MAKING PRACTICE VISIBLE: ANALYSING THE INTERACTIONAL TASKS OF VOLUNTARY COUNSELLING AND TESTING

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Declaration of originality

I herby declare that this thesis, except where indicated to the contrary in the text, is my own original work and has not been submitted for any degree at any other university.

Signed on this   day of   2009

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ABSTRACT

Voluntary counselling and testing, the cornerstone of HIV/AIDS prevention efforts worldwide, is at the centre of a policy debate regarding its effectiveness. Informed by social constructionism and drawing on various tools from ethnomethodology and conversation analysis, a sample of twenty-seven videotaped simulated counselling interactions in South Africa was analysed. The aim was to assess how the interactional tasks of the voluntary counselling and testing session were worked through by clients and counsellors, and how this was done against the public health and counselling frameworks that inform voluntary counselling and testing practice. The goal of the analysis was not to examine practitioners' competencies, but to examine their unfolding actions in the situation and to consider the interactional functions these actions might serve.

The results show that of the three interactional tasks of voluntary counselling and testing, information-giving lays the foundation upon which the advice and support goals are realised. It is constructed as critical to client and counsellor identities and is a powerful tool through which hope is dispensed. Both the information-giving and support tasks of voluntary counselling and testing combine to manage client distress into more concrete and manageable terms that encourage client coping. Counsellors draw on a range of advice-giving strategies – those that place the onus of responsibility on the client to those that view the counsellor as the moral guide able to direct client change – in order to encourage clients to reflect on their risk behaviour. In general, voluntary counselling and testing is framed as a moral activity, and this is most evident in the advice-giving segments. The public health and counselling frameworks that inform voluntary counselling and testing create a dilemma for counsellors. In practice, counsellors orient

towards a directive and health-advising role rather than a non-directive, client-centred counselling role.

The implication of this research is that voluntary counselling and testing needs to be defined and framed more clearly – i.e. as a public health intervention with preferred outcomes that draws on a set of client-centred skills. Reconceptualisations of voluntary counselling and testing need to acknowledge the moral framework under which it operates. Clear implementation guidelines (and training) on what voluntary counselling and testing is and that define its goals more clearly will be useful in assisting counsellors to implement the policies that govern their practice.

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To my parents Vernon and Lucy van Rooyen, who died too early but who gave me so much.

CHAPTER ONE

INTRODUCTION

INTRODUCTION

Acquired immune deficiency / immunodeficiency syndrome (AIDS) is a major public health concern in virtually every country in the world, and controlling this epidemic remains one of the greatest challenges to humankind, and public health practitioners in particular (UNAIDS, 2007). Twin efforts in mounting an effective response to the human immunodeficiency virus (HIV) are prevention and treatment. Against the backdrop of relatively slow and limited progress in identifying suitable preventive biomedical interventions (such as a vaccine or microbicide) as well as the perceived inability of current prevention programmes (such as voluntary counselling and testing or VCT) to effect a change in individual risk behaviour – there have been renewed policy calls to shift programmatic efforts and resources from prevention to treatment. The call has been strengthened by the introduction of affordable, highly active antiretroviral treatment (HAART) in many resource-constrained parts of sub-Saharan Africa (Asante, 2007).

In the context of a devastating disease fuelled by a complicated and mutating virus that frustrates the best scientific efforts to control or eliminate it, work in the HIV/AIDS field is often characterised by a quest to find the "magic bullet" – the one thing that will bring an end to this epidemic. Along these lines, most attempts at researching VCT have been towards determining that it "works" to achieve certain public health outcomes. The VCT literature reveals this public health agenda in that much effort and

publication space is dedicated to quantitative studies that seek to prove that VCT "works" to achieve particular HIV risk-reduction goals. Over the years, an increasing number of qualitative studies into VCT in both resource-constrained and resource-rich contexts have emerged. Framed by different research questions, this research places greater emphasis on process-related issues i.e. *how* does VCT work to achieve certain outcomes. This research seeks to add to the growing number of process-related studies on VCT.

This desire to explore and understand the VCT process has been significantly influenced by my work in the HIV/AIDS field since 1992. During this time I have worked as a clinical psychologist in various capacities – as a counsellor, counsellor trainer, supervisor and mentor of counsellors, researcher and manager. An ongoing motivation in all these roles has been a desire to better understand, support and improve HIV/AIDS counselling practice. A PhD seemed a logical conclusion to this life's work and has allowed me to address what I believe is a key struggle for counsellors and the VCT programme as a whole. In its prevention and support goals, VCT is framed within two competing discourses. On the one hand, it is constructed as a public health intervention with clear practitioner-determined behavioural outcomes. On the other, it is considered to be a counselling intervention where outcomes are more open-ended and dictated by the client. My observation over the years was that most counsellors struggled with how to implement these dual, and at times competing, policy agendas in practice (Balmer, 1991, 1992; Irinoye, 1999).

An extensive evaluation (using a combination of qualitative and quantitative methodologies) into HIV/AIDS counselling services in South Africa (Richter, Durrheim, Griesel, Solomon & van Rooyen, 1999) that I was instrumental in, provided

an opportunity to explore this prevention/support dilemma in more depth. While the evaluation revealed useful findings about counselling service provision at the time, it was constrained by its broad parameters. By focusing on the qualitative data from the evaluation, and in particular the videotapes of counselling with simulated clients, this study aimed to assess how clients and counsellors negotiated the prevention and support goals that underpin VCT.

1.1   RESEARCH PURPOSE AND APPROACH

Most of the qualitative research that has been conducted thus far into the VCT process adopts a familiar stance in studying VCT practice. The common methodological approach is to investigate using interviews the counsellors' experiences and perceptions of their roles in providing counselling and testing in different settings. All these approaches seem either to circumvent the actual VCT interaction or to gain insight into VCT practice via practitioners' and users' descriptions of it. I wanted to start with practice, with actual client and counsellor discussion and interaction in their natural environment as my data source for the PhD. The primary thrust of this research is that qualitative, process-related research – such as this study – that focuses on actual client counselling practice is uniquely positioned to inform broader political debates about the utility of VCT as a prevention tool.

Using a social constructionism approach and drawing on elements of ethnomethodology and conversation analysis as strategies of enquiry, I hoped to find a more direct route to understanding VCT client-counsellor interaction than previous qualitative studies conducted in South Africa have allowed. I was particularly interested in constructivist and discursive approaches to research that focused on talk itself as a

form of action (Kitzinger, 2000; Wilkinson, 2004) and how everyday counselling reality is produced in and through their talk by those who engage in it (Wilkinson, 2004). Research into VCT practice often assumes a normative stance when assessing counselling practice. Adopting a more constructionist and discursive analysis of client-counsellor talk might allow for a new set of insights to emerge about counselling practice, with the focus less on what it should look like and more on seeing what VCT practice is actually about.

1.2   AIMS OF THE STUDY AND RESEARCH QUESTIONS

The aim of the study is to provide a detailed description of how the interactional tasks of VCT are achieved, and how these tasks are achieved against the backdrop of theoretical frameworks that shape counselling practice. More specifically, I want to explore:

1. How the interactional tasks of information, advice and support are constructed by participants.
2. How the information, advice and support goals of AIDS counselling are discursively accomplished.
3. How these discursive accomplishments and constructions impact the unfolding interaction.

1.3   OUTLINE OF THE THESIS

This introductory chapter is followed by seven chapters. In Chapter Two, the literature review is organised into three sections: the first section contextualises the broader

policy debates that shape counselling practice; the second reviews the available research on VCT as a prevention and support intervention; and the third section outlines the rationale for this research. Chapters Three and Four describe the research design of the thesis. Using a natural history account or a narrative of discovery approach, I discuss my process and development as a researcher as I engaged with this PhD research and also introduce the reader to the theoretical frameworks and strategies of enquiry that framed this research. Chapter Four is a companion to Chapter Three, in that I articulate in this chapter the various methodological elements that inform this research: research aim, procedures and methods, sampling, data management and analysis.

Chapters Five and Six, the empirical chapters, are the heart of the thesis. Chapter Five foregrounds the strategies that clients and counsellors use to work through the interactional tasks typical of VCT. In Chapter Six, the approach shifts to focus on how these interactional tasks are informed and shaped by broader theoretical frameworks that result in dilemmas of orientation for participants. Chapters Seven and Eight bring the thesis to an end. In Chapter Seven, the findings of this study are discussed in relation to other literature in the field, and the implications of this study for VCT practice, programmes and policy are considered in Chapter Eight.

CHAPTER TWO

LITERATURE REVIEW

INTRODUCTION

The literature review is structured in three parts. Part one contextualises the research by framing the broader policy debates pertaining to HIV/AIDS counselling and testing. These dominant discourses create the backdrop against which counselling practice – the unit of analysis for this thesis – needs to be understood and reviewed. In the second part of this chapter, I focus on a particular counselling and testing approach – i.e. voluntary counselling and testing – that is the focus of this research. I describe the common constructions of VCT as both a prevention and support encounter, and review the literature to date that explores its effectiveness as an intervention. In the third and final section of the review chapter, I provide a rationale for why this research is important and what contribution it hopes to make to VCT research and practice.

2.1   CONTEXTUALISING HIV COUNSELLING AND TESTING

Globally, 33, 2 million people are living with HIV, with sub-Saharan Africa (SSA) accounting for 24, 7 million of the infected population; new infections continue to rise in these settings (UNAIDS, 2007). Informed by public health concerns regarding the unprecedented scale of the HIV epidemic and the generalization of HIV infection in most parts of southern Africa (Brockway, 2007), international policy developers and commentators have called for a massive scale-up of HIV testing in these contexts (Centres for Disease Control (CDC), 2006; Joint United Nations Programme on

HIV/AIDS (UNAIDS), 2003; World Health Organisation (WHO)/UNAIDS, 2007; WHO/UNAIDS, 2004). Expanding testing will "enable a greater number of HIV-infected individuals to know their status, be motivated to change their behaviour and prevent transmission, and seek available care, support and treatment" (UNAIDS, 2003, p.2). Two key issues, prevention and treatment, therefore drive this call to expand HIV testing.

2.1.1   Prevention is critical

There is no cure for AIDS. Nor is there – more than two decades into the pandemic – a suitable vaccine to prevent HIV infection. As a result, public health responses to HIV/AIDS are focused on containing and bringing the pandemic under control. Central to these efforts is the prevention of infection through behaviour change with personalised counselling and knowledge of HIV status the cornerstone of this strategy (Grace, 1994; Swanepoel, 2004; van Rooyen & Richter, 2007).

From a public health perspective, knowledge of HIV status could influence the behaviour of individuals at risk and their partners. All individuals, and in particular high-risk individuals who are not aware of their HIV-status but continue unsafe sex practices are major drivers of new infections. This has an impact on efforts to control the epidemic (Brockway, 2007; de Cock, Mbori-Ngacha & Marum, 2002; Obermeyer & Osborn, 2007). Similarly, early identification of infection could help to prevent much of the early morbidity and mortality experienced by HIV-infected persons (Rietmeijer, 2007).

2.1.2   HIV testing and treatment are closely linked

Many writers point out that the increased availability of antiretroviral treatment (ARVs) through public health facilities in many African countries is another reason why testing should be scaled up in these contexts (Asante, 2007; de Cock et al., 2002). First, treatment acts as an important incentive for people to people to know their status. Second, from a service delivery perspective, HIV testing is considered the "gateway" to antiretroviral treatment and prevention (Strode, van Rooyen, Heywood & Abdool-Karim, 2005). Once people have been tested and know their status, preventive measures to protect themselves and their sexual partners can be reinforced, and referral can be made to available treatment, care and support services.

