person. This calculation is based on the premise that clients who test positive will reduce their risk -- either by using condoms or choosing other positive partners -- thereby preventing new infections. This premise was based on equivocal research findings concerning the effectiveness of test counseling as a prevention method (Higgins, 1991).

With each new wave of treatment advances, the rationale for test counseling increasingly shifted toward secondary prevention. Routine testing, it was assumed, would allow for early detection of HIV infection and thus maximize the potential benefits of new treatments. Yet recent research questions the utility of testing for secondary prevention. In a study of positive testers in eight states, Bindman and colleagues found that a large percentage of the HIV infected population delay treatment as well as testing until after AIDS symptoms have developed (Bindman, 1998).

The average time between an HIV-positive test and an AIDS diagnosis is 400 - 700 days. That's an appalling number. It tells us that the current

system is failing individuals. They are not learning their status early enough. It doesn't matter how good our system is if people aren't using it (Bindman quoted in Kaiser Family Foundation, 1998).

Clearly, the new treatments are no panacea. They have many side effects and frequently fail once the virus develops resistance. The need for strict adherence combined with the side effects and questionable effectiveness makes the decision whether to enter treatment extremely complex. A test result disclosure session is not sufficient in itself to counsel people who test positive to actively seek treatment. Although CT is often advocated as an important gateway into treatment, this recent data suggests that CT is clearly not enough.

As the testing program grew rapidly, renewed attention focused on the content and quality of the counseling and referrals to other services. Two meta-analyses of the effects of testing on behavior change showed little positive effect, particularly for those who tested negative (Higgins, 1991; Wolitski, 1997). These reviews revealed a lack of consensus on the definition of counseling and how to measure its efficacy. Wolitski acknowledged that test counseling in the majority of studies was information-based education rather than client-centered counseling (CDC, 1997). The results of these studies suggested that hundreds of millions of dollars were being spent on an intervention that lacked a recognized standard and appeared to have limited efficacy. The opportunity costs of funding such a large and ineffective prevention policy are enormous.

In 1993, the CDC commissioned an external review of its HIV prevention strategies (CDC, 1994b). The review detailed a number of fundamental contradictions in the testing and counseling program. The testing program provided little in the way of risk reduction *counseling*, yet encouraged clients to test every three or six months. Most counseling consisted merely of admonishments to use condoms, and the same level of services were provided to low and high risk clients alike.

There was little effort to assist people in reducing high risk behavior. Many people with persistent high risk behavior were given condoms and advised to return for repeat testing in 6 months (3 months in one state, for no apparent reason).

Several counselors expressed frustration that people with high risk behaviors continued those behaviors but returned for testing every 6 months to see if they had become infected.

The confusion and frustration over the limits of the test counselor's role is not simply due to lack of training. Test counseling was never intended to serve as a stand alone behavioral intervention. Training stresses the importance of referrals to other prevention services that can provide more intensive counseling over multiple sessions. However, according to the CDC external review, "referral services for people with high risk behaviors were usually non-existent. When they did exist, counselors at the CTRPN sites were unaware of them" (CDC, 1994b: 65). Thus, testing is encouraged in order to assess the client's need for other prevention services, yet no referrals are made.

Because a continuum of prevention services is lacking, test counseling is increasingly seen as a primary prevention intervention in itself, rather than a gateway to other, more-targeted and effective services. Due to political resistance to publicly funded community-level AIDS education, testing remains the only politically acceptable prevention modality in most jurisdictions. In a political context that favors surveillance and easily quantifiable individual-level interventions, test counseling will naturally be funded over other interventions regardless of what research says about its effectiveness.

As the only HIV prevention intervention in most jurisdictions, test counseling is held to the same outcome standards as science-based, multi-session, behavioral interventions. Such expectations are a set up for failure because test counseling, as practiced in the field, lacks the resources for training and supervision needed for proof of concept studies such as the CDC's Project Respect or HIVNET's Project EXPLORE.

Without adequate funding and leadership to implement a coordinated approach to targeted, community-level HIV prevention that includes expanded access to medical and social services, the over-reliance on testing alone will not slow the epidemic.

One positive outcome of the evaluations of the CDC's HIV prevention programs was the HIV Prevention Bill sponsored by Congresswoman, Nancy Pelosi and crafted by her AIDS policy adviser, Steve Morin. Under the new policy, local prevention planning groups at the state and county level conduct needs assessments and apportion prevention funding accordingly to local organizations. This was a radical departure from the centralized and competitive disbursement system that was run entirely by the CDC. Although the CDC still oversees the activities of the planning groups and provides guidance and technical support, local planning groups are free to set the levels of funding for testing and other prevention activities. Under the new local planning system, which began in 1995, allocations for testing and counseling have dropped significantly and more emphasis has been placed on more targeted outreach and evidence-based prevention interventions.

California's Testing Program ca. 1997

The short-sighted reliance on testing and counseling as the primary prevention modality has placed prevention program administrators in a catch-22 situation. California's testing program is no exception. Many of the contradictions noted by the CDC External Review of 1993 were evident in comments made by Steve Truax, director of California's testing and counseling division, during a meeting for Northern California test site coordinators that took place in Oakland in May, 1997. The purpose of the meeting was to explain a series of changes to the form and the reimbursement system that

would begin in July, 1997. Among the changes were new standards for the amount of time counselors should spend providing referrals to high-risk clients.

The contradictions of the test counseling program were evident in Truax's justifications for the changes. Despite what his superiors in the state government have believed, Truax recognized the limited role of testing and counseling for changing behavior, yet also recognized that repeat testing is the only referral.

And one of the things that has been good for counseling and testing over the years is that we recognize that counseling and testing is not the cure-all. Very literally, especially the farther up the uh food-chain [of government] you go people have of thought of it [counseling and testing] as "the cure." And, of course, counselors knew all along what was going on because they're closer to the action, recognizing how difficult this job is for many individuals.

And so we're sort of relieved of this overall burden of fixing them on one try. And in fact, shall we say, the "culture" of counseling and testing allows us more than one opportunity to deal with the clients that we see [through repeat testing], and hopefully we can make some kind of a dent....

A psychologist by training, Steve Truax is director of prevention research for the State Office of AIDS and oversees the large database of client information collected by counselors. Truax's task is a difficult one. He must balance the state's need for population level surveillance with the needs of the counselor to provide adequate risk reduction counseling. As the designer of the risk assessment form, Truax is in a pivotal position within the grid of power relations that flow back and forth between the CDC and the local health departments that collect the data. He must stress the importance of test counseling to stakeholders who are continually looking to cut expensive and controversial programs, while keeping in mind the needs of test site administrators to provide services and meet their budgets.

Truax operates in an essentially flat budget environment requiring a great deal of creativity to enhance the quality of the existing framework of service delivery. The rate restructuring offers a good example of this creative allocation of funds. Under the new reimbursement plan money is redistributed from low-risk clients to high-risk clients. "Low" and "high" risk are somewhat arbitrarily defined by the risks checked off on the form by the counselors. Risk factors that are positively correlated with HIV infection in the database are now distinguished by shaded boxes on the form (see the form in Appendix 1.4 and the risk profile in Appendix 2). According to the new reimbursement protocol, all clients receive the same 20 minute pre-test counseling, however low-risk clients are to receive minimal post-test counseling while higher-risk clients receive enhanced counseling and referrals to other services. Low-risk post-test sessions are not reimbursed at all, while high-risk post test sessions are reimbursed both for prevention counseling and for providing referrals to other prevention services. From the local test site administrator's perspective, the new policy translates into more money for forms that show higher risks. Truax takes it on faith that test sites will complete forms accurately and counselors will allocate more time for higher-risk clients.

Truax went on to explain to the test site administrators how the allocation of time for referrals was essentially a means for adding five minutes to the counseling standards, thus increasing the reimbursement rate for high-risk clients another five dollars.

But partly this is more of a window dressing thing, more of a PR kind of thing that we want to emphasize the referral aspect of it, and it was also very effective at getting another five minutes in our standards. Don't laugh, this is important. If you (laughs) sometimes you have sell things in different ways and this was one of the ways in which we could break up the overall time that was committed to counseling as a standard that

helped us out.... They get five minutes of referrals for risk reductions. That's worth another five dollars.

Truax goes on to emphasize the importance of repeat testing, not as an opportunity for prevention counseling, but as an opportunity to provide referrals to other services. But herein lies the contradiction.

There's a statistic that I used to quote that said a third of the people that we test positive we'd seen them when they were negative. And now they're half.

This statistic generates a number of “wows” and “mmms” among the test site administrators. Truax continued,

Okay? Half of the people that we find HIV infected, we counseled and tested them before they were infected. Okay. That's why it's so critical to primary prevention that we make that referral counseling work. And a big part of why it doesn't work is that well right now because there's nowhere to go. There are not appropriate services for that individual.

The rhetorical effect of Truax's alarming statistic on repeat testers is predicated on the assumption that HIV test counseling should in fact work to prevent infections. Yet as he pointed out a few minutes earlier, “we know” it doesn't work and the “counselors are relieved of the burden” of changing behavior within a twenty minute session. This is ostensibly the task of other, albeit non-existent services. Hence the Catch-22.

A number of other contradictions follow from these. Because testing serves as the gateway to other prevention services, these referrals are only available to those people who are willing to learn their status. Therefore, thousands of people who have chosen not to test are never targeted for prevention interventions. If other prevention services did exist, and counselors provided referrals to them, would these referrals be used? In San Francisco, a continuum of prevention programs does exist and extensive referral lists

have been provided to counselors by the D.P.H. (Marx, 1999). Yet in a study designed to evaluate the follow up rate for specific prevention referrals, the health department found that the intervention failed to influence test clients in accessing the referrals (Marx, 1999). In fact the control arm showed better follow-up rates than the arm that received referral counseling. One reason for this discrepancy is that once a person receives a negative result, there is little incentive for him or her to view their behavior as problematic and seek services. Thus for the 98 plus percent of clients who receive a negative result, the reassurance provided by the result itself will tend to negate the effect of prevention counseling and referrals. Not surprisingly, several studies show increased STDs and risk behaviors as sequellae for clients receiving negative results, raising questions about the iatrogenic potential of HIV testing (Cohen, 1994 #822; Chamot, 1995 #810).

Client-Centered Counseling

The terms “client-centered” and “counseling” have largely been emptied of their original meaning when applied to the bureaucratic and clinical context of HIV testing services. The concept of “client-centered counseling” is derived from the psychotherapeutic approach developed by Carl Rogers. Rogers’ work represented a radical paradigm shift for psychology that had been focused almost exclusively on diagnostic criteria and psychometric testing (Rogers, 1980; Tourette-Turgis, 1996). In Rogers’ humanist model of counseling, each individual is endowed with an organic capacity for growth and change (Rogers, 1951). The counselor’s role is to feed this

natural capacity through empathy and unconditional acceptance. The primary technique of client-centered counseling is to actively listen and reflect the client's narrative in a non-directive manner, thereby providing a safe environment for the client's self-exploration. This non-directive reframing of the client's feelings is not a mechanical repetition of the client's last words, as caricatures of this approach often portray. The counselor's relationship with the client enables her to clarify the client's feelings without imposing external assessments or values (Rogers, 1975).

The term "client-centered" counseling has been used extensively in the literature on test counseling. The context in which Rogers developed his methods is very different from test counseling. HIV is a highly stigmatized, deadly, and transmissible infection with unprecedented economic, public health, clinical, and legal consequences both for individuals and society. This unique context makes a twenty-minute HIV counseling session very different from the types of problems that client-centered counseling was developed to address over multiple, and comparatively lengthy, sessions. The development of a counselor-client relationship is the crucial element of client-centered counseling. In a test counseling situation, however, there are simply too many tasks for the counselor to complete within a small window of time. These tasks have nothing to do with the client's issues but serve the institution's need for consent, charting, billing and data collection. Building a working relationship on trust and empathy is simply not possible within the institutional framework of a public health service.

Test counseling also differs from a therapeutic relationship in that it is provided to clients who have not requested it.

It simply comes as part of the package if you request an HIV test. The clients of HIV counsellors may not have brought 'problems' that they wish to talk about and so may often adopt a more 'passive' role (Silverman, 1997: 8).

One can question how a counseling relationship can be created when it is imposed unilaterally. To incite the client to speak under such circumstances requires the deployment of power in order to break the bureaucratic frame. In my experience as a counselor, I found that most test clients did not view their behaviors as necessarily problematic. Each client constructs a highly individualized set of strategies for avoiding risk. For many, seeking a test is an important component of this strategy and not problematic in itself. For this reason, clients have difficulty seeing their need for a test as problematic or requiring counseling. Moreover, because clients are primarily interested in learning their status, the counselor's attempt to either problematize their behaviors or engage them in a counseling discussion will usually be met with passive, and sometimes even active resistance. This usually takes the form of gestural cues to speed up the session -- fidgeting, looking towards the door, taking condoms -- or by simply showing requisite contrition for past lapses and swearing it will never happen again. Another form of resistance to test counseling is manifested in the high number of clients who do not return for their results (Valdisseri, 1993).

Rogers' client-centered counseling is antithetical to behavioral approaches typical of public health. The latter approach typically imposes a top-down assessment of the client's needs and capacities for change. In a top-down model, the therapeutic relationship is used to make the client accept the counselor's analysis of the situation. Public health targets individuals for intervention, not to help individuals but in the

interests of the larger population. At the core of biopower is a fundamental distrust of the subject, who is in fact no longer a subject but an aggregate of risk factors.

There is, in fact, no longer a relation of immediacy with a subject because there is no longer a subject. What the new preventative policies primarily address is no longer individuals but factors, statistical correlations of heterogeneous elements. They deconstruct the concrete subject of intervention, and reconstruct a combination of factors liable to produce risk. Their primary aim is not to confront a concrete dangerous situation, but to anticipate all the possible forms of eruption of danger. 'Prevention' in effect promotes suspicion to the dignified scientific rank of a calculus of probabilities (Castel, 1991).

In public health discourse, individuals are invariably defined in terms of a deficiency – a lack of information, socialization, or self-efficacy. By contrast, Rogers worked from the bottom up, working from within the client's phenomenal world to guide the client's own problem solving capacities.

Despite the fundamental incompatibility of the humanist approach of counseling with the behaviorist and population focused approach of public health, “counseling” and “self-help” have increasingly been adopted as techniques of biopower applied at the level of the individual – what we might call “pastoral biopower.” Public health services have become increasingly de-centralized, privatized, and community based. With deinstitutionalization, state-sponsored family planning, genetic testing, and the “war on drugs,” there has grown a need for individual, face-to-face interventions by street-level bureaucracies. With the rise of individual focused medical and case management services to address a growing list of social and ethical problems -- teen pregnancy, drug use, delinquency, and new reproductive screening technologies -- counseling techniques were appropriated from the psychotherapeutic context and applied in clinical, judicial, and social work contexts.

Once these new individualized services offered in a clinical context, a new cadre of para-professional “counselors” was created. In the case of substance abuse and AIDS, "counselors" were recruited from target populations, thus emphasizing life experience over clinical or theoretical training in counseling (Brown, 1993). This emphasis reflected the need to serve a large population using lower paid workers -- ideally volunteers -- because such programs lacked the funds to hire professionally trained counselors. Moreover, trained professionals were, for the most part, neither willing nor trained to work with stigmatized and marginalized populations.

In essence, counseling in a clinical context is recast from a therapeutic encounter to a highly routinized assessment, screening, and consent process that facilitates the deployment of a clinical intervention, be it abortion, HIV testing, or genetic testing. A number of interesting parallels can be drawn between abortion counseling and test counseling. As Simmonds and Joffe reveal, counseling in a clinical environment is hampered by its relatively low status compared to the biomedical interventions (Joffe, 1986; Simmonds, 1991). Abortion counselors work under time constraints since their work has to follow the dictates of the medical/surgical staff. Abortion counselors are typically not allowed to accompany their clients during the procedure, as if all the emotional issues are expected to be resolved by the time the medical staff is ready to do the procedure. Simmonds noted how a strong punitive discourse carries over from the medical staff into the work of the counselors. The existence of counselors, ostensibly attending to the emotional and educational needs of the clients, only serves to reinforce

the judgmental silence of the medical staff. The counselor's task is to produce a docile subject to facilitate the workflow of the medical staff.