As HIV infection becomes a more treatable condition, the public health approach seems to have shifted in focus from those not infected and at risk, to those who are already infected and are at risk for ongoing transmission. As Rietmeijer (2007) observes, this marks a revision of the traditional "test and treat" public health paradigm and a "steering away from primary prevention through behaviour change" (p. 6). Where HIV test counselling was once considered the gateway to other prevention and treatment services, policy makers now argue that it acts as a "bottleneck", preventing people from accessing these services (CDC, 2006; UNAIDS, 2003; WHO/UNAIDS 2004). Koo, Beiger, Henn, Sepkowitz, and Kellerman (2006) argue that the lengthy pre-test counselling and the separate written informed consent it requires have prevented HIV testing from becoming a routine part of medical care resulting in numerous missed opportunities to diagnose, treat, and stop the spread of HIV.

But, treatment aspirations are far removed from the realities of treatment availability and access in high prevalence, resource-constrained settings. Strode et al. (2005) argue that ARV treatment is still not widely available in these contexts and – despite initiatives like the WHO "3 by 5" strategy (which aimed to put 3 million people on treatment by the year 2005 in developing contexts) – treatment only reaches a fraction of those who qualify for it. Asante (2007) confirms that even though ARV treatment is available in many developing countries, only 18 out of 53 countries in Africa had 25% coverage or more in June 2006.

The reality of treatment access is severely hampered by the lack of capacity of African health systems, such as an acute shortage of health personnel, poor management and inefficient resource allocation and utilisation (Asante, 2007). In these settings, treatment scale-up needs to occur alongside the scale-up of HIV testing, if the policy goals regarding testing are to be realised. It is possible that the current form and practice of HIV test counselling – people have to undergo counselling before they get tested – may be limiting the number of people that are tested in busy hospital settings, and eventually get linked to treatment. However, this seems like a simple programmatic tweak to a multi-faceted and complex issue. As Asante (2007) concludes, given the weakness of African health systems, any drastic improvement in HIV/AIDS testing, treatment or care would require simultaneously addressing some of these systemic factors in the health system.

2.1.3   HIV testing needs to be scaled up

A primary driver behind the call to scale up testing in high prevalence settings is the major concern about the gap between those who *should* know their HIV status and

those who *do* know their status (Brockway, 2007), despite the widespread availability of these services. Recent surveys conducted in high-prevalence countries in sub-Saharan Africa indicate that on average 12% of men and 10% of women in the general population have been tested and know their results (WHO, 2007). South African studies show that HIV testing uptake is better here as compared to other African countries, but not by much: only one in five South Africans who are aware of VCT services have actually used them (Kalichman & Simbayi, 2003).

In order to achieve the massive scale-up of testing that is needed to shift the epidemic, proponents suggest a policy shift away from the current standard of testing – a voluntary, client-initiated, rights-based encounter that combines counselling before and after the HIV test is administered (i.e. voluntary counselling and testing or VCT) – to other provider-initiated testing approaches that are less reliant on the individual autonomy of "voluntariness" and counselling (de Cock et al., 2002; de Cock, Marum& Mbori-Ngacha, 2003; de Cock, Bunnell & Mermin, 2006).

2.1.4   Solution to the testing problem

To promote greater access to HIV testing, the World Health Organization and UNAIDS (WHO/UNAIDS 2004) are encouraging the expansion of counselling and testing models to include more routine testing (RT) models. The policy suggests that providers routinely offer HIV testing in health care settings as well as community-based health services to clients at increased risk of HIV infection. Clients considered to be at high risk are those with sexually transmitted infections, tuberculosis and those attending antenatal care services. Routine testing is also recommended for those who are asymptomatic, but who fall into the at-risk age categories.

According to this model, all patients who enter the health care system will be routinely asked if they would like to be tested (opt-in testing); alternatively, they will be informed that they will be tested for HIV as part of routine testing procedures in the facility, unless they refuse (opt-out testing). Obermeyer and Osborn (2007), point out that RT as described in the various policies needs to be distinguished from what is widely practised in most medical establishments – where the doctor routinely performs the HIV test without informing patients or seeking consent.

The central difference between the two approaches is that in RT, the health care provider offers testing, rather than testing being initiated by the client seeking out the service. The idea is that by removing the voluntary condition associated with testing, and locating this in the hands of the provider, most, if not all, who enter the system will be tested (Bayer & Fairchild, 2006; Koo et al., 2006; Rietmeijer, 2007). These writers argue that this move appropriately shifts the burden of responsibility from those who would choose to undergo an HIV test to those who would refuse – in order to curb the epidemic effectively, this latter group needs to be targeted.

2.1.5   The role of counselling and informed consent in the routine testing model

The 2006 CDC guidelines on counselling in health care facilities propose some adjustments to the three Cs typically associated with VCT. Prior to this, all VCT was governed by three key principles: 1) confidentiality concerning the test results and the entire testing process; 2) counselling – including information about HIV/AIDS – before and after the test; and 3) consent for testing to be informed, specific and voluntary (Cseste & Elliot, 2006). The current policy makes counselling *advisable* but not *mandatory.* In addition, pre-test counselling informed consent is reduced and streamlined

into a single consent procedure that covers all medical conditions, not only HIV. Lastly, it is recommended that post-test support be retained (Obermeyer & Osborn, 2007). Some suggest that pre-test counselling be eliminated completely (de Cock et al., 2002, 2003, 2006).

RT proponents have based these policy decisions on several issues. First, the content and process of VCT (the amount of time it takes to do counselling and help someone make an informed decision around testing), is often cited as creating the bottleneck in busy hospital settings. Second, some of the research evidence regarding the efficacy of HIV testing and its prevention goals (discussed later in this chapter) is offered as justification for the removal of individual pre-test counselling. These policy decisions (removing pre-test counselling, and/or streamlining the individual consent process for HIV testing) are considered necessary to promote and support the kinds of change that will be necessary for the pandemic to be brought under control (Bayer & Fairchild, 2006; Brockway, 2007; de Cock et al., 2002).

Research indicates that RT is effective in improving testing uptake, identifying previously undiagnosed HIV infections, and facilitating earlier referral and access to care in a range of settings where it has been implemented (Bassett, 2002; Delva, Mutunga, Quaghebeur & Temmerman, 2006; Perez, Zvandaziva, Engelsmann, & Dabis, 2006; Rennie & Behets, 2006). These data indicate that RT is increasingly acceptable and feasible in a range of African settings and is likely to play a key role in scaling up counselling and testing in these contexts.

While the evidence for the prevention goals of VCT might be inconclusive in some respects, it is on the basis of the whole intervention counselling *and* testing, that some

of the behaviour change outcomes of VCT have been established (Beardsell, 1994). However, apart from the acceptability and feasibility studies, very little evidence to date has been provided to support the RT claims about the relationship between HIV testing without counselling and automatic behaviour change (Denison, O'Reilly, Schmid, Kennedy, & Sweat, (2007); Strode et al., 2005). In fact, routine testing operates on the assumption that testing alone will effect standard behaviour change (Yeatman, 2007). Similarly, the shift in focus from linkage and identification to treatment and care does not adequately address the prevention and behavioural-change aspects of HIV – there is an assumption that once on treatment, people will receive the prevention services that will reduce the likelihood of ongoing transmission (Rietmeijer, 2007). The accumulation of this evidence is important for supporting the positive claims that routine testing could have an impact on prevention, behaviour change, treatment, stigma reduction and normalization of the epidemic.

The RT/VCT debate has its roots in a historical, long-standing struggle regarding the influences of public health and human rights in shaping HIV and AIDS policy and practice in general, and HIV test counselling in particular. The remainder of this section addresses these issues.

2.1.6   Human rights versus public health

An ongoing tension within HIV/AIDS policy and research revolves around safeguarding the individual rights of individuals at risk or infected with HIV as well as promoting broader public health goals that act in the interests of the general population (Phillips & Coates, 1995; Strode et al., 2005; Yeatman, 2007).

Human rights discourse positions individual agency and the rights to confidentiality and decision making about health and illness as being paramount to broader public health goals that seek to uphold the safety of others who may be endangered if information about the person's HIV status is withheld (Yeatman, 2007). These competing goals are prevalent in the current debate over whether "testing should be universal, routinely practised, routinely offered, or only performed at an individual's request and where indicated for individual cases" (Obermeyer & Osborn, 2007, p. 1).

An understanding of the present situation requires an examination of past practices. Since the inception of the HIV test in 1985, measures commonly accepted for other diseases (such as compulsory testing, contact tracing, and quarantine) were called into question for HIV/AIDS (Bayer & Fairchild, 2006; de Cock et al., 2002, 2003, 2006; Obermeyer & Osborn, 2007). Against a backdrop of fear, stigma and relative clinical powerlessness at the beginning of the epidemic, AIDS activists and public health officials adopted approaches that would respect the autonomy and privacy rights of people with or at risk for HIV infection (Bayer & Fairchild, 2006). In addition, the adage of "test and treat" did not immediately apply for HIV infections since without the available treatment, an HIV-positive diagnosis was seen as a death sentence and widespread testing was not widely advocated (Rietmeijer, 2007). These circumstances led to the development of "exceptionalism" when it came to AIDS (Bayer, 1991) which set it apart from the way that other diseases were managed and controlled at the time. De Cock et al. (2002, 2003, 2006) argue that the exceptionalism afforded to HIV may have had the paradoxical effect of enhancing the stigma associated with the disease rather than reducing it.

The other side of the exceptionalist position – advocated by many activists, commentators and social scientists – suggests that HIV/AIDS does warrant "special treatment". HIV/AIDS is different from other forms of health care: it is a health problem with diverse consequences for an individual, but equally a problem for society (Keeling, 1993; Kiemle, 1994). Bor, Miller, Scher and Salt (1998) point out that the psychological effects of the disease are felt by individuals, families and health care staff; this together with the nature of the illness – a potentially fatal, incurable, transmissible disease – elevates the need for counselling in HIV infection to that of a major priority. And as Keeling (1993) elaborates, when dealing with the "interrelated problems of health and society, we cannot depend on the traditional biological, technical and quantitative approaches by which we treat and monitor most diseases; we need responses that help us deal with multiple levels of HIV disease" (p. 306).

Further, many believe that the current social context is not that different from 1985. The potential for stigmatization and discrimination against HIV-infected people continues to exist in many high-prevalence and resource-constrained contexts; hence, measures that protect individuals and respect their human rights must inform any proposed intervention, even if such measures might weaken a public health response (Brockway, 2007). In addition, the massive scale-up of testing, as a public health response, is not likely to achieve the normalisation and stigma-reduction goals that are attached to it (Strode et al., 2005). A response to HIV that includes testing and prevention but that also addresses the many other structural and contextual factors that shape the disease, is more likely to bring about this response.

The "special treatment" of HIV/AIDS has had a positive ripple effect on health care in general. HIV activists and advocates insist that HIV/AIDS has forced the medical

profession to "raise the bar" in terms of the care and management of individuals and families and to re-appraise the needs, expectations and rights of patients: "This move for improved interaction between patients and health care providers is providing new opportunities for the empowerment of patients, the mobilisation of communities around issues of quality of life during illness, and the importance of psychosocial support in disease prevention" (Carballo & Miller, 1989, p. 117) .

2.1.7   Finding a way through the polarities: thinking about rights and responsibilities

Dixon-Mueller (2007) argues that the debate should not be about abstract notions of "human rights and public health" or the right to privacy versus public interests. She argues that when we focus on these abstractions we miss the individuals at the centre of both human rights and public health. She prefers to see the debate as a conflict over the disputed boundaries of sexual freedom and sexual responsibility (ibid). In other words, the debate is framed by the questions *where do my freedoms and entitlements as a sexual being, as well as my integrity and self worth, living in a time of AIDS, begin and end?* and *how do I negotiate these freedoms against a sense of social responsibility?* These questions express an "obligation to respect the equal rights – the freedoms and entitlements – of others, as well as one's own integrity and self worth" (Dixon-Mueller, 2007, p. 285).