Counseling in both contexts is held to unrealistic expectations for changing complex behaviors such as unprotected sex. Many abortion counselors express frustration and even anger whenever clients seek repeat abortions. Clients are blamed whenever services fail to change sexual behaviors that counselors deem problematic. Despite the best intentions of counselors to be non-judgmental and "client-centered," the top-down, normalizing discourse that sees hormonal birth control as the only solution, renders such efforts meaningless.

New Test Counseling Guidelines

The CDC released new guidelines for "client-centered" counseling beginning in 1992. The new guidelines placed more emphasis on behavioral and counseling theory and explicitly stressed the inadequacy of information-based approaches. The client-centered model was clearly at odds with current practice and was a welcome change from the perspective of program managers and stakeholders alike. It is difficult to argue with the notion that counselors should regard clients as human beings and tailor the sessions to their particular needs. Yet, without specific reference to the local practices, many of which make the transition to a client-centered model difficult if not impossible, these new guidelines have limited relevance. The new guidelines attempted to combine several approaches that are incompatible with each other as well as with the institutional culture of test counseling. From the counselors' perspective, the new standards placed an

enormous and unprecedented expectation on counselors to be able to change sex- and drug-related risk behavior within the limits of a twenty-minute session.

Despite the incompatibility of this model with the established practice of test counseling, the “client-centered” approach is now codified in training materials as well as state and federal guidelines for HIV test counseling. The CDC guidelines released in May 1994 offer a broad description of the goals, but are silent on the question of method or technique.

Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs. This counseling avoids a preconceived set of points to be made by the counselor and encourages the client to do most of the talking. The focus is on developing prevention goals and strategies with the client rather than simply providing information. An understanding of the unique circumstances of the client is required -- behaviors, sexual identity, race/ethnicity, culture, knowledge, and social and economic status (CDC 1994a).

The revised State of California HIV Counseling and Testing Guidelines provide a more descriptive version of the “client-centered” approach (DHS/OA, 1997). Two necessary conditions for client-centered counseling are:

Unconditional positive regard refers to the counselor’s respect for, not necessarily approval of, the client’s feelings and concerns. If a counselor feels very different than a client regarding a significant issue related to HIV risk, it is imperative that the counselor detach from his/her perspective completely in order to communicate effectively with the client.

Framing the session in the client’s terms refers to the counselor’s effort to work within the “frame” of a client’s life experience and the client’s description of that life experience. Clients often feel that they understand their “issues,” and the counselor may even use the client’s own words and images to reflect back that understanding to the client. Although the counselor may disagree with the client’s understanding, client-centered framing techniques can help the client begin to reframe his/her issues. This reframing can help the client clarify reality-based issues and risk taking in way that the client finds valuable and usable. Helping the client

to do his or her own reframing is the primary object of client-centered counseling (DHS/OA 1997).

In this text, "client-centered" principles are altered to reflect the fundamental distrust of the clients' understanding of their own issues and the privileging of the counselor's unilateral access to "reality-based" expertise. The guidelines correctly stress that remaining "client-centered" is not a *laissez-faire* attitude as Rogers' non-directive approach is often misunderstood to be. As Susan Dietz explained at a recent CDC workshop on perinatal testing

Sometimes there is a misunderstanding that a client-centered interaction is a free-form conversation about anything that happens to come up, such as the weather or what happened to the client that day or something totally unrelated. That is not the point of a client-centered interaction. The counselor does have a responsibility to keep the session directed toward HIV prevention.

What is different about client-centered counseling is that it is the client's HIV prevention issues that become the main topic. Sometimes that is difficult to do, and a counselor does have a responsibility to bring that discussion back to HIV prevention, so that there is a specific prevention goal at the end of the session. There must be a prevention goal, no matter how small—some incremental step should be agreed on by the end of that counseling session (Dietz, 1998).

Hence, the only reframing possible is one that sees risk taking as highly problematic from a public health standpoint, rather than attempting to understand the client's phenomenology of risk behavior. This reframing comes with a host of pre-suppositions about the client's values about risk-avoidance. Unless counselors can disengage from the risk elimination stance taken by public health, and become more empathic (in Rogers' sense) it will be difficult for them to enter into an honest dialogue with clients about their risk behaviors.

The new emphasis on behavioral theory was evident in the change between the first and second counselor trainings I attended in 1994. For example the 1991 version of

the California Basic Training was entitled “HIV Antibody Counseling: Sharing the News.” This evangelistic title reflects the largely catechistic approach to the session. This initial training was structured around a detailed checklist of information to review with each client. These topics included the accuracy of the test, the window period, available treatments, risk reduction methods, and whether the clients fully consent to test and learn their results.

Another focus of the training was cultural sensitivity. Part of this involved a recognition of our own biases towards target populations and attitudes about sex. The group underwent desensitization exercises in which slang terms were gathered from the group and written on the wall. These were supplemented with handouts prepared for the training that listed slang terms for sex and drugs. Trainees were thereby furnished with a new vocabulary with which to translate prevention messages into the appropriate vernacular of the *indigene* (see Patton, 1991 for critique of this form of linguistic colonialism). This cross-cultural sensitivity tended to reify stereotypes about each group's particular cultural risks factors (i.e. deficiencies in relation to the normalizing clinical language of the trainers).

The enhanced risk-assessment training was provided six months later once novice counselors had gained some experience with clients. This two-day training had been developed in 1994, after the CDC published first client-centered recommendations. Very different from the first training, this training focused on the problem of “relapse” to unsafe sex and the stages of change model. Through role-plays we learned skills such as assessing the context of risk behaviors, prioritizing the intervention, “constructive confrontation,” and how to respect one’s limits as a counselor. Where the previous “testing 101” model was a generic and fact-based curriculum, the updated training

emphasized an individually tailored approach to the clients' level of knowledge and even their developmental "stage of change" (Prochaska, 1992).

In 1995, a new version of the basic training was developed featuring many of the same changes as the enhanced risk assessment training. Missing from the new version of the training were the checklists of standard information. The counselors' role as health educator was replaced with their "limited" role as risk reduction counselor. As the new "client-centered training pointed out,

Information alone does not lead to behavior change: Behavior change is a complex process. Providing information as the sole, or main, intervention is generally not sufficient to lead a person to change behaviors (Quackenbush, 1995).

Another justification for the de-emphasis of education was that levels of HIV knowledge had increased since the early years of test counseling. In addition, many clients had already been tested and counseled, making much of the information appear redundant. Indeed many of the clients living in highly impacted areas such as the San Francisco Bay Area knew considerably more about HIV/AIDS than the counselors.

Despite the trend toward saturation with HIV prevention information from electronic and print media, HIV information has also become more complex and contradictory. As clients are exposed to more and more HIV information, test counselors and HIV hotlines are increasingly sought to resolve contradictions or explain the relevance of recent studies reported in the media. Clients also tend to discuss AIDS with other lay people more than before. The democratization of AIDS information has meant that already complex and distorted messages become even more inconsistent. Religious groups actively circulate "science" on the lack of efficacy of condoms in order to promote abstinence messages.

Therefore, a crucial task for HIV test counselors is to help clients understand where they stand in this sea of information and to critically interpret the relevance of prevention messages to their situation. Thus, by no means has the client's need for information diminished. In fact, it could be argued that the counselor's role as educator is more important than ever. Rather than providing information, counselors must provide critical thinking skills that will allow clients to judge the merits of contradictory AIDS information. While a return to the primarily didactic model of test counseling would be undesirable, counselors cannot assist clients in reducing their risk without making sure the client has an accurate understanding of relevant transmission and risk reduction information.

The Fine Line between Risk Assessment and Surveillance

One of the more ironic aspects of the State's "client-centered" model of counseling was the revision of the form to accommodate the new approach. The amount of data required to complete the form was increased several fold. The form became double sided, and the questions increased in both number and complexity. For example, clients are now asked to detail condom use for oral, vaginal, and anal intercourse with each type of partner -- Male, Female, Sex Worker, IDU, HIV positive, and Bisexual Males. The number of recreational drugs surveyed doubled on the new form, meaning that counselors spent considerably more time attempting to explain what the form is asking and why the state needs all this information.

Why does the state need all this information? California is one of a few states heavily impacted by HIV/AIDS that lacks an HIV reporting system. Only AIDS cases are reported, providing a delayed perspective on trends in HIV incidence. The data collected by test counselors are an important tool for filling this gap and this can explain the

increasing resemblance of the form to other epidemiological surveys. For Truax, client-centered counseling is primarily a question of proper risk assessment, which requires a more complex form. A description of the previous refinements of the database appeared in the 1994 Quarterly Report of the Counseling and Testing Section.

A key component of the new client-centered approach to HIV counseling is the establishment of a risk assessment process. The risk assessment process HIV counselors now follow to determine the client's HIV prevention needs provides a more complete and useful description of risk patterns than ever before. Few special studies match the thoroughness of this data and the resulting State database is large enough to provide reliable findings for even very small groups. While the function of this risk assessment process is to permit the most effective client-centered counseling possible, the accumulation of this data provides us with a unique opportunity to better understand HIV risk.... (DHS/OA/CTS Quarterly Report, July-September, 1994).

It would appear from this description that the form also serves to advance epidemiological understanding of the disease.

Yet Steve Truax, the form's chief architect, denies that the form serves as an HIV surveillance instrument. Since counselors were not trained to collect such epidemiological data, I asked Truax how he accounted for interviewer biases and distortions when analyzing the data.

You can see by the way it's constructed, it's not a structured interview approach. If you were doing a structured interview, you'd provide them with a script that's very detailed and branches and deals with all of the things that you would cover so that the process is highly stylized and there's not much variation possible. The form that we've developed is very economical in that regard and simply highlights the points to be made because of what the counselor has to obtain in the way of information to fill the form out (Truax, personal communication, 3/5/97).

Nevertheless, in the same Quarterly Report describing the new form, Truax writes that the data provided by the form on one third of all new infections in California are

extremely valuable for determining the nature of risk and trends in risk....This should be particularly true for emerging risks that AIDS cases do not adequately describe and belatedly identify. Also, in time, we should be able to trace changes in patterns of safer sex and needle sharing behaviors with these data.

Despite the limitations of test client sampling and the vagaries of the data collection process by untrained counselors, the data are clearly used on some level to gauge "trends in risk" and fill in the gaps of AIDS case reporting. While using test clients as a sample may seem unorthodox the data are ultimately being used for HIV surveillance. Numerous research studies based on this database have been published and presented at conferences by the State Office of AIDS (See DHS, 1996 for a list of research reports based on this data). While these studies note the limitations of self-reported data and a self-selected sample, the authors claim that the data represent Californians at risk for HIV because the CT data resemble the AIDS case reporting data (Forquera and Truax, 1997). Can counselors simultaneously provide client-centered counseling and collect key data for State HIV surveillance purposes? As the following discussion suggests, these two goals may be mutually exclusive.

Accuracy in Completing the Form

According to the 1997 revision of the State of California HIV Testing and Counseling Guidelines, client-centered counseling should not be form-centered.

Be flexible in filling out the form. Although it is appropriate to complete some information as it is asked (e.g. zip code, age, ethnicity, number, results and dates of past tests), some counselors choose to wait until the session is over before completing the CTR form. Still others take notes on a separate sheet of paper or write in the columns as appropriate. Every counselor's style is unique. It is important that each counselor develop his/her best method.

Yet throughout this same document counselors are reminded to complete the form accurately, both for fiscal and counseling reasons. Two paragraphs below the instruction to be “flexible in filling out the form,” the manual reminds counselors to

Document accurately. Incorrect information charted during the risk assessment will either cause inappropriate counseling interventions to be attempted and/or use up unnecessary information correction time in disclosure sessions.

Although, the form is supposed to recede into the background, the forms are very difficult to fill out accurately without directly asking the clients. In the 42 recorded sessions, all counselors completed an even simpler version of the form (Appendix 1.2) while the client was present. I have never observed a counselor complete the form without the client present. The expectation that counselors will complete the form after the client has left is unrealistic and would clearly jeopardize the accuracy of the data recorded.

In the latest revision of the form, accuracy is paramount, as the data on the form directly impact the level of reimbursement to the clinic. Because the form is first and foremost an invoice, and secondarily a tool for data collection, a stress on accuracy is not surprising. Higher risk clients, defined as clients for whom a shaded box is checked on the form, net the clinic double the rate of lower risk clients. Local health departments have an interest in accuracy and consistency in completing the form because their ability to enter the data onto the state database to ensure accurate billing depend on the counselors’ thoroughness. The stress on accuracy and completeness is naturally passed along to each counselor by their supervisor. For example, on the new form counselors are encouraged to probe more about drug use, since certain drugs are flagged as higher risk (see Appendix 1.4). The two-tiered reimbursement system and the complexity of the drug questions make it more likely that counselors will ask these questions, much as if they are completing an epidemiological survey. Like the questions on exchanging sex for

money, questions about drug use are particularly sensitive because they ask the client to report illegal behaviors to a representative of the state. To justify these questions, counselors must explain the complex relationship, assumed by the question, between use of certain drugs and increased risk behavior.

In terms of counseling strategy, the issue of drug use and its relation to drug use is best addressed in response to the clients' own narratives about their risk behavior. The clients' own narrative, however, is never elicited because the focus is on completing the form using closed-ended "yes" or "no" questions. Moreover, as drug abuse counselors know, clients are not likely to admit that their drug or alcohol use is "out of control" or even an issue needing to be addressed. By asking clients directly about their drug use, for the purposes of filling out the form, clients are more likely to lie about their drug use. They are also more likely to deny the relevance of their drug use for their risk of unprotected sex. As one client retorted, "I haven't used condoms when I've been sober either, so I guess that doesn't apply to me."

Because counseling occurs one-on-one, with infrequent direct supervision, the form is one of the only ways supervisors can regularly assess a counselor's performance. As I have learned from experience, counselors who fail to complete the forms consistently will attract unwanted attention from their supervisors. Similarly, a test site coordinator who turns in incomplete forms to the health department will attract not only unwanted attention, but potential delays in reimbursement as well. In this way, counselors learn early on the importance of completing the form accurately and consistently. This accounts, in part, for the importance the form assumes in structuring the counseling session.

Checklist Counseling

In the recorded sessions, counselors used a previous version of the form that did not contain checklists (Appendix 1.2). Nevertheless, all counselors appeared to use some type of mental checklist as a mnemonic device to structure the session and be sure to provide the client with all the necessary information. This was evident when one compared successive sessions by one counselor. Counselors used a set script and clients appeared to sense the rote nature of the interaction and politely allowed the counselor to perform their routines undisturbed. A few counselors took the checklist approach to an extreme, providing each client with a veritable blitz of information, risk reduction advice, and prevention messages that were by and large irrelevant to the client's situation. For example counselors discussed the risks of neonatal transmission, or the use of certain types of anti-fungal vaginal creams which contain oil-based ingredients even though clients indicated that these were not issues for them or their partners. These counselors clearly envisioned the appointment as an "AIDS 101," discussing new combination therapies, recent research on oral sex between gay men, survival time with AIDS, basic information about STDs, and the window period.

Counselors using the information blitz format used a number of strategies to justify their approach to the client. For example, after covering a number of rather esoteric topics, one counselor exclaimed, "We're into educating you here!" Hastily adding, "But you seem pretty well educated." This statement attempts to frame the lecture format as a routine enacted with all clients, and not an insult to this particular client's intelligence.

A number of counselors asked clients to begin the session by summarizing what they know about how the virus is transmitted. This quiz format is patronizing since it assumes that the client can readily verbalize their knowledge to someone positioned as an expert on the subject. Clients were generally expected to recite the list of four bodily

fluids that can transmit HIV, not merely those with which they might have contact. Most clients avoid the embarrassment of making a mistake and plead ignorance, realizing that the counselor will probably correct them anyway. This allows the counselors to justify their lectures as if the clients had solicited it. Needless to say, those brave clients who do attempt to summarize the modes of transmission are only able to stumble through a sentence or two before the counselor jumps in and proceeds again down the checklist. This type of checklist pedantry is precisely what the “client-centered” model was intended to displace.

Client-centered counseling, as described by the 1997 DHS/OA Guidelines,

involves an interactive, highly personalized exchange between client and counselor. Counselors working with clients in a client-centered manner *will not be wedded to a preconceived set of points (or checklist)*. Rather they will engage in a dialogue that encourages the client to do most of the talking (emphasis added, IV.10).