She points out that the concept of sexual responsibilities she refers to is different from the moralistic and conservative attitude that continues to permeate much of the HIV/AIDS discourse. This shift in discourse will be a challenge to attain, as moral culpability, blame, shame and punishment are likely to be intertwined with notions of sexual and social responsibilities. In relation to HIV/AIDS, "moral culpability adds a crucial dimension in that health care workers (and the world at large) regard differently

those illnesses and disabilities which are seen to have arisen from psychological causes, or worse, the voluntary actions of human beings, and this shame and punishment is internalised by clients" (Kiemle, 1994, p. 343). Further, the moral connotations linked to the mode of HIV transmission are concerned with guilt and blame, with children considered victims and adults as guilty which reflects a sense of responsibility for them contracting the disease (ibid).

Often when rights and responsibilities are spoken about, they are presented as somewhat abstract notions that seem to operate outside of individuals, circling above their contexts. For individuals to achieve this balance between claiming sexual rights (a relatively easy thing to do as it comes from a position of entitlement) and exercising social responsibilities (a relatively difficult thing to do as it requires a shift from a sense of entitlement towards thinking about what is best for others), there needs to be a corresponding shift on many other levels. Individuals are shaped and interact in a dynamic way with their immediate contexts, and with the broader systems and structures that surround them; these too need to shift in order to encourage and facilitate such individual reflection and action. Dixon-Mueller (2007) recognizes the importance of these contexts in shaping individual behaviour when she advocates a vision that supports a "powerful normative message that being regularly counselled and tested for HIV and other STIs – individually and with one's partner – and keeping one's partner informed is not only a right but also the right thing to do" (p. 287).

2.1.8   Conclusion

Preventing the further spread of the virus is a legitimate public health concern. In fact, there is consensus that early identification is beneficial both from the perspective of the

individual and from a public health perspective (Rietmeijer, 2007). We need both prevention and treatment. There is a concern that reverting back to the traditional "test and treat" public health approach places greater emphasis on treatment, and ignores the parallel and continued need for prevention in our response to HIV/AIDS. Even in countries with the highest rates of new infections, the numbers of people who test positive will remain significantly less than those who test negative. Prevention interventions that focus on behaviour change amongst HIV-negative and HIV-positive people – such as HIV test counselling – remain critical.

The value of testing is not just in being tested, but in what it means to the individual and what happens outside the testing rooms (Obermeyer & Osborn, 2007), in their immediate social contexts, and in their lives and relationships where HIV/AIDS finds a place. The arguments for routine testing have not adequately acknowledged the range of social, physical and psychological consequences associated with testing, and knowing and disclosing one's HIV status. In truth, given these consequences, one model may not be appropriate for all countries, and countries may well need to consider both RT and VCT approaches, rather than polarize them as mutually exclusive options.

Given the enormity of the problem posed by HIV/AIDS, it is imperative that both groups polarised by the human rights versus public health debate help find solutions to the problem. The human rights-based approach to the HIV epidemic has helped us develop more caring and humane ways of dealing with health problems, and we should not compromise these gains. Similarly, these human rights values don't exist in isolation and need to be critically reviewed against the backdrop of an evolving and devastating epidemic. Public health and human rights can have common goals; we need to find out

what these are and how they can combine to serve the interests and needs of those at risk, those living with HIV/AIDS and their families (Strode et al., 2005).

In the midst of these controversies and acrimonious debates are the counsellors, who have to find a way of providing a "psycho-social counselling that complements HIV prevention and risk reduction, that not only encourages individual action and responsibility but, more importantly, allows individuals to assess the feasibility of that behaviour and the implications for life-style and social relations" (Carballo & Miller, 1989: p. 118). Counsellors attempt to achieve these goals against the backdrop of these debates and controversies that frame and shape their activities. Practitioners have to distil a set of workable understandings of their tasks and responsibilities, and of what it means to do voluntary counselling and testing, in order to transform the aspirations outlined in policy to the reality of practice. This thesis explores this interface.

2.2 FROM BACKGROUND TO EVIDENCE ON VOLUNTARY COUNSELLING AND TESTING

Of the various approaches to HIV testing and counselling discussed in the previous section, this thesis focuses on VCT – the cornerstone of counselling and testing efforts in most high-prevalence, resource-constrained countries (including South Africa) – and the approach currently being called to account for its efficacy and its usefulness in response to the epidemic.

2.2.1   Defining voluntary counselling and testing

VCT involves the combination of two activities, counselling and HIV testing, into a

service that strengthens both. The World Health Organisation (1995) described the aims of VCT as the prevention of infection and the provision of support for those infected and affected by the virus.

The failure of other public health interventions, such as mass media and education campaigns in the mid to late 1980s, to effect behaviour change (Balmer 1991, 1992; Irinoye, 1999; Moses & Plummer, 1994) led to the call for a new public health strategy that would move beyond information to address human behaviour believed to be the core driver of HIV transmission. Counselling for general health promotion – i.e. the avoidance of disease – was implemented as a public health response to HIV/AIDS (Bor, Miller, Sher and Salt, 1991; Irinoye, 1999).

Since then, health promotion efforts in many countries have operated on the belief that behaviour can be changed by providing those at risk with information, and by challenging prevailing beliefs or attitudes about risky sexual activities through counselling for risk reduction and addressing clients' own motivations and self-efficacy for change (Bor, et al., 1991; di Scenza, Nies & Jordan, 1996; Moses & Plummer, 1994). The prevention goals of VCT are most clearly understood from this perspective.

People also come to VCT with a range of psychosocial problems – perceptions of themselves as a person at risk for HIV or reactions to receiving an HIV-positive result. Through the provision of support (i.e. encouragement, enhancement of morale, maintenance of sociability) together with practical assistance, these psychosocial problems are addressed (Chester, 1987 in Silverman, 1997). The aim, therefore, of the supportive component of VCT is to help reduce the psychological and social morbidity associated with HIV disease (Allen, Karita, N'Gandu, & Tichacek, 1999).

VCT is typically an individual intervention, consisting of two sessions (pre- and post-test) performed before and after the HIV test. Pre-test counselling addresses a client's risks and concerns relating to HIV, provides information about HIV and the test, addresses the implications of testing and ultimately facilitates an informed decision regarding testing. Post-test counselling focuses on helping clients cope with their HIV test result and the implications of the result for themselves and others in their lives, and focuses on support and facilitated decision making following testing (UNAIDS, 2001).

2.2.2   Theoretical frameworks or models

VCT is constructed in two distinct ways in the literature. It is framed as a public health intervention with health-promoting goals implemented specifically to address HIV risk and disease (Blankenship, Friedman, Dworkin, & Mantell, 2006). VCT is also framed as a counselling activity defined as the skilled and principled use of a relationship to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources (Silverman, 1997). I explore the theoretical models that inform these constructions of VCT both as an intervention and as a counselling encounter, and return later in the chapter to consider the implications that this dual identity has in considering VCT efficacy and counselling policy and practice.

2.2.2.1 Behavioural approach

The construction of VCT as a public health intervention is informed by behavioural theory (Balmer, 1991, 1992, 1993). Behaviour therapy had its origins in animal experiments conducted in the early 1900s by Thorndike, Watson and Pavlov. By the 1950s, this research had become formalised into therapeutic systems, with Eysenck

most widely credited for proclaiming the scientific efficacy of behaviour therapy (Feltham, 1995).

According to Feltham (1995), behavioural therapy focuses on problems that can be observed, studied, measured and reliably changed. Whether abruptly or gradually, the client is encouraged to face certain situations or extinguish unhelpful behaviour patterns. Problematic behaviours are identified and altered, and desirable but missing behaviours (for example, certain social skills) are taught. In the case of HIV/AIDS, for example, risk behaviours for HIV would be the problem under study, with certain social skills, such as condom use, and negotiation skills as key behaviours that would need to be taught to the client.

Within this approach, VCT is viewed as a directive activity with clear public health outcomes. These public-health goals are designed to prevent transmission of the virus as well as to provide psychosocial support to those infected with and affected by HIV/AIDS. With individual-level interventions, such as VCT, behaviour change is often the outcome of interest and individuals are assumed to have considerable autonomy to make and act on their choices (Blankenship et al., 2006). Operating from this perspective, VCT involves the delivery of medical advice and information intended to influence or persuade the client to change risk behaviour (Rollnick & Nick, 1992), with the counsellor as an expert consultant (Feltham, 1995). Some of the predetermined behavioural outcomes of VCT that the counsellor would address with the client include: the elimination of risky behaviour; adoption of safer sex behaviours; reduction of transmission to others; taking the HIV test; and disclosing his or her HIV status, so that the virus is not transmitted to others.

2.2.2.2 Humanistic approach

The counselling component of VCT is influenced by the humanistic, person-centred/client-centred model, made popular by such theorists as Carl Rogers (1967). Rogers saw therapy as comprising three core conditions: unconditional positive regard, empathy and genuineness. Within this framework, human beings who have their own sense of inner worth are viewed as self-directed and creative, and through skilful use of the three core conditions, individuals are enabled to reach their true potential. Many AIDS counselling approaches draw on, in various forms and degrees, some of the elements of this client-centred approach.

With the client-centred approach, the starting and finishing point of counselling lies with the client's perceptions and the client's views of their problems (Burnard, 1992). The task of the counsellor is to facilitate the client's self-discovery and growth, and not to interpret things for the client or to set agendas (Feltham, 1995). Counselling, according to this second approach, is viewed as a supportive and empowering process that should assist individuals in making various decisions through conversation without being didactic.

VCT, conceptualised as a counselling activity, is primarily a non-directive and client-driven encounter which views clients as authors of their own existence who are best placed to decide what they need. To this end, clients should be "empowered", their self-directedness increased, and their own experience treated as the relevant starting point (Vehviläinen, 2001). Given the client-centred focus of counselling, the outcomes of counselling cannot be predicted nor can concrete goals be set – unless these are devised by the client at their request (Burnard, 1992).

2.2.2.3 Two competing frameworks shape voluntary counselling and testing practice

These theories and models are aspirational, "consisting of ideals and visions of the best possible situations" (Peräkylä & Vehviläinen, 2003, p. 728). These theoretical frameworks tend to describe the best possible situations or the broad aims of the approach, but may fail to articulate adequately the actual goals that organise institutional practice as well as the skills of the counsellor – i.e. they may fail to guide appropriately the counsellor's understanding about the client and the client's behaviour, and what counsellors understand their task to be (Heritage, 2004; Irinoye, 1999).

These two theoretical frames, VCT as a health-promotion activity and as a counselling activity, create a dilemma for practitioners. Vehviläinen (2001) refers to this as a "dilemma of simultaneous orientation" (p. 373). The one orientation privileges client experience and perspectives, and the other values the authority of the professional perspective through the information, advice and support they impart. A further tension inherent in VCT practice exists between the directive biomedical public health approach, which is linked to specific outcomes, and the counsellor-determined approach, where outcomes are more open-ended and determined by the client, and not the practitioner.

The potential for a dilemma of orientation is evident when one moves beyond the broad goals of counselling, to look more closely at what counsellors actually do in practice. For example, the conditions or elements described by these different (and perhaps competing theoretical frameworks) might be difficult to translate into practice. In other words, how do counsellors accommodate the disease-centred approach and

epidemiological concerns of infection control with the practice and theory of counselling?

Sketchley (1989, in Burnard, 1992) explains that VCT involves three domains: educational issues, advice and psychosocial support. Chester (1987, in Silverman, 1997) describes education as involving answering people's questions about the virus and about the likelihood of becoming infected with HIV/AIDS; advice involves imparting authoritative information, explanation, guidance, and clarification of options regarding which safer sex measures to adopt; and support as the provision of encouragement, enhancement of morale, and maintenance of sociability together with practical assistance.

In reviewing these core VCT activities, a point of contention between the two approaches is the role of advice in HIV test counselling. Feltham (1995) points out that contemporary counselling, in most of its forms, distinguishes itself from advice-giving. Stein and Brouard (1994), argue that "to counsel, is anything but to advise; to advise people is to tell people what to do; to counsel is to enable the client to make and act on their own decisions and choices" (p. 12). This understanding of advice from a counselling perspective is in direct contrast to the public health goals of HIV counselling which seek to advise people about HIV risk and how to prevent that risk (Balmer, 1991, 1992).