Inexplicably, the new form -- “designed in intensive collaboration with the HIV training curriculum development staff, HIV counselor trainers, and senior counselors,” -- contains *five* checklists, reproduced below.

Counselor: Review/Assess these Introductory Issues

- Client’s reason for HIV testing.
- Confidentiality/anonymity.
- Risk Assessment Process.
- Purpose of this form.
- What the HIV test measures.
- Meaning of results (positive, negative, inconclusive).
- Accuracy of the HIV test.
- Impact of HIV on the immune system.

Counselor: Review/Assess these Testing Issues

- Window period.
- Date of any follow-up test.
- Process of testing.
- Coping with waiting for test results.

- Client's readiness to be tested.
- Offer testing, if appropriate.
- Set immediate, short and long-term goals.
- Specific HIV prevention & support referrals.
- Encourage the client to return for results.

Counselor: Review/Assess these Risk Reduction Methods

Condom or Barrier Types used:

- Latex condom
- Natural Membrane Condom
- Latex Barrier
- Plastic Wrap
- Polyurethane condom
- Reality© condom
- Latex/Vinyl Gloves
- Other, Specify _____
- None, Why: _____

Counselor: Review/Assess these Basic Issues

- Cultural/peer influences.
- Demonstrate proper condom and barrier use.
- Role play with client to build needed skills.
- Safer sex guidelines.
- Partner risks as they relate to client risk.
- Communication of HIV risk/reduction with partner(s)
- Domestic violence/sexual assault.
- Voluntary partner/spousal notification (self or assisted).
- Pregnancy concerns in relation to HIV risk.
- Maternal transmission (in utero, at birth, breastfeeding).
- Integration of birth control/risk reduction.

Counselor: Review/Assess these Drug and STD Issues

- Prevention/harm reduction/safer sex with IDUs.
- Demonstrate proper needle cleaning.
- Encourage/support substance abuse treatment and recovery.
- Alcohol/drug use with sex as a cofactor for HIV risk.
- STD history (e.g. hepatitis, syphilis, gonorrhea, herpes, warts, chlamydia, NSU/V).
- Other sexual behaviors affecting STDs (rimming, etc.)
- Presence of STDs as a co-factor for HIV risk.
- Health effects of concurrent STD/HIV (e.g. PID)

The guidance for completing the form describes these checklists as

lists of potential topics that all HIV counselors should consider discussing with each client. Some must be discussed with every client but few clients will require the discussion of every issue. A check off box for each topic provides a handy means of noting what was covered with the client in the counseling session, important information for disclosure session. Using these boxes provides prompts, notes coverage of topics and provides communication to disclosure counselors (VI.A.10.)

The form does not distinguish which of the 45 topics must be covered for each client. If counselors were to actually address these issues in a “client-centered” way, that is by letting the client raise these issues themselves, a test counseling session would probably take several hours, perhaps days. In twenty minutes, the only way to cover a small fraction of these topics is for the counselor to lecture and for the client to remain passive and silent. The proliferation of checklists on the new form reveals the state's ambivalent embrace of client-centered principles and a lack of confidence in their counselors' ability to implement them. The changes to the form also reveal the data fetish that appears to drive the counseling and testing program.

Behavioral Homework

According to the new “client-centered” guidelines, counselors should assist the client in developing a realistic risk-reduction plan. The non-directive, client-centered model is clearly in conflict with the highly directive, behaviorist agenda of risk reduction counseling. As Sikkema and Bissett observe in their review of the relevance of various counseling models for HIV test counseling,

HIV counseling may include skill development through role-plays, proper use of condoms, or needle hygiene. These tasks are behavioral or cognitive behavioral by nature. As such, they differ fundamentally from a client-centered approach which does not encourage therapist direction of

the client in, for example, behavior rehearsal or homework assignment (Sikkema, 1997).

The emphasis on behavioral outcomes of test counseling is also reflected on the new 1997 form. Two new boxes were included to help counselors document the client's immediate and long-range risk reduction goals.

Establish Immediate Risk Reduction Goal(s):
(to be accomplished by client before disclosure session)

At disclosure, mark one of the following below:

- (1) No Immediate Goal was Established**
- (2) No Effort Made**
- (3) Attempted**
- (4) Achieved**

Short & Long-term Risk Reduction Plan:

In my conversation with Steve Truax about the new form, he pointed to several purposes behind the new section on goals. First, the form reflects a changing understanding of the behavior change process.

In a large way, the form really follows the evolution of counseling. In fact really, OA policies often times are not really leading anything but are conforming to the evolution of theory and practice in the field. And this

case is certainly one of them where the recognition of risk reduction has not simply the acquisition of knowledge and the consequent automatic change in behavior based on new knowledge, but that we're dealing with highly motivated behaviors which clients have a difficult time dealing with even if they have full knowledge.

So we recognize that we're dealing with a more difficult process and that that process is a kind of a herky jerky one. Some days are good days and some days are bad days and some situations they change and some situations they don't, and sometimes they revert. And so the prose sections where we're talking about, the short and long term goals and having them written out, is really following that trend, but is using the form to make it easier for counselors to follow that flow, they've got a place to write it down.

Like all HIV prevention interventions, effects are difficult to measure. Behavioral interventions typically use some form of pre and post-test instrument to evaluate the short-term impact of an intervention. The difficulty in evaluating the impact of test counseling on behavior has always been the Achilles heel of the CT program. Truax appeared hopeful that new form could provide one way, albeit limited, to assess the outcomes of the test counseling process.

Where in the past we've been dealing with defining client characteristics, we've done really nothing to define the outcomes of the counseling process. We don't think that it's gonna work so much that it will tell us, "look how counseling works or doesn't work." But it may be helpful for us to look at in relationship to, for instance, client characteristics or look at it from the standpoint of the history of that client with previous counseling and that kind of thing. And it may allow us to feedback to counselors, "here's the circumstances under which those immediate goals seem to be achieved and here's the circumstances under which they seem to be less likely to be achieved." And that may help.

On the other hand it, it's very loose in a sense that each of those 800 counselors will be setting the goal for the individual in a variety of ways and then assessing the adequacy with which that goal's been achieved by their own yardstick.

Separating the needs of individual counselors from those of the surveillance program appears to be very difficult from Truax's perspective as an administrator. As his description of the potential uses of behavioral outcomes reveals, the form reflects not only scientific notions of effective methods but also attempts to satisfy the requirements of evaluators and stakeholders for quantifiable outcomes.

Counselors will have completed the risk assessment by the time they discuss the two boxes related to risk reduction plans. This means that the context for the discussion of future plans will be the inventory of the clients' lifetime risks just completed. This is not the ideal context that encourages a sense of self-efficacy. In order to establish realistic risk reduction goals the clients' past *successes* in reducing their risks should be the context framing the discussion, rather than their past failures. This is clearly reflected in the CDC's prevention counseling training that is meant to update the client-centered model (CDC, 1998). Nowhere on the new form is there a space to record the client's successful steps in avoiding risks. Yet it is these successes that must serve as the basis for any discussion about the future risk reduction plan.

It is also unclear why so much emphasis is placed on achieving immediate, measurable results. The interval between pre-test and results disclosure produces a great deal of stress for clients. Counselors see this period as a liminal time when the issues discussed at the pre-test session prompt clients to reflect on their past behaviors. Yet does this period of stress and uncertainty lend itself to change and experimentation? Or does the stress foster denial mechanisms and an overvaluation of the test result as a verdict on past behaviors? Clients may interpret a negative result as a validation of past strategies rather than a cause for reflection and change. In the near future, this issue will be moot. As soon as rapid testing technologies are licensed and adopted at testing centers, the interval between pre- and post-test counseling will disappear.

The fact that counselors are supposed to grade clients on a behavioral homework assignment reveals the extent to which counselors are held to the same standard as multi-session behavioral interventions. As Sikkema and Bisset observe,

several significant aspects of HIV counseling offer challenges to a "pure" client-centered approach. First, the short duration and limited frequency of counseling sessions in HIV CT provide a less than optimal opportunity to develop and implement a behavior change plan based on a good therapeutic relationship. Second, the need to disseminate critical risk transmission information requires a directive counseling style (Sikkema, 1997).

The expectation that clients will change their behavior immediately would not even be appropriate for an intervention that involves a true counseling relationship. Moreover, clients are unlikely to develop a constructive relationship with a state data-collector within a few minutes. The emphasis on grading contributes to an already patronizing dynamic that is antithetical to the Rogerian notion of "unconditional positive regard."

Do you share objects/fingers?

Counselors devote a large percentage of the session attending to the absurdity of a number of questions on the form. The logic of the form reflects the data software it feeds, and the logic of a population based, epidemiological survey is completely foreign to the clients' "frame" for their "issues." The logic of the questions is also antithetical to the conversational risk assessment style recommended by the client-centered model.

Several questions are "catch-all" questions, arbitrarily grouping a set of HIV risk behaviors into one, for example, "_____Shared Objects/Fingers Inserted in Mouth, Anus or Vagina." The numerical response entered on the line is 0 if it does not apply or "1" in the last year, "2" for two years ago, etc. up to "9" for "9 or more years ago." What is particularly absurd about these questions is the fact that counselors ask the question

according to their interpretation, and depending on the interpretation, the same client could answer either “yes” or “no.”

This is not an easy question to ask in any context, and counselors are eager to emphasize that they are not the source of the question. For this reason, most counselors employ a common distancing technique. They read the questions almost exactly as they appear on the form, making it clear that it is asked for the purposes of the state database.

C: Shared objects, fingers inserted in the
mouth anus or vagina.
P: Yes.
C: Same [time] frame?
P: Yes.

Other counselors read the question and then paraphrase it according to their interpretation of the question.

C: Okay. Do you share objects or sex toys
with your partners?
P: Nnno.

While this paraphrase may clarify the meaning of the question, it does not address the issue about fingers, or even fisting for that matter. Other counselors ask only about fingers and provide an explanation of the question regardless of the client’s answer.

c: Alright. Okay. Any fingers inserted in
the anus, the vagina, or the mouth
during sex play
P: No [breathy]
C: Okay. If there is, I mean sometimes for
stimulation and stuff, it's not necessarily HIV,
obviously, theoretically it could pass HIV if you
have a cut on your hand, you broke into the
partner's (1) somewhere. Partner did that to you,
if they're stimulating you, by stimulating you
through your rectum, and stuff. The thing is it's
more likely your going to get a sexually
transmitted disease than you're going [to get HIV
P: [than HIV

Another counselor asks only about fingers but justifies it by stressing the ease with which it can happen, even unintentionally.

- C: No, okay. And do you ever insert your fingers in one of your orifices and then in your partner's. It can very easily happen during sex, (laughs) but.
- P: (No)
- C: No. Okay. Basically what they are trying to get at here is that you know that's a potential way of spreading the virus as well.

Another counselor paraphrases the question so much that she never directly asks the question. Risk reduction advice is incorporated into the discussion as well.

- C: Okay this next question kind of covers a lot of ground not necessarily related to HIV transmission but it's about (.) um fingers inserted in mouth, anus, vagina [and it also
- P: [yeah
- C: includes sex toys. So anything in that
- P: Well (.) well I've inserted fingers in all those places I guess
- C: Okay
- P: And dildos
- C: Okay The risk is mostly for transmitting STDs that um are transmitted through fecal-oral contact. So hepatitis A and any kind of amebic thing any kind of gastro you know enteric thing so you know be real careful to wash your hands
- P: Yeah I'm pretty paranoid. I mean I'm (.) pretty paranoid to make my partners wash with me.
- C: Yeah. And you can use condoms on dildos as well.
- P: Yeah::h yeah. I think we used to do that.
- C: Okay.
- P: Then I had my own I just used it alone.
- C: Right then that's not an issue. It's only if it's with someone else.

Because the question is so vague it can include sex toys, fingers, or even oral-genital contact. The question arbitrarily groups these activities, and clients are somehow

expected to grasp the logic of this relationship. As with many questions on the form, the epidemiological significance of this class of activities is unclear. Counselors differed in their interpretation of the question's significance with regards to either HIV or other STDs.

The question has appeared unchanged on the last three forms. Counselors can only assume that sharing fingers and objects is a risk activity like any other. However, on the latest form this question is not flagged as higher risk, thus the question's relevance for HIV risk remains unclear. In the 1994 summary data, 24% of clients answered "yes" to this question and this item was negatively correlated with HIV seropositivity (DHS/OA 1996). How are we to interpret these data when the question is asked in so many ways?

Are your partners all virgins?

Another absurd question on the form is “ ____ One or more partners who had other partners.” The main confusion for counselors and clients alike is that it is unclear whether the question is referring to concurrent or past partners. When asked verbatim, most clients will catch this contradiction and ask the counselor to rephrase the question.

- C: Okay. Have you ever had sex with a partner who's had multiple sex partners?
- P: You mean at the same time or just previously?
- C: Either, and or both.
- P: Yes.
- C: And that would be that that they've had previous sex par[tners or are you into
- P: [yes
- C: *ménage à trois*::
- P: Previous.
- C: Okay. And that's with the two partners you've had this year?
- P: (1) I'm sorry? HH
- C: Um and that's that goes for the two partners that you've had in the last [twelve months?

P: [yes

The extract reveals how easily this question can lead to confusion and waste time.

The above exchange also reflects a tendency of some counselors to use the catch-all questions as a sort of “kinkiness” or “lifestyle” index for the client. For example, another catch-all question combines blood to blood contact in such behaviors as S&M, tattooing, and piercing, suggesting that these behaviors are frequently linked to HIV transmission. Yet these are not high-risk behaviors for HIV because they do not generally entail blood to blood contact. Nevertheless when faced with a series of these catch-all questions -- on multi-partnering, sex toys, “rough sex,” blood-sports -- clients are likely to interpret them as assessments of their character.

If the counselor interprets the question as meaning concurrent partners, then she is essentially asking an extremely delicate question: “To your knowledge, have any of your partners slept around on you?” This question is subject to a high degree of face-saving response bias. Few clients would admit that a) their partners have been disloyal and b) that they knew about it and therefore put up with it. To avoid this problem, many counselors interpret the question quite differently.

C: Okay. Uhm. What about somebody who::::: (.)
This is a funny question. Basically they're
trying to get at like have all the people
you've been with been virgins or have they
had previous sex partners?
P: Poss. Probably say like 80% [have
C: [have
P: had previous sex [partners
[okay okay and you know
they're just like trying to make you aware of
well you're basically sleeping with all the
people that that person's slept with
P: Right
C: So and I'm sure you're aware of that HH
P: Yeah::::
C: which is why you're using condoms.

This question is ostensibly intended to disqualify high-risk behaviors with no-risk (virginal) partners from signifying risk in the database. Yet, in the process of explaining the question, the counselor transforms it into a rather frightening prevention message. The beauty of the above exchange is the skill with which the counselor delivers this message without taking responsibility for it. The counselor uses the form as a way to channel the state while appearing neutral himself.

Because the form is not scripted and so many questions are somewhat cryptic, it seems likely that counselors routinely misinterpret questions when paraphrasing them to their clients. The actual meaning of this question -- whether the term "multiple" signifies past or concurrent partners -- is not explained in the guidelines for completing the form. Yet each interpretation of the question will lead to opposite responses -- a "yes" since few people have only slept with virgins, or a "no" since few people will admit that their partners slept around. In the last quarter of 1994, of the 13,307 "men who have sex with men" tested, 62% answered "yes" to this question and it was not significantly correlated with HIV infection. These multiple interpretations of the catch-all questions raise important questions about the accuracy of the database and the conclusions program officers may draw from the data.

Temporal Parameters of Risk

The temporal logic of the form is also a frequent source of confusion for clients. The form asks about the occurrence of behaviors over the entirety of the client's life. Thus risks that may have occurred years in the past, and even though previous negative

tests may have rendered these past risks moot, these past risks must be divulged in great detail and recorded on the current form. Only those risks that have occurred since a few months before the last test are relevant for a focussed counseling discussion. The temporal logic of the form forces counselors to juggle multiple time frames. This is especially difficult on busy shifts since the current client's history tends to blend together with the previous client. Because most counselors use the form as a risk assessment tool, past risks that may be irrelevant to the clients current concerns or reason for testing can take on an unwarranted significance. As a result, the relevance of the client's current situation in relation to their decision to re-test is glossed over.