2.2.2.4 Conclusion

HIV/AIDS counselling is described in two senses in the literature: as counselling and as a public health intervention. This has implications for practice in that each of the

constructions of VCT is informed by competing and contradictory theoretical frameworks and aims that ultimately shape what happens in practice. The resultant dilemmas of orientation between VCT as a counselling activity and a public health intervention are evident in the kinds of research that is conducted on HIV/AIDS counselling and in the research questions that are asked, and need to be borne in mind when considering the effectiveness of VCT. We turn to these considerations now.

2.2.3   Reviewing the evidence: does voluntary counselling and testing work?

At the core of the recent debates regarding the need to scale up HIV testing is a concern about the effectiveness of VCT as a prevention intervention. Reflecting the bias and interest in VCT as a public health intervention, questions are often levelled at the efficacy of VCT as a prevention intervention, rather than its role in support. I review the available literature pertaining to both these VCT goals.

2.2.3.1 Has voluntary counselling and testing achieved its prevention goals?

A strong biomedical discourse and agenda has driven the response to the epidemic since its discovery. Friedman, Kippax, Phaswana-Mafuya, Rossi and Newman (2006) point out that biomedical research funding for HIV has overwhelmingly focused on the basic sciences, clinical research and epidemiology. These developments reflect the dominance of the scientific paradigm. In order to convince donor agencies that an intervention deserves funding, a case must be made that it has a clear impact on reducing the spread of the disease and is cost-effective (Allen, et al., 1999). Biomedical research relying on quantitative approaches is best placed to answer these questions.

Ideally, effectiveness is best tested through randomised controlled studies comparing the intervention (VCT) with another intervention or the current standard of practice (Allen et al., 1999). Other research designs, less able to test intervention efficacy accurately, are outcome studies that use objective measures (e.g. HIV incidence or STIs following VCT) and subjective measures (e.g. self reports on behaviour change such as condom use, decrease in number of sexual partners etc). The latter, rather than the former, have formed the bulk of the studies conducted to establish VCT efficacy (Allen et al., 1999; Glick, 2005; Higgins et al., 1991; Solomon, van Rooyen, Griesel, Gray, Stein & Nott, 2004).

Several studies conducted in both international and regional settings reveal that VCT is an effective behaviour change strategy (UNAIDS, 2001). According to Glick (2005), outcomes-based research using self-report methods, provide evidence for some reduction in self-reported risk behaviours following VCT (i.e. studies report less unprotected sex, fewer cases of multiple sex partners and fewer casual partners). Further, a recent study using a randomized clinical trial evaluated didactic health education against client-centred VCT to assess which accounts for greater behaviour change in research participants (The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). A CDC trial also evaluated, using a randomised control trial design, the impact of HIV-prevention, client-centred counselling (i.e. impact over and above that of testing for persons who are HIV seronegative). Researchers found that client-centred counselling plus testing was better than testing and health education and resulted in more consistent use of condoms and reductions in incidence of STIs for all participants in this group (Kamb, et al., 1998). The model was promoted as having real public health value, was acceptable to clients, was feasible in busy clinic settings and

cost very little to implement (Kamb et al., 1998; Metcalf et al., 2005; The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000).

Studies show stronger, positive VCT effects with certain specific groups. Several reviews and meta-analyses of VCT studies in international and developing contexts suggest that the evidence for behaviour change following VCT is strongest among sero-discordant couples tested together (Allen, et al., 1992) and among HIV-positive individuals, particularly with their non-primary partners (Denison et al., 2007; Higgins et al., 1991; Kamb et al., 1998; Metcalf et al., 2005; The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000; UNAIDS, 2001; Weinhardt, Carey, & Johnson, 1999; Wolitski, MacGowan, Higgins, & Jorgensen, 1997). The effectiveness of VCT as a prevention strategy for HIV-negative people, as well as the long-term preventive effects of VCT for all testers, remains unclear (Higgins et al., 1991; UNAIDS, 2001; Weinhardt et al., 1999; Wolitski et al., 1997). Thus far, there remains insufficient evidence on whether behaviour changes for both those who test positive or negative can be maintained in the long term (UNAIDS, 2001).

2.2.3.2 Limitations of voluntary counselling and testing efficacy studies

Most of the reviews and meta-analyses conducted locally and internationally into the efficacy of VCT as a prevention intervention, point out that weak study designs and limited replication mitigate the strength of evidence that exists (Denison et al., 2007; Higgins et al., 1991; Solomon, et al., 2004; Weinhardt et al., 1999; Wolitski et al., 1997). As alluded to earlier, one of the methodological limitations with many VCT efficacy studies is that they were not randomised, controlled clinical trials. Consequently, efficacy becomes difficult to measure, as various other factors having to do with the

person or situation may contribute to the changes evident in the intervention group – not just the fact that they participated in VCT. Further, VCT efficacy studies commonly measured through retrospective self-reports are biased in terms of recall and social desirability (Allen et al., 1999; Glick, 2005; Solomon, et al., 2004).

Higgins et al.(1991) note that in all the studies they reviewed, variations in counselling were not well documented – failure to specify the independent variable (i.e. VCT) threatens the validity of any study – and makes if difficult to know what components of VCT are responsible for change.

Further, the nature and content of the counselling session are uncontrolled factors in the available VCT efficacy research. Solomon et al. (2004) suggest that in these studies the process of VCT has not been well defined, with the result that there are important differences across the studies in terms of key aspects of VCT (i.e. length and/or number of counselling sessions, what actual counselling procedures were used, etc.). As the contents and methods of VCT vary so widely, it is possible that studies may not even be evaluating the same thing, and it would be erroneous to hypothesise that they could have a uniform effect on behaviour (Beardsell, 1994).

Reviewers have identified various ways in which people come to counselling and testing services i.e. self-referred, provider or researcher-referred. Weinhardt et al. (1999) showed that greater behaviour change occurred among participants who actively sought counselling and testing compared to those who were approached by researchers. Denison et al. (2007) in a recent review of VCT studies in developing countries, point out that given the current debates regarding scaling up CT services, we need to better

understand how these variations in the implementation of VCT have an impact on behavioural outcomes.

Higgins et al. (1991) observe that with only a few exceptions, VCT studies have not been informed by theories of behaviour change and investigators have paid little attention to the psychological factors that may interact with testing to affect behaviour. They argue that this is central to the iterative process of theory-driven research, and can guide the development and refinement of interventions.

A final limitation of VCT efficacy research has to do with its status as an individual-level intervention. Beardsell (1994) argues that the relationship between VCT and behaviour change, with the hypothesis of a linear relationship, is rooted in an outdated model of individual behaviour change. Coates, Richter and Caceres (2008) point out that these individual and highly cognitive theories of behaviour change assume that people have the motivations and agency to adopt protective actions. David (1994, in Goss and Mearns, 1997) adds that in the counselling milieu "cause and effect relationships are not necessarily linear – a single intervention, such as VCT, may have any of many potential results on individual risk behaviour, depending on the individuals involved, their relationship, the context and so on" (p. 191).

VCT cannot be expected to rearrange human sexual behaviour on its own (Solomon et al., 2004). The effectiveness of VCT is likely to be increased when it is integrated and combined with other prevention services. Recently, there has been widespread promotion of the idea of adopting a comprehensive framework for HIV prevention in the context of HIV/AIDS (Coates et al., 2008). Writers argue that comprehensive prevention approaches that combine individual-level behavioural approaches, and

structural and biomedical prevention paradigms and approaches offer the best hope for success in prevention (Merson, O'Malley, Serwadda, and Apisuk, 2008). A much more structural approach to prevention which acknowledges that individual agency and risk behaviour are constrained and shaped by contextual, normative and environmental factors, might lead to better prevention outcomes (Blankenship et al., 2006). The causes of these risk behaviours and the root causes of the HIV epidemic are primarily social and economic. Influencing the underlying causes of the epidemic will do much more to control the spread of HIV infection than the best educational or counselling programmes (Moses & Plummer, 1994).

Glick (2005) concludes that taken as a whole, the efficacy research gives the impression that VCT leads to reduced risk behaviour in certain groups who elect to undergo the test – HIV-positive people, couples and especially sero-discordant couples. But, the data offers less reason for optimism for those who test negative. Effective HIV prevention requires attention to multiple layers of social influence at the national, community, inter-personal and individual levels. VCT needs to be constructed as "one part of and not the centrepiece of primary prevention efforts" (Coates et al., 1988, p. 120). Current experience suggests that we have been unsuccessful in doing this, and that VCT continues to be burdened with unrealistic expectations emanating from its perception as the sole prevention strategy in the epidemic.

2.2.3.3 Have the voluntary counselling and testing support goals been achieved?

In comparison with the prevention terrain, less research relating to the support goals of VCT has been conducted. Most of the research on this topic is largely qualitative, and

for the most part anecdotal. Solomon et al. (2004) argue that this reflects a bias and (a valuing) of the public health and prevention goals of VCT over the role of VCT in providing emotional support to people with HIV and AIDS.

A comprehensive review (UNAIDS, 2001) showed that VCT does play a role in supporting people to cope better with their HIV status. Situated as it is around the HIV test, VCT seems best placed to help people adjust to the news of an HIV-positive diagnosis and deal with the consequences of such a diagnosis for themselves and others in their lives. Emotional responses to an HIV-positive diagnosis are to be expected, but counselling can help people cope with an HIV-positive diagnosis and prevent serious or long-term, intractable problems.

More specifically, research has shown that VCT can help reduce the stress often associated with receiving a positive result (Perry, Jacobsberg, Fishman & Weiler, 1990); help alleviate anxiety and depressive reactions (Camara, 1991); help women cope with their disease by reducing fears regarding disclosure, and possibly prevent suicide (Krabbendum, Kuijper, Wolfers & Drew, 1998); improve personal coping and help clients gain emotional and social support (Baggaley, 1997; Lie & Biswalo, 1994;) and help facilitate disclosure between the client and significant others (Lie & Biswalo, 1996).

A study in Nairobi indicated that VCT is able to help people cope with the psychological consequences of an HIV-positive diagnosis (Vollmer & Valadez, 1999). One of the main advantages of counselling associated with VCT is assisting people to accept and cope better with their HIV status. "Coping" with HIV was defined by staff and clients participating in this study as "an acceptance of being HIV-positive and

having a positive attitude towards making the most of each day" (UNAIDS, 2001, p. 39).

A recent randomised clinical trial (The Voluntary HIV-1 Counselling and Testing Efficacy Studies Group, 2000) supported some of the above findings. HIV-positive people, following VCT, reported better coping skills to deal with their situation, increased hope, disappearance of suicidal thoughts and help in decreasing isolation and normalizing their situation. While most HIV-positive people described their distress as transient following VCT (more like an adjustment disorder), some participants reported persistent feelings of sadness, desperation and a sense of loss (Sangiwa, van der Straten, Grinstead, & The Voluntary Counselling and Testing Efficacy Study Group, 2000).

Stein (1996) argues from a more critical vantage point that we need to look at what coping means in different contexts. The current literature on effective coping reflects a dominant Western psychological discourse on counselling. She points out that that there are important differences in the avoidance coping strategies employed in African contexts and that the active coping models (i.e. the goal of supportive Western counselling) are less useful in these contexts. She argues that avoidance coping is not necessarily "denial" but may actually be a rational strategy and conscious act of will, which from the perspective of HIV-positive persons is a prerequisite for ongoing mental and physical health.

And lastly, Meursing and Sibindi (2000) found that while VCT improved basic factual information regarding HIV/AIDS, it failed to address the more subtle problems in patients' conceptualisations and understanding of HIV that have far reaching consequences for their preparedness to deal with the test results. As discussed earlier,

VCT is a limited intervention comprising of two, and at times three sessions designed to achieve a range of prevention and limited support outcomes. Krabbendam, et al. (1998) and Meursing and Sibindi (2000) show that VCT programmes on their own are insufficient in helping people infected with HIV and AIDS to cope effectively with the consequences of a positive diagnosis – and that in order for these support objectives to be met, VCT needs to be complemented by ongoing counselling service provision along a continuum of care (Solomon et al., 2004).