The counselor's reliance on the form to assess the client's risk distorts the time perspective of the session. For example, in the following extract the client describes the current context of his test in terms of a) a rumor that his previous girlfriend may not have disclosed certain risks and b) his concern about having unprotected sex with his current partner. Instead of following up on these issues, the discussion is mired in confusion over the relevance of past risks.

- P: And (.) fo:r whatever reasons since then like I don't know if I (.) entirely believe her so I just rather get tested and I'm in a relationship now with somebody and I want to find out before I (.) sleep with them unprotected if I'm (.) okay.
- C: Okay. Okay, so:: let's see. I guess I should say, when a lot of the things I'm filling out on the form are things that relate to something that might have happened in the last year, but I guess a lot of like your overall risk, since you've never been tested in your life
- P: There there's nothing, there's no specific incident like that I was that I noticed like a lesion or anything like that I would think that would make at any more at risk than (.) than

normal, the the sex pretty n much n normal, there was no kind of (.)

C: yeah

P: I didn't think, well, I don't know what could be risky. I didn't notice anything that could cause a transfer.

The counselor, apparently filling out the form during this exchange, begins to explain the temporal parameters of the form: any risk over his entire life. The client hears this information as a probe about past risks and answers defensively, stressing the word “normal” several times. Clients cannot change past risk behavior but do have control over current risks. The counselor's efforts to revisit the past will invariably cause the client to put up defenses. A valuable opportunity for client-centered counseling is lost whenever the form reframes the session in terms of the form or past risks and ignores the client's current concerns.

Confronting the client with the form

"Constructive confrontation" is a technique advocated by the state in their recent “client-centered” counselor training manuals. This technique serves to point out contradictions within the clients' narrative or between their statements and their body language. In form-centered counseling, however, the client is not provided an opportunity to assess their risk in a narrative format and it is left to the form to define the client's reality. As a result clients are confronted with the form's decontextualized assessment of their risk practices, rather than with their own phenomenological experience of a coherent risk averting strategy.

One counselor routinely took this form-centered confrontation to its logical conclusion by asking the client to turn the form's gaze onto themselves. After a long 17 second silence, during which the counselor is presumably completing the form, the following exchange occurs.

- C: Okay. (17) Okay. Now I'm going to turn the tables on you and I'm going to let you play Ms. Counselor with you. Why don't you take a look at the demographic sheet I've just filled out based upon your answers
- P: M hm
- C: And I'd ask you to rate that client for me as either low medium or high risk (.) for exposure to HIV.
- P: (4) Well, it's hard to say because (3) ah (5) I sort of knew this was going to happen umm. I suppose a couple times now I think one time I was very high and then otherwise I'm just low.
- C: So maybe like nine or ten years ago you were a higher risk?
- P: No I think this one time three years ago when I had sex with someone that was an IV drug user.
- C: Ohh
- P: That was the high time.
- C: Okay
- P: And I think that all the other times I've been low.
- C: Okay. And your contact with the IV drug user. Was that unprotected sex?
- P: No but the condom broke.
- C: Ah:::. So that
- P: So it was unprotected right.
- C: yeah I mean it wasn't deliberate it was just that [there were other okay
- P: [oh no yeah

The client's understanding of her risk is situational and time sensitive. It therefore does not translate well onto the asynchronous and categorical logic presented by the counselor when using the form to label her as a high, medium, or low-risk. The counselor has used the form to put her on the spot about past behavior she cannot undo. She feels forced to justify her risk by stressing that she had in fact used a condom, although it broke. The

counselor attempts to deculpabilize her by agreeing that she had not “deliberately” put herself at risk. The ultimate message conveyed by this exercise is extremely patronizing and judgmental, because the client cannot measure up to the exacting normative standards of the form.

Do you have any more questions?

The few times that clients did ask questions, counselors appeared to avoid addressing the content of the question, offering standard risk reduction advice in lieu of a direct response. Counselors also tended to provide simplistic answers to clients' questions, even when these display a high level of knowledge about HIV transmission. This reinforces a patronizing dynamic in which clients are unlikely to ask further questions. For example, in this session, a female client asks a rather sophisticated question about how the risk of vaginal sex compares to oral sex and how that differential risk is measured by researchers.

- P: How do they determine what the level of risk is for different behaviors.
- C: For example?
- P: For you know penile vaginal sex or oral sex or like how do you how do they rate them? Like saying having um how do they know like how many people get HIV from oral sex. I don't think they really know.
- C: Basically there have been a number, a small number granted, but a number of documented cases where the person's only contact with HIV would have been through oral sex. I know gay men who engage in no other behavior other than oral sex. No anal intercourse no nothin.
- P: M hm

- C: So if that person tests HIV positive during the regimen of the treatment they'll ask them "How did you get it. How was this transmitted." And this is part of the data that the CDC wants. What would make something a higher risk behavior well. Let's say you have oral sex with a man. He comes in your mouth. You spit it out or you swallow it. The majority of the semen that's swallowed into the stomach is going to be eaten up by the acid in the stomach.
- P: M hm
- C: The problem with oral sex, unprotected oral sex is that if you have any periodontal problems, receding gums, bleeding gums, you floss and you look at the floss string and it's got blood on it.
- P: Oh.
- C: Chancre sores in the mouth. That's a portal of entry.
- P: M hm
- C: Now that as opposed to say (.) anal intercourse where say it's rough, it's non-protected
[And there's a tearing of
tissues
- P: [Yeah I guess I can see that
So you're telling me not to floss?
HHHHH
- C: Well I'm telling you that if you're going to go out and you're going to perform oral sex, floss afterward not before.
- P: Alright HHHH
- C: Or carry your bottle of listerine and gargle. Which would probably look gross on a date.
- P: yeahHHHH
- C: "Excuse me dear" HHH. I mean for instance with um anal intercourse where there's more of a potential for tearing

- [and ripping of tissues. You've got blood
P: [right
C: you've got semen it's mixed together. Boom there's a very powerful portal of entry.
P: Exactly I understand that.
C: Other questions? ((shuffles papers))
P: I don't think I have any more.
C: Okay great. So what I'm going to do...

The counselor avoids answering the question and instead gives a standard discourse on the risk of oral sex along with some advice on oral hygiene. She never mentions vaginal sex or how the differential risks are determined. She does use the opportunity to warn against anal sex. Body language, such as shuffling papers, can also signal that the counselor is eager to move on and complete the paper work.

This type of information/advice sequence given in response to an unrelated question from the client was a common feature of the recorded sessions. Silverman and Kinnell have recognized such sequences as an important strategy used by counselors to provide unsolicited and often irrelevant advice disguised as answers to client's questions (Silverman, 1997; Kinnell, 1996). Sometimes, the counselors' unwillingness to give a direct answer reveals an unwillingness to admit that they do not know the answer. Positioned as experts, counselors appear more willing to discuss simpler causal relationships, such as the risk of anal sex, than admit ignorance regarding more complex, multi-factoral risks.

- P: Um (4) Is the female or the male more at risk, more or less at risk
C: I often hear, well, uh er the: thing that I often hear is uh, (1.5) it's easier for a woman er uh a man to infect a woman than it is for a woman to infect a man.
P: Okay

- C: And that isn't sa::y a heck of a lot, because it depends on the overa, so many factors involved here, you know what I'm sayin,
- P: yeah
- C: it's just ther's a v a variability that can you know there's always going to be something that's going to be the other the other extreme so
- P: yeah
- C: But I think that () is pretty much what's up now-a-days. So in that sense, umm (1) yeah, like I said it's easier for you to infect her than her to infect you.
- P: M hm
- C: And again it also depends on the kind of behavior (.) the kind of sexual involvement,
- P: Yeah
- C: where you pretty well um have to know what your doing, you know, um for example the u:h anal insertive, if you're not using condoms, (.) well you'll leave yourself open because the anus is not made for sex (.) it's for a different *function* (.) so it's a very tight muscle type of thing it's a sphincter is what they call it.
- P: M hm
- C: So when you insert it it's like forcing the skin to open, and that you know that it could have tears in there. It also leaves your penis torn sometimes, 'cause it you know the pressure of putting it in there or inserting could put tiny cuts along the penis head, you know that kind of thing (.) or if you're not circumscized you wouldn't even know (.) you know what I'm sayin'. So it's the sort of thing that "Well I've got to take cautions here, what am I really doing here."
- P: Yeah
- C: Anything else you want to ask or
- P: Uh no

Pat answers such as this send a strong message to the client about what topics the counselor is willing to discuss. Because counselors tend to package their answers along

with unsolicited risk reduction advice on anal sex, it is not surprising that clients ask few follow up questions.