2.2.3.4 Conclusion

The above review suggests that VCT is able to play a role in supporting people to cope better with their HIV status and deal with some of the mental health impacts following HIV diagnosis and infection. While VCT is capable of providing people with support, many other services along this continuum of care, capable of catching people at various critical points beyond the HIV test, should be encouraged and equipped to provide ongoing support and counselling to people living with HIV/AIDS.

Generally, the type of research conducted to assess whether VCT has met either its prevention or support goals is similar. The approach is to assess whether or not a particular prevention (risk behaviour, condom use, etc) or support outcome (coping, disclosure, reduction of anxiety or depression, etc) is produced by VCT. There is considerably less focus in the literature as a whole on how VCT works as an interpersonal encounter or intervention to achieve its prevention or support goals.

2.3 RATIONALE FOR THE STUDY

In the first two sections of the review I outlined the broader context that shapes HIV counselling and testing in general, and then focused more specifically on the literature pertaining to the prevention and support goals of VCT. In this final section, I argue why this research is important and what contribution it hopes to make to VCT policy and practice. This objective will be achieved through discussing the limitations of the predominantly quantitative, outcomes-based approach to studying VCT and the role that process-oriented, qualitative research could play in addressing these shortcoming; through assessing what has already been established thus far from process-oriented and/or qualitative research in the field of HIV counselling; and discussing how this study seeks to supplement that body of knowledge.

2.3.1 Limitations of outcomes-based research

Since the discovery of the HI virus, the dominance of the scientific paradigm in framing research and policy has meant that considerable effort has been placed on determining if VCT works to achieve certain very specific outcomes. The VCT literature reviewed thus far has revealed a predominance of research that focused on whether or not particular prevention or support outcomes have been achieved. Beardsell and Coyle (1996) comment that as a result of this focus, voluntary counselling and testing tends to be conceptualised as a series of discrete events (e.g. prevention or support) rather than as a dynamic process that consists of both these related processes.

While quantitative approaches to researching VCT have produced useful information regarding the relative value and utility of HIV test counselling, outcomes-based

research on both the prevention and support goals of VCT has been unable to show how VCT works to achieve its prevention and support outcomes. These studies, because of the questions they ask, have been unable to show how counsellors and clients negotiate issues of HIV risk and prevention. Nor have they been able to show how counsellors facilitate and encourage coping and support. Patton (2002) argues that qualitative inquiry is better suited for studying these process-related questions about VCT practice. He explains that "a focus on process involves looking at how something happens rather than or in addition to examining outputs and outcomes" (p. 159), and is particularly useful when addressing issues relevant to psychotherapy and counselling.

Phillips and Coates (1995) agree that little is known about how counselling and testing are conducted and that practitioners may not be following the recommended procedures for conducting VCT. Consequently, more than twenty years into the epidemic, we still don't understand enough about how VCT works – or doesn't work – to achieve the prevention and support goals associated with it. Qualitative, process-related research that focuses on the nature of the interactions that occur during HIV test counselling – on how the counsellor approaches the issues and how the client responds to them – can produce findings of sufficient depth, that are needed for shaping VCT policy and practice (Goss & Mearns, 1997). Given the current policy-driven debates regarding the structure and value of VCT – on whether pre-test counselling needs to be reduced or dropped altogether as part of the package of VCT services – qualitative research addressing these process issues could meaningfully inform this debate.

The dominant thrust in the social science literature and the field of public health directs researchers towards quantitative methods, and in-depth approaches tend to be under-

emphasised (Simmons & Elias, 1994). Many argue that qualitative research is able to produce contextual or holistic explanations of a phenomenon such as VCT, depict systems' workings, and provide a thorough description of these processes (Shaw, 2003; Simmons & Elias, 1994). Consequently these qualitative studies are better suited to the "complexities of the practitioners' world than the blockbuster randomised controlled trial" (Shaw, 2003, p.62). These contextual, detailed explanations of a particular phenomenon are essential for fully understanding client-counsellor interactions and for designing user-oriented and effective VCT programmes. Following McLeod (2001), this research will use qualitative research to focus on VCT practice in South Africa with a view to questioning basic assumptions and accepted practices related to it, and contributing to changing those practices if required.

There is a small, but growing body of qualitative research that address the process issues in HIV/AIDS counselling, locally and in other contexts. The predominant qualitative research approach in assessing counselling practice is to explore, through interviews, counsellors' experiences and perceptions of their roles in providing counselling and testing in different settings. There are a few notable methodological exceptions in the literature that look beyond the interview to understand HIV/AIDS counselling practice. One of these is the Richter et al. (1999) counselling evaluation that compared counsellor interviews on their role and practice, with observations of simulated VCT interactions using a rating scale. The other was a piece of ethnographic research (using field notes, reflective diaries, informal interview notes and transcripts of interviews) conducted in several prevention-of-mother-to-child-transmission settings across Swaziland, Namibia and South Africa, that looked at perceptions and experiences of providing VCT in an infant-feeding context (Buskens & Jaffe, 2008).

2.3.2   Key findings from qualitative research on the counselling process

In a South African study, Stein, Steinberg, Allwood, Karstead and Broaurd (1997) explored how nurse counsellors constructed their prevention and support roles as VCT practitioners. In practice, nurses tended to adopt a primarily didactic, disease-oriented model of counselling, with strong elements of advice-giving with a view to obtaining patient compliance on a range of matters. In a similar vein, Richter et al. (1999) found that while non-professional and professional counsellors conceptualised their work as being client-centred and open-ended, in practice, in almost all settings, they adopted a more directive and health-advising model of counselling. Buskens and Jaffe (2008) in their analysis of counselling in an infant-feeding context found that counsellors drew on two competing and largely incompatible frameworks: non-directive counselling based on a client-centred approach and infant-feeding information based on a directive approach to health education. Similarly, Bond's (1991) survey of British specialist nurse counsellors found some tension between counselling viewed as a client-centred activity in which the client sets the agenda for the counselling sessions and identifies their own goals, and the introduction of HIV-prevention strategies derived from an externally generated agenda and a series of goals determined by the counsellor.

Stein et al. (1997) argue firstly that HIV test counselling in practice resulted in an uneasy form of reassurance and advice-giving which may well be counterproductive to and undermining of the aims of VCT, and secondly that in the absence of proper training in the theory and methodology of facilitative counselling, VCT inevitably becomes a prescriptive, advice-giving activity, albeit one that is personalised and tailor-made to the clients' circumstances. Richter et al. (1999) show in their analysis of VCT that the combination of counselling and health education prevention approaches as

applied in VCT has produced a model of counselling that may mask possible tensions for counsellors in practice, and that ultimately this may compromise the efficacy of VCT.

Delaney (2002) used a discursive approach to analyse counsellors' construction of their health-promotion and counselling roles, and the possible tensions that counsellors may experience in implementing these two modes in practice. She identified certain "trigger points" that forced the counsellor out of a client-centred mode into a more prescriptive mode. Contextual triggers were described as those in which there was the potential for harm to self and others, as well as disclosure situations. She argues that VCT is a "highly emotive issue involving a degree of preferred outcomes that are not present in other forms of counselling" (p. 78); hence, the urgency of the issues that are being dealt with, as well as the moral imperatives of the disease compel the counsellor to reconsider her HIV/AIDS counselling mode.

When asked to describe their activities as counsellors, nurses conducting VCT in the United Kingdom (Burnard & Morrison, 1988) identified themselves as being more proficient in being informative and prescriptive than supportive. Two South African studies reveal similar counsellor constructions of their roles. Fawcett (2001) interviewed health care professionals in a district hospital in South Africa about how they understood their role as counsellors – they saw their jobs as involving "education", "giving advice" and "making clients see things" (p.24). Further, nurse counsellors in the Eastern Cape in South Africa reported knowing the difference between prescriptive/educational models and empathic/client-centred models, but none reported difficulties moving between these two modes (Nulty & Edwards, 2005). Significantly, most counsellors experienced a greater sense of control when they were in

the factual or information-delivery mode as they were "never sure what to expect, nor what to say in response" when operating in the non-directive counselling mode (p.3)

2.3.3   Focusing on counselling *in situ*

Goss and Mearns (1997) point out that while studies that draw on counsellor experiences have offered interesting perspectives on counselling practice, they still do not provide the practitioner with concrete information on how he or she might improve effectiveness across a range of future situations. In response, McLeod (2001) and Silverman (1997) suggest that a focus on counselling in its natural environment, with a particular emphasis on the micro-processes of practice, would provide the detailed and concrete descriptions of VCT practice that might assist in improving practice and shaping policy and/or in understanding how the aims of VCT are actually being implemented.

Simmons and Elias (1994) make a powerful argument for studying client-provider interactions. They suggest that "these encounters provide a lens through which programmes appear in a new and realistic light, often revealing extensive gaps between policies and the reality of service delivery – researching this interface has the potential for leading to major improvements in the quality of care, the designs of programmes and in policy choice"(p. 12). Generally, there is limited research that combines a focus on counselling in its natural environments *and* a more discursive approach to analysing client counselling interactions. Exceptions are the work of Silverman in the United Kingdom, and Peräkylä and colleagues in Finland. These writers use theoretically inspired approaches to analysing talk in counselling interactions and have explored the structure and content of HIV/AIDS counselling communication formats (Miller &

Silverman, 1995; Peräkylä, 1995; Peräkylä & Bor, 1990; Peräkylä & Silverman, 1991a).

Silverman (1997) argues that a theoretically informed analysis of detailed transcripts of actual counselling *in situ,* can make a significant contribution to counselling practice in that it allows us to assess how counselling actually proceeds. In doing so, unnoticed skills of both counsellors and clients, as well as the communicational and interactional functions of "dysfunctional behaviour" might be discovered.

This PhD is a qualitative study of VCT process and responds to the need for more research on how VCT works to produce its prevention and support outcomes. It aims to build on the understandings of other process-related studies into VCT that have been conducted in South Africa thus far (Buskens & Jaffe, 2008; Delaney, 2002; Fawcett, 2001; Richter et al., 1999; Stein et al., 1997) that have outlined the difficulties counsellors have in implementing the prevention and support goals of the epidemic. This study hopes to develop the understanding of VCT practice gleaned from these studies one step further by looking at counselling *in situ* and by conducting a theoretically informed analysis of the micro-processes of counselling interactions in South Africa, following the work of Silverman and colleagues. The intention is that, using this method and approach, this study would provide a more detailed account of how these prevention and support goals of AIDS counselling are operationalised, and contribute to VCT outcomes. In so doing, it is hoped that more detailed and in-depth knowledge about counselling is revealed that could be used to inform VCT policy, programmes and practice.

CHAPTER THREE

THEORETICAL FRAMEWORK AND STRATEGIES OF

ENQUIRY

INTRODUCTION

In framing these design chapters, I am guided by Silverman (2000) and Alasuutari (1995) who advocate writing these chapters in a qualitative study as a natural history account or a narrative of discovery. In making the argument for this approach, Alasuutari points out that the qualitative research process rarely "advances in a straightforward fashion as a set model of hypothesis-testing" (p. 174). The process is dynamic and iterative and often when "conducting qualitative research you have to look back and revise your premise several times" (p. 174). Developing the argument further, Silverman (2000) argues that students conducting qualitative research should write up these methodological chapters in the form of a discussion where you "explain the actual course of your decision making rather than [make a] series of blunt assertions in the passive voice" (p. 235) and where you outline "the history of your research, including your responses to various difficulties and dead ends that we all experience" (p. 236).

This chapter is organised into two parts. In the first part, using the natural history account, I discuss key research design issues and eventual decisions I made during the process of this research. In so doing, I track my theoretical development as a researcher from naïve realist to social constructionist. In the second half of the chapter, I describe

the strategies of enquiry that connect my research question, methodology (discussed in Chapter Four) and subsequent analysis (Chapter Five).

3.1 THE PERSONAL CONTEXT OF RESEARCH

For the most part, my ways of making sense of the world have been informed by realist, positivist assumptions about the nature of social reality. I have trained and worked for more than 10 years as a clinical psychologist in the HIV/AIDS sector as a counsellor trainer, supervisor and mentor of counsellors. All these roles were educative, corrective and supportive towards a "right way of being and doing counselling". These "right ways of being and doing counselling" reflect my normative models and theories about counselling that come from my professional background and training as a clinical psychologist; these framed how I worked with counsellors in my various capacities in HIV/AIDS organisations. Peräkylä and Vehviläinen (2003) explain that these theories and models concerning interaction (or stocks of interactional knowledge – SIKs) form the knowledge base of practitioners and professionals and serve to "give norms, to describe and to legitimize or oppose existing practices" (p. 474).

In 1999, I joined a University of KwaZulu-Natal – then University of Natal – research team to co-ordinate a study commissioned by the National Department of Health to evaluate counsellor service provision within the South African context, with special reference to HIV/AIDS counselling (Richter, et al., 1999). The evaluation was framed as a need by government to "take stock" and to determine if the extensively funded project (R20 million in 1997/8) to implement a lay counsellor-driven HIV/AIDS counselling service was working.

Our research team sought to determine three key points in the evaluation: 1) what HIV/AIDS counselling services existed in South Africa (with a special focus on lay counselling services); 2) what the standards of counselling were in the country, i.e. what models of counselling were being implemented, and how relevant, efficient and proficient were counselling services; and 3) what the HIV/AIDS knowledge, attitudes and practices of service users and providers were. In sum, the evaluation attempted to establish the nature, quality and effectiveness of HIV/AIDS counselling service provision in the country using a combination of quantitative and qualitative methodologies (these are discussed in more detail in Chapter Four).

Most evaluation research is concerned with how well something works (Ritchie & Lewis, 2003), and relies on an assumption that there is an external, outside reality – a standard, a norm – against which all else needs to be measured and compared. An example of this approach, used in our evaluation and many others like it, is to evaluate observations of counsellor practice on a range of skills and competencies, using rating scales that allow one to assess counsellor performance. My involvement in the evaluation served to deepen my ontological and epistemological assumptions about the nature of social reality (and the nature of research) – that there is an external social reality of HIV/AIDS counselling that we could access through interviews, questionnaires and observations, and rating scales.

Our evaluation successfully addressed the questions we set out to answer. But I was left with a sense that we could have done more to understand HIV/AIDS counselling service provision in South Africa. The frustration stemmed in part from the breadth of our activities – trying to assess counselling services across the country – that allowed us to describe only in very broad terms the nature of counselling service provision at that

time. I realised that I wanted to say something more about HIV/AIDS counselling practice than the "aggregate evidence" that emerged from the national evaluation (Whittemore, Chase & Mandle, 2001, p. 524). Shaw (2003) addressed these frustrations when he described qualitative research as being better able to "depict system workings, contextual factors and elusive phenomena, and provide thorough description", and better suited to the "complexity of the practitioners' world" (p. 62). The decision to focus on a smaller subset of the overall dataset, using a qualitative approach, with a view to developing a descriptive and detailed account of VCT practice was formed at this point.

In making an argument for secondary data analysis, Akerstrom, Jacobsson and Wasterfors (2004) suggest that data can always be recycled and revived by applying a new perspective to it. Silverman's book, *Discourses of HIV/AIDS Counselling* (1997), was instructive in thinking about new analytical frameworks and perspectives, and helped me articulate my growing interest in the process of counselling as compared to the dominant field of counselling outcome research. Silverman argued, through his analysis of transcripts of counselling sessions, that counselling research spent an enormous amount of time trying to show that counselling "works". In so doing, researchers spent more time investigating the environment *around counselling* rather than the phenomenon of counselling itself. Bergin and Garfield (1994), in reviewing the development of psychotherapy research, noted a similar preoccupation with measuring through outcomes whether psychotherapy works. These observations struck a chord. Research had been so consumed with assessing whether HIV counselling works (through outcome studies) that little emphasis was placed on the process elements of counselling – i.e. how VCT works to contribute to the achievement of certain outcomes or what

sequences of behaviours or actions are engaged in by either the client or counsellor or both, together (McLeod, 2003).

At this stage, a few things were clear as I worked with the evaluation dataset. The first was that, motivated by my role as practitioner, I wanted to focus on what clients and counsellors do, i.e. counselling practice. Second, I wanted to understand counselling practice in greater depth and detail than the evaluation allowed, and so I knew I wanted to use a qualitative approach to do this. And finally, and perhaps critically, I had a broad area (and possible question) that I wanted to address in the PhD. The question revolved around what many believed to be a key dilemma for counsellors – how counsellors negotiate both the prevention (i.e. to get people to test, to change their risk behaviour, to disclose to others) and support goals of HIV/AIDS counselling (Balmer, 1991, 1992; Irinoye, 1999). This research question shifted and changed as I engaged with various methodological approaches and conducted the analysis. But, a focus on HIV/AIDS counselling practice, and in particular how participants negotiated these prevention and support tasks central to HIV/AIDS counselling, remained a guiding force as I worked on the thesis.

Given my interest in the activities of clients and counsellors, and my research question, the videotapes of counselling with simulated clients conducted before and after the HIV test, seemed like a good place for further exploration and analysis (my rationale for doing so, procedure and sampling strategy used in selecting the videotapes are discussed in Chapter Four).

Reading Silverman and several other critical discursive writers (Burr, 1999; Potter 1998; Potter, 2004; Potter, 2005; Potter and Wetherell, 1994; Wilkinson & Kitzinger 2000;

Willig, 2001) introduced me to the broader philosophical challenge that social constructionists were making to positivist science. These writers challenged the view that language merely describes an external reality or is a tool for labelling or communicating private motives or internal states. Instead, constructionist approaches place language centre stage, and give it a highly constructive role (Burr, 1999). As Potter (1998) argues "reality is constituted in one way or another as people talk it, write it, argue it and undermine it" (p. 235) The "turn to language" as a "new paradigm", and in particular, the interest in language as the structuring material for human understanding and practice (Burr, 1999; Potter, 1998; Potter, 2004; Potter & Wetherell, 1994) represented a significant turning point in my PhD journey.

In particular, the "productive" or "performative" role of language (Willig, 2001, p. 88) was the most enlightening aspect for me, i.e. that people do things in, through and with their talk. As Baker (2003) states, talk is social action – people achieve identities, realities, social order and social relationships through talk. Wilkinson (2000) suggests that in analysing participant talk the focus is on "how participants talk to each other and understand what their talk is doing as that understanding is displayed in the talk itself" (p. 365). This approach prioritises the participants' analysis of the interaction as revealed in their talk and the conversational patterns that they use – rather than depending on the researcher's analysis (Wilkinson, 2004, p. 95). The possibility that I could look at counselling practice, but from a different interpretive framework, was beginning to hold the promise that I might "see" new things in the old.

But, shifts of this magnitude from naïve realist to social constructionist are never as straightforward as this, in that they fundamentally challenge the way one typically makes sense of the world, and one's place in it. As Richardson observes, qualitative research

involves "making sense of our relationship to the world and therefore in discovering things about ourselves, even as we discover things about some phenomenon of interest" Richardson (2000, in Patton, 2002: p. 432).

While I was intrigued about the potential of social constructionism, I often returned to those methodologies with more realist assumptions about the nature of social reality. Like countless students before me and no doubt many more after me, I was drawn to grounded theory. My attraction was linked to the ontological and epistemological assumptions that underpinned the approach. But I was also seduced by the seemingly simple, recipe-like methodology that worked so hard to fit the good science model of quantitative science (Denzin, 1994). For students wading through the "complex historical field" of qualitative research, characterised by "successive waves of epistemological theorizing" (Denzin & Lincoln, 1998), grounded theory appears to provide a safety net of clearly defined methodological and analytical steps for the overwhelmed student. Once you engage with grounded theory though, you soon realise the skill and complexity behind the simple step-by-step method.

I was beginning to realise that qualitative research demands much from its practitioners. It takes time, patience and a willingness to figure out the "intellectual puzzle" (Mason, 2002 in Ritchie, Lewis & Elam 2003) that links the theoretical framework to the research question, to the methodology, to the analysis and the interpretation. As a student, one is often tempted to forego these critical process-learning steps in favour of "knowing" the answer to that puzzle. In moving between the promise of social constructionism and the comfort of the post-positivist paradigm that informs grounded theory (Denzin, 1994), I was beginning to appreciate the dynamic and iterative process of the qualitative craft. Patton (2002) is commenting on qualitative data analysis, but he

could easily be referring to the entire qualitative research process, when he states: "No formula exists for [the] transformation [from data into findings]. Guidance yes, but no recipe. Directions can and will be offered, but the final destination remains unique for each enquirer, known only when – and if – arrived at" (p. 432).

I had to grapple with two additional epistemological concerns to gravitate closer to adopting social constructionism as a framework for my research. These were the notions of inductionism and reflexivity. While these are rightly methodological concerns and are addressed in Chapter Four, they are linked to ontological concerns about the nature of social reality. They also tie in with my interpretive framework, and belong in this discussion at this point.

Inductionism reflects an epistemological view that it is possible to "let the data speak for itself", i.e. it is possible for the researcher to uncover what the participant is saying in its "pure form" without polluting the participant's words with the researcher's interpretation of these words (Billig, 1999 in Korobov, 2001). The discovery of the idea that I could "let the data speak for itself" emerged in one of my vacillations back to grounded theory, as I was struggling to settle on a theoretical framework and a suitable methodology. Early grounded theorists talked at length about the central role that inductionism plays in the generation of theory-grounded in data. Further, proponents of grounded theory argue that the creation of analytic codes and categories should emerge from the data and should not be preconceived hypotheses (Charmaz, 1995).

I liked this idea of being able to uncover what counsellors had to say in its "pure form" as I felt burdened and unable to move beyond my normative accounts of counselling. Through years of experience and training as a psychologist I had particular theoretical

frameworks through which I a) formed particular ideas of what counselling should look like, and b) evaluated counselling practice – either as meeting a particular standard, or falling far short of it. Inductionism presented an opportunity for me to "suspend my normative accounts of counselling" and let "the data speak for itself", and fed into my still dominant assumptions about the way knowledge is acquired and the nature of qualitative research.

The notion of "simple inductionism" that implies that reality is a single, static object awaiting observation by the researcher (Denzin & Lincoln, 1998; Silverman, 2000) was anything but simple, and in actual fact left me in an awful bind. On the one hand, blinded by my schemas of good and bad counselling practice, I was excited by the idea of "suspending" my normative accounts and waiting to see what emerged from the data. At the same time, I felt trapped, hesitant and uncertain about how to organise and approach the data, without drawing on my background or experience. As many discursive writers point out (Korobov, 2001; Miller & Fox, 2004; Potter, 1998), it is impossible to bracket or avoid the broader backdrop of your experience and knowledge. As you analyse your data and make decisions about what to focus on, you are informed by your research question, as well as your theoretical concerns, experience and background As a methodological tool, striving to ground one's claims or explanations in the data before you, inductionism makes for good qualitative research. But at this time, it was how this idea fed into my early understandings of the nature of social reality and research that caused so many problems for me at this point.

In the end, the epistemological position that informs the more interpretive approaches to research helped resolve this impasse created by the idea of inductionism. Snape and Spencer (2003) discuss the impossibility of "empathic neutrality" when they contend

that research cannot be value free and that researchers need to make their assumptions apparent. These writers talk about the importance of reflexivity in reflecting on the potential biases that a researcher's background, beliefs and conduct could have on the research process. Other writers acknowledge that all researchers approach fieldwork with some orienting ideas, foci and some conceptual orientation (Silverman, 2000), that lead them to ask the particular research questions that they ask, and approach research in the way that they do. Miller and Fox (2004), writing from a social constructionism position, reject the claims that data are objective facts that "speak for themselves". They argue that qualitative data, like other depictions of social reality, are influenced by the researchers' assumptions about social reality and methodological practices.