Distancing Strategies

The data collection form makes client-centered counseling difficult because it impedes the counselor's ability to elicit a narrative from the client. Ironically, it is the delicacy of the questions themselves that reinforces the didactic model of test counseling. Counselors feel awkward when asking clients about HIV risks, and this is commonly reflected in the counselors' distancing strategies. This can be seen in the tendency of many counselors to explain the epidemiological justification for the questions. Thus, the interactional problems created by the delicate nature of the questions lead counselors to treat each question as part of a generic checklist. The client's participation in the session is limited to providing the appropriate answer and passively listening to epidemiological factoids that each question is "getting at."

Given the clinical context in which test counseling occurs it should not be surprising that traditional doctor patient communication formats would occur. The client's passivity in the face of the physician's greater technical knowledge and experience in assessing risk fits with the client's expectations of a highly bureaucratic and form driven medical system. In his analysis of pediatric clinics in the UK and US, Strong notes the importance of forms in structuring clinical interaction between the parent of the patient and the provider.

Doctors and nurses worked with the form openly displayed and ticked off items one by one as they were covered. The presence of the form and of an official pen hovering over it defined the nature of the parental task: the production of brief answers that could be filled in as quickly and efficiently as possible (Strong, 1972: 133)

As with HIV test counseling, the questions on the form were highly charged -- in Strong's pediatric context, the questions were essentially an assessment of parental fitness. The use of a generic form helped to depersonalize the interaction and allow delicate questions to be asked in a routine and efficient manner.

Doctors could also use official form-filling to indicate that nothing very serious was at issue... All were asked with the same light and routine air, even though some doctors asked for more precision than others. It should also be noted that some of the junior American doctors who did the work-up, which was also a highly standardized affair, did so in a heavily bureaucratic manner as if to display their subordinate status. They were filling in a form for the Chief and not for themselves. (Strong, 1972: note 4, p. 242)

The form is useful to counselors because it triangulates and de-personalizes the questions. But in routinizing the discussion of difficult areas of human experience, opportunities for counseling are lost.

The form is thus not merely a tool to be used by the counselor. The counselor serves as a tool of the form and the surveillance apparatus it serves. It is to the counselor's advantage to keep this dual frame when filling out the form. The counselor can use the form to ask questions that would otherwise seem out of context and inappropriate, and yet the counselor must also maintain rapport with the client. To do this, counselors ally themselves with the client against the form and yet frequently justify the questions by explaining their purpose.

C: Um. Have you ever had sex with a prostitute or sex worker...or um received money or drugs for sex.

P: (No)

C: No. Yeah, and again this is the State of California talking, so excuse the nature of of the question. I personally think the drugs, money or prostitutes are irrelevant, the relevant thing is are they using condoms

or whatever. Umm, what about blood to blood contact during sex?

The counselor manages to distance himself from the question and yet use it as an opportunity to insert risk reduction information/advice. Some counselors are able to maintain a certain degree of levity, particularly when asking about sex trade and blood-to-blood contact. The following counselor is particularly skilled at asking the questions in a joking manner while still managing to justify the questions in terms of the state's goal of risk assessment counseling.

- C: A:hh ever been with a prostitute? (0.5) Ever received money or drugs for sex? Would you ever like to? No, that's not one of the questions HH.
- P: I wouldn't mind.HH
- C: It's not a recruiting question. (.) Any piercing, tatooing, branding, ah what else can we come up with for categories. Any categories?
- P: No, none of those.
- C: You know every question we ask has a reason behind it.
- P: Uh huh
- C: Cause if you say something then there may be something that we need to talk about....or something like that..and some of them we need to explain. I TALKED about the fingers. At school, work, play, home, dorm, any blood exposure or anything like that?

The challenge for the counselors is to use the state warrant when it is useful, and yet be able to distance themselves from the state when it does not serve their strategy, for example when attempting to confront the client in a non-judgmental way. The form requires counselors to maintain two simultaneous roles and this can be a challenge for even the most skilled counselor. This dual frame limits the counselor's ability to be genuine with the client.

Counselors rely on the state form as warrant to ask awkward questions and frequently use the “we recommend” to give their advice more weight. However, when counselors subsequently position themselves as allies with the client against the state or the clinic -- for example by not rushing the session along, being “sex positive,” or even “client-centered” --the effort rings hollow against the juridical, sex-negative and depersonalized context of the risk assessment. For example, this counselor is filling out the form nearly ten minutes into the session. After establishing that the client’s reason for testing is that he is engaged to a long-term monogamous partner, the counselor asks the following question.

- C: And how many sex partners have you had in the last year?
P: Uhm, one.
C: We have room for nine-hundred and ninety nine, here on the form. We’re sex positive here at the Free Clinic HH.

Upon repetition, the questions seem routine and non-problematic to the counselor. The counselor’s attempts to inject a hint of absurdity to the proceedings can be seen as an attempt to defuse the juridical quality of the interaction.

The dictates of accuracy and consistency require that every client be asked every question, whether or not the counselor already knows the answer. For example, after a female client describes that she has come to get tested with her boyfriend, the counselor asks, “Have you had any male sex partners in the last year?” Several counselors asked all their male clients if they were pregnant and then pointed out that the question did not specify “for females only.” Other counselors not only read the questions verbatim, but actually read the instructions such as “Mark all that apply.” These distancing strategies only make sense in terms of the counselor’s desire to distinguish between the two competing interactional frames. When speaking as counselors they look at the client and use informal vernacular and normal conversational techniques. Whenever they switch to

their data collection role, they use the language and absurd logic of the form as a sign that the frame has switched.

Due to repetition, the order of the questions appears self-evident to the counselor. Yet to the client, naturally unfamiliar with the form and positioned in the “hot seat,” each question is intensely personal. As in any conversational situation, the sequence of the questions has enormous implications. To ask about the client’s number of partners suggests either that the counselor was not listening during the previous discussion, or that the counselor is trying to confirm his suspicions about the client’s moral character. In this way, the unnatural sequence of questions on the form clearly inhibits the counselor’s ability to maintain a posture of “unconditional positive regard” for the client. The interaction takes on a forensic dimension in which it appears that the counselor is attempting to poke holes in the client’s story. Jokes about the questions can help to break the juridical frame and bring the counselor and client closer together. However, observing these distancing strategies from the sequential perspective of a transcript reveals the degree of power imbalance created by the form.

Conclusion

Since 1994, state-sponsored HIV testing in California has operated under the rubric of a “client-centered” approach. Clearly, this term does not reflect the actual practice of test counseling. This raises a number of opportunities for program administrators and counselors interested in improving the relevance of test counseling in primary prevention. Counselor trainings must acknowledge the role of the form in structuring the content and quality of the interaction and the counselors’ view of their role. By focussing less on normative models and more on strategies counselors use in naturally occurring situations, counselors would be better prepared to mitigate the

institutional barriers to client-centered counseling. The use of transcripts to evaluate different counseling strategies is further explored in chapter six.

The State Office of AIDS requires client-centered training yet squanders the opportunity by using counselors as mere data collectors. The risk assessment form makes open-ended prevention counseling all but impossible. Future revisions to the form should reflect the methods and goals of counseling rather than the goal of collecting accurate HIV surveillance data. One obvious solution would be to do away with the risk assessment form and allow counselors to chart the session using prose. The new CDC prevention counseling guidelines clearly point in this direction, emphasizing the documentation of a multi-stage risk reduction plan for each client (CDC, 1998). Differential reimbursements for high and low-risk clients could be based on whether the client fits any of the risk criteria as previously defined by the database and not depend on completion of a data collection form.

Using test counselors as unwitting surveillance data collectors is unfair to clients and counselors alike. Moreover, this policy results in inaccurate data. HIV surveillance is an essential tool for HIV programs, yet it is a specialized form of epidemiological research that should be conducted by trained interviewers using state of the art data collection instruments. Counselors' good-faith efforts to live up the standards set by their training are undermined when an HIV surveillance form is deployed for "client-centered" counseling.