The shift in my theoretical orientation from realist to social constructionism was almost complete. I was beginning to appreciate that as a researcher I would describe VCT interactions but that this account would simultaneously describe and constitute that reality (Potter, 2004). Further, I was beginning to see that the version of HIV/AIDS counselling practice that emerges from and through this research is unlikely to be value free, or without the influence of my experience, my values and assumptions about the world. Through my engagement with the various design elements of my PhD research, I was finally beginning to understand my position as researcher and "co-constructor of a social reality".

In working on this project, I seldom felt that the shift from naïve realist to social constructionism was 100% complete. I constantly struggled with my normative theories and models of counselling practice as I analysed the data. My realist eye is dominant, well honed, expert and all seeing! It was a constant and ongoing challenge to remain conscious of these things. Ongoing reflexivity helped – I took to writing down the

normative accounts of counselling that reside in my head as a way of making them conscious and bringing them out into the open. Doing this enabled me to be more aware of them, and to recognise when I slipped into normative assessments of counselling, and to rein myself in when I did so.

I took comfort from Potter (2004), who referred to discursive analysis as an "analytical commitment" to studying how people construct social realities in and through their talk (p. 203). I had made the analytical commitment to looking at the data through a new lens but the conversion did not happen instantaneously or miraculously. There were amazing moments of insight with the new approach but mostly it felt like a conscious, deliberate effort to try to see the data in a different way. Akerstrom et al. (2004) sum up this transition well. In reflecting on their experience of trying a new perspective that involved an emphasis on forms of talk, rather than evaluation of content, they admit that one struggles to get rid of the old frames while grappling with the new.

Thus far in my journey, I was still intent on pursuing how clients and counsellors work through the competing goals of prevention and support in voluntary counselling and testing. I remained focused on counselling practice, and the videos of counselling sessions from our national evaluation provided a useful data set through which I could assess this practice. Most significantly, in reality television parlance, I was undergoing an extreme makeover by moving from a positivist, realist epistemological perspective to embracing the challenge of social constructionism as a framework to investigate my research question and analyse my data. The missing pieces at this point were the steps that I would take from these conceptual issues about the nature of research and social reality towards the mechanics of implementing the research. I turn to that process now.

3.2   STRATEGIES OF ENQUIRY

Theoretical frameworks do more than define the researcher's ontological and epistemological assumptions about social reality; they also give meaning to the practice of qualitative research. Denzin and Lincoln (1998) suggest that the link between interpretive framework and method is provided by the researchers' strategies of enquiry; these are defined as the skills, assumptions and practices used by the researcher when moving from paradigm to research design to data collection. Put differently, research strategies implement and anchor paradigms in specific methodological practices.

I discovered two strategies of enquiry that I wanted to draw on for this research. Ethnomethodology (EM) and conversation analysis (CA), both with strong roots in the discipline of sociology, both fall under the broader constructionism theoretical framework that I intended to use. Both approaches seek to address how social realities are constructed through language and the reflexivity of our accounts (Korobov, 2001; Miller & Fox, 2004; Potter, 2004). Many writers view conversation analysis as the most influential and visible form of EM research but also as a related, as well as separate, discipline (Maynard & Clayman, 1991; ten Have, 2002; ten Have, 2004). I outline some of the areas of similarity and difference between the two approaches in the following section and explain what elements of each I used for the strategies of enquiry that would frame this research.

3.2.1　Ethnomethodology

Garfinkel's pioneering work in 1967 was instrumental in advancing ethnomethodology as an approach to studying social reality. He explains that ethnomethodological studies "seek to treat practical activities, practical circumstances, and practical sociological reasoning as topics of empirical study "(p. 1). This is a key aim of an EM study. Ethnomethodology is interested in ordinary people's methods of practical reasoning and is primarily descriptive; it sets out to show how human behaviour works, rather than to explain why some particular type of behaviour occurs (Holstein & Gubrium, 1994; Maynard & Clayman, 1991). As Kitzinger (2000) indicates, EM offers a model of people as agents and an interest in 1) how people construct social order rather than how they are animated by it, as well as 2) how everyday reality is produced by those engaging in it. An EM study focuses on how participants undertake conversation interaction – including how they make sense of each other or how they fail to do so; how they negotiate these constructions of each other and how they characterise and connect the worlds they talk about (Baker, 2003). Drawing on aspects of this approach, I would like to explore how clients and counsellors construct the reality of VCT sessions – how they manage their interactions and pursue their objectives in the session.

From an epistemological perspective, ethnometholodologists see people as possessing practical, interactional and linguistic competencies (Holstein & Gubrium, 1998; Maynard & Clayman, 1991), and examine what methods and practices participants use to make sense of settings, people and events that they encounter. As Baker (2003) states, an EM study is about how things are accomplished: "How do people accomplish their identities, their activities, their settings, their sense of social order" (p. 396). Words

are part of utterances that are treated as activities – analysis of conversational interaction involves tracing the work that is done turn-by-turn by each speaker (Baker, 2003).

Goffman (1983) defines social interaction as that which uniquely transpires in social situations, that is, environments in which two or more individuals are physically in one another's presence. He elaborates that our daily life is spent in the immediate presence of others; and that whatever they are, "our doings are likely to be in the narrow sense, socially situated" (p. 2). He refers to this as the interaction order, and treats this "face-to-face domain as an analytically viable one and a domain whose preferred method of analysis is microanalysis" (p. 2). The social interaction of HIV/AIDS counselling operating at the microanalytical level was starting to develop as a useful way through which I could explore my interests in what clients and counsellors do in practice.

A distinguishing feature of EM is that it conceptualises social life as normative. Goffman (1983) explains that the orderliness of social interaction "is predicated on a large basis of shared cognitive presuppositions, if not normative ones, and self-sustained restraints works" (p. 5) in that "each individual enters a social situation carrying an already established biography of prior dealings with the other participants – or at least with participants of their kind; and enters also with a vast array of cultural assumptions presumed to be shared (Goffman, 1983, p. 4). An EM study would focus on rules (norms, roles, etc.) of social interaction and these are treated as both topics and features of the settings they organise (Maynard & Clayman, 1991). In other words, ethnomethodology describes a set of norms and behaviours for any social context. These are routine and what we all know. They create social order in this way in that we expect ourselves and others to behave in a particular way. Both participants in a VCT

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encounter would "invoke their knowledge of the community of understandings" (Garfinkel, 1967, p. 27) regarding counselling. As such, they would have some idea about how interactions of this kind typically work, and what would be expected of them. VCT has a set of norms that govern the interaction: norms about when to speak and when to listen, about who speaks first and who responds, norms regarding how participants ought to conduct themselves in that interaction, on how to do prevention and support talk, and so on.

Potter (1998), explains out that norms in interaction are typically *oriented to* (i.e. supporting or favouring a particular point of view or set of beliefs) rather than governing action. He suggests that we could expect to find regular deviations from norms and that these orientations to or departures from the routine ways of doing things, and the impact this would have on the unfolding interaction, would be a useful aim of an EM analysis.

In summary, EM is informed by social constructionism and views language as the mechanism through and in which social reality is jointly constructed. EM also focuses on the language that people use to construct their social realities. It is descriptive and focuses on how social order is achieved. Social order is made possible through the normative rules, the routine ways of doing things that we are all aware of. EM is concerned with process, with how members use their common-sense resources, practices and methods to maintain the social order of things, or to get their objectives met in these circumstances.

3.2.2   Conversation analysis

Like ethnomethodology, conversation analysis focuses on the interactional and interpretive competencies of interactants, and how they collaborate to construct social realties (Miller & Fox, 2004). CA is informed by social constructionism in that by exploring talk-in-interaction in conversation we are studying social action and in particular how speakers both construct the ongoing event and their social selves (Schegloff, 1986). Talk-in-interaction is viewed as sequentially organised turns at talk through which speakers reflexively construct a context for their interaction, and work together to establish and maintain purposeful talk (Miller & Fox, 2004; Schegloff, 1992; ten Have, 2004,). Both EM and CA focus on the local achievement of order by the use of socially organised procedures. While EM shows an interest in turns of talk, it does so in much broader and less technical terms than CA does (Baker, 2003). The extensive exploration of the sequential organisation of talk is seen by many as the emergence of conversation analysis as a related but separate discipline to EM (Korobov, 2001; Maynard & Clayman, 1991; Miller & Fox, 2004; Schegloff, 1992; ten Have, 2002; ten Have, 2004).

CA focuses on meaning and context in interaction, and does so by linking these to sequences of talk (Heritage, 2004; Korobov, 2001). Heritage (2004, p. 222-3) explains that underlying CA is a fundamental theory about how participants orient to interaction, and how these create meaning. This theory involves three inter-related claims:

1.   In constructing their talk, participants normally address themselves to the preceding talk, and particularly to the immediate preceding talk (in this sense talk is context-shaped).

2.   In performing the current action, participants normally project and require that the next action should be performed by a subsequent participant (in doing so they maintain or renew a context for the next person's talk).

3.   By producing a next action, participants show an understanding of a prior action and do so at a number of levels (for example, by accounting for their risk behaviour, the client indicates that he/she has heard the counsellor's question as a request to do so).

Of analytical interest in this study is how basic action sequences are organised, (for example how prevention and support talk are dealt with, and how conversations on these topics are opened and closed) as well as deviations from these turn-taking and interactional sequences (Heritage, 2004, p. 222). Like an EM study, conversation analysis views the procedures that inform these interactional sequences as normative in that participants can be held morally accountable both for departures from their use and for the inferences for their use that departures from their use may engender (ibid, p. 222).

3.3   UNDERSTANDING CONTEXT

As the previous discussion has just highlighted, CA adopts a local view of context. Meanings and a subsequent relation to the ongoing sequence of actions depend on what has come before, and every current utterance will form the immediate context for the next utterance (Korobov, 2001).

Conversation analysts counter the "bucket theory of context" in which pre-existing institutional circumstances are seen as *enclosing* interaction (Heritage, 2004, p. 224).

Instead, CA starts with the view that context is both a project and the product of the participant's actions (Korobov, 2001). Context is achieved through language – it is through interaction that context is built up, invoked and managed (ibid). This is a much more dynamic view of context as something which is both locally produced and transformed at any moment. As Peräkylä (1995) observes, context is an "awareness of what is said, when it is said, how and by whom and to whom" (p. 32). Talk in VCT is unique in both the things that are talked about but also in its action orientation – i.e. what participants do with their talk. For example, how do participants create contexts that can be heard as "doing information talk or advice talk or support talk"? In this study, I am interested in a more local and dynamic view of context in that I want to investigate how through an analysis of client-counsellor talk, particular HIV/AIDS contexts are built up, managed and invoked.

Holstein and Gubrium (2004) argue that the CA focus on the sequential development of conversation can limit the researcher to focusing on the procedural *hows* of the interaction. Wetherell (1998) believes that the focus on the orientation of the participants (how they hear the previous turn, and respond to it in their next turn) is too narrow. These researchers argue that in looking at talk-in-interaction we need to look at the larger *whats* that compel us to talk in particular ways (i.e. meaning-making discourses and how they operate in practice) (Holstein & Gubrium, 2004; Wetherell, 1998).

On the other hand, CA researchers argue that context is constituted on every occasion in social interaction, and are resistant to appeals to external contextual explanations for what is happening in the interaction. Doing so too soon in the analysis deflects the researcher from describing how the parties concerned attend to the local production of

shared understandings (Silverman, 1997; Silverman & Gubrium, 1994). These writers argue that there is nothing wrong with a search for explanations provided that the search for explanations is grounded in a close understanding of how the phenomena being explained are put together at an interactional level. Once you have understood the how, you then move to explanations about why this phenomenon happens in the way that it does.

And finally, I am interested in the settings where VCT takes place – in both medical and non-medical contexts. I think about settings in a similar way to how I think about how context is created in and through the talk – i.e. settings are not an external category imposed on the talk. Instead, like the dynamic view of context, social settings can be thought of as providing members with discursive resources and opportunities for constructing a variety of social realities. In addition, as Miller and Fox (2004) point out, institutional settings or contexts are unlikely to provide all members with equal opportunities and resources for pursuing their interests in the interaction, thus producing social conditions in which some definitions of reality are more likely to prevail than others. Particularly important to my study of social organisation of a counselling encounter was to explore how participants assemble their conversations in order to produce social contexts within which some interactional patterns and social relationships are encouraged over others (Gubrium & Holstein, 1997).

This is a study of the institutional context of a voluntary counselling and testing interaction. Institutional interactions are those that normally involve the participants in specific goal orientations which are tied to their institution-relevant identities – in this case that of HIV/AIDS counsellor or client (Heritage, 2004). In institutional interactions, parties co-construct and identify various goals or tasks relevant to the

completion of their business together (Heritage, 2004). Sketchley (1989, in Burnard, 1992) identified HIV/AIDS counselling as comprising of three core interactional tasks or activities: 1) giving information, 2) giving advice and 3) providing support.

Within this study, I intend to investigate how participants jointly construct and maintain the social order of a counselling interaction. Using tools from both EM and CA, I want to analyse how participants construct the various goals or tasks relevant to an HIV/AIDS counselling interaction together. This CA/EM-inspired study will allow me to adopt an ethnomethodological distance (Peräkylä &Vehviläinen, 2003) in describing counselling practice in that the goal is to analyse practitioners' unfolding actions in real situations – not to actively discuss competent practitioners, or good or bad practice. To this end, I focus on various strategies participants use to work through the information, advice and support tasks of the encounter; how they progressively develop a sense of the task that is to be accomplished; and how they explore the role that each plays in the process.

CHAPTER FOUR

METHODOLOGY

INTRODUCTION

This methodology section has a dual focus. I start off the chapter with a description of the phases of data collection used in the broader counselling evaluation. I highlight the procedures and methods used to collect the simulated client video data – the dataset subjected to further analysis in this PhD. I then address some of the methodological and ethical issues relating to the use of the simulated client method in social science research. These methodological aspects of the 1999 evaluation provide a useful backdrop to discuss how this PhD study differs from this prior work which it draws on in terms of its interpretive framework (discussed in detail in Chapter Three), its research aim, strategies of enquiry and sampling strategy. I conclude this second part of the chapter by discussing how the data was managed and analysed, and address the reliability and validity issues I observed when conducting the research.

4.1 THE COUNSELLING EVALUATION

4.1.1 Background

The dataset of video recordings of simulated counselling sessions was collected as part of a larger study that evaluated HIV/AIDS counselling service provision in South Africa (Richter et al., 1999). The aim of the national counselling evaluation was to assess counsellor service provision within the South African context, with a special

focus on HIV/AIDS counselling. More specifically, a range of quantitative and qualitative methodologies were used, either on their own, or in combination to address three key questions: 1) what HIV/AIDS counselling services existed in South Africa; 2) what the standards of counselling in the country were – what models were used and how relevant, efficient and proficient these counselling services were; and 3) what the knowledge, attitudes and practices of service users and providers were – with a particular focus on the ability of counselling to influence these outcomes in clients.

4.1.2   Phases of data collection[1]

There were three data collection phases to the counselling evaluation; each addressed either some or all of the three overarching questions that framed the evaluation. The three phases of the research were as follows:

1.   Creating the framework for the investigation:

This stage involved:

   a) facilitating cooperation and buy-in for the study from relevant stakeholders on a national, provincial and district level;

   b) conducting key informant interviews with both governmental and non-governmental groups and producing a situational analysis of counselling in South Africa;

   c) an analysis of archival documentation and unpublished "grey" literature on HIV/AIDS counselling; and

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[1] In 1999 in South Africa, formal structures such as ethics review committees, mandated to ensure that the research being conducted would protect human subjects, were not as prevalent as they are today. While we were not required to submit our research proposal for ethical approval, we observed the many requirements for conducting ethical research as discussed in this chapter.

d)   a comprehensive literature review of HIV/AIDS counselling.

2.   Conducting a postal survey of HIV/AIDS counselling services:

The postal survey targeted facilities and institutions in the public, private and voluntary sectors, including businesses, health care facilities, and social and religious organisations, to ascertain some broad parameters of the HIV/AIDS counselling service provision in the country.

3.   Site visits to a range of facilities across the country:

On the basis of responses to the postal surveys, exemplary sites across the country were identified and selected for more detailed investigation. These site visits involved: interviews with management staff, counselling supervisors, counsellors and clients; administration of questionnaires assessing the knowledge, attitudes and practices of clients and counsellors; and videotaped sessions of simulated counselling sessions with role-playing "clients".

Of the three sets of data collected, phase three – the data collected during the site visits pertaining to counsellors – was of interest to me. The rest of this section focuses on some of the questions that guided this phase of the research, as well as the research methods and procedures used in the site visits.

4.1.3   Methodology for site visits

4.1.3.1 Selection of sites

Using information obtained from phase one, HIV/AIDS counselling services were grouped into key strata that reflected major sites and settings where counselling was occurring (medical and non-medical). Simple random samples were drawn from each of the nine provinces in South Africa along the above strata. Through this process a total of 17 organisations were selected for more in-depth investigation.

4.1.3.2 Aim of the site visit

The counselling evaluation used multiple research methods or methodological triangulation (Gobo, 2004) to assess the quality of counselling from various perspectives. We administered questionnaires to assess clients' and counsellors' HIV/AIDS knowledge, attitudes, practices and behaviours; we conducted in-depth interviews with counsellors, counsellor supervisors and managers of counselling sites to assess their understanding of counselling and its application. Lastly, we observed and rated counsellor performance via videotaped sessions with simulated or standardised clients.

4.1.3.3 Data collection procedures

Using two research teams, comprising three to four staff members per team, the 17 sites were visited over a six-week period. Once the sites were identified, organisations were telephonically interviewed in order to verify information obtained in the postal survey. In addition, these calls were used to assess each site's availability and willingness to participate in the site visits. Permission to contact counselling site managers and staff was also obtained at this point. Once these permissions were obtained and a willingness to participate in the research was established, an initial briefing letter outlining the

evaluation's purpose, the aim of the site visit and what would be required of the sites and potential participants was sent to each site (see Appendix I).

At the site, all interested staff were invited to attend a briefing meeting with the researchers. The aim of the meeting was to introduce the study and the researchers to staff. As outlined in Appendix II, several issues pertaining to the research were discussed at these meetings: the confidentiality of our procedures in respect of protecting the individuals' and the sites' identities, data access and management, as well as how we would manage research outputs (i.e. reports, publications and other research outputs that may emerge from the research) and dissemination of results. This brief input was followed by a question-and-answer session.

Managers, supervisors, and counsellors interested in participating in either the questionnaires, interviews and/or the simulated video sessions were then given further information about what each of these activities would involve. Potential participants were informed that they could elect to participate in any one of the activities or all three of the research activities (i.e. interviews, questionnaires and/or simulated videos), without any fear of consequences for themselves. Interested participants were given an individual consent form to sign (see Appendix III).

4.1.4   The simulated client method

4.1.4.1 Profile of simulated clients

Using actors or fieldworkers to hide their identities and intentionally pose as users of that service, (i.e. the simulated or standardised client), has been increasingly employed

as a viable method for obtaining an understanding of service user's experience of a particular service (Hazelkorn & Robins, 1996; Huntington & Schuler, 1993; Leon, Quiroz, & Brazzoduro, 1994).

In keeping with other studies using the method, two specialist multi-lingual role-player clients were recruited to conduct the simulated sessions. Madden, Quick, Ross-Degnan, & Kafle (1997) argue that recruiting the right people to do the work of a simulated client is important. They recommend that people with acting experience might be desirable, particularly if the scenario has highly emotional content, as ours did. The simulated clients were chosen to best reflect the demographics (both were black – one was male and the other was female – and in their early to mid-twenties) of the population likely to be seen at sites across the country. The male role-player was a specialist in drama and role-play in education, while the female was a psychology student, with training in role-play methods. The simulated clients participated in a day-long training session with researchers in preparation for the site visit. The training comprised:

   i. A briefing on the study and their role within the evaluation of counselling sites.

   ii. Training on various aspects of role-playing with a focus on how to maintain boundaries between "self" and the "role", and how to manage this.

   iii. A detailed discussion in which the counselling vignettes and associated roles were created.

   iv. An opportunity to practise role-playing the sessions.

The role-play clients were each assigned a prescribed character and a role vignette that was repeated for each simulation and consistently maintained throughout the sessions.

Counsellors were only exposed to one of the simulated clients. Our intention with the vignettes was not to trick clients or make it overly difficult for them. We wanted to assess counsellors' skills and ability, and so we worked on creating believable, credible and realistic clients, with a range of problems and situations that counsellors were likely to encounter, and hence would be able to deal with.

In the first pre-test counselling scenario, the interactions are initiated by the client who comes in enquiring about an HIV test; the client is not convinced that he or she should test. In the second post-test counselling interaction, the client has already tested and received his or her positive test result. The focus of these interactions was on disclosure of status, adjustment concerns in respect of knowledge of HIV-positive status and general associated problems in living (see Appendix IV for each of the vignettes).

Simulated clients were supported throughout the process of the site visits. Daily debriefing sessions were held at the end of each day, as well as after individual sessions, if required. Debriefing was conducted by the research team, who were all trained psychologists.

4.1.4.2 Procedures for simulated client method

The role-playing clients were introduced together with the rest of the research team on arrival at each of the sites. However, in order to minimise contact and familiarity with the counsellors, the simulated client stayed in the background for most of the research proceedings, apart from the one activity they were directly involved in.

Towards the end of the briefing meeting we gave staff more information about the simulated client method. We explained that we needed some counsellors to be video

recorded conducting a counselling session. We pointed out that this will be a "mock counselling session" in which someone will play the role of a client and that we would like the counsellor to demonstrate how he or she would go about counselling the client. We explained that the aim of these video recordings was to see what kinds of things people normally do when they are counselling.

At the end of the briefing meeting, counsellors who were interested in participating in the videotaped counselling session were asked to volunteer and consent to the process. No counsellor refused to be videotaped at any of the sites. All counsellors were free to counsel in the language of their choice. Participants were reminded that they could opt out at any stage of the process, without any fear of any negative consequences to them. No information about the simulated client was given to the counsellors. The counsellors were instructed that a counselling room would be set up with a small digital video camera mounted inconspicuously on a tripod and activated remotely. Once the counsellor was in the counselling room, the client would present himself or herself for counselling. Counsellors were instructed that the counselling session should last for approximately 20 minutes. During this time counsellors should do as much as they could in terms of conducting a typical pre- or post-test counselling session. At the end of the session, a researcher would knock on the door, indicating that the session was over. No blood draws were to be taken from the client.

4.1.5   Methodological and ethical issues relating to the simulated client method

4.1.5.1 Rationale for the simulated client method

The use of the simulated client method (SCM) where actors hide their identities and

intentionally pose as users of that service, has been used extensively in non-medical settings – such as marketing – as a simple and inexpensive way to gain an understanding of consumers' experience in a variety of sectors (Hazelkorn & Robins, 1996; Huntington & Schuler, 1993; Leon et al., 1994), and in the training of medical students (Herrera, 2001).

The method has become increasingly common in investigating health problems (and especially health provider behaviour) throughout the world (Beullens, Rethans, Goedhuys, & Buntix, 1997; Creel, Sass & Yinger, 2002; Kamenga, Coates & Rehle, 2001; Madden et al., 1997). The SCM appears to be a practical, adaptable and reasonably economical method for studying the quality of services and identifying areas for the improvement of the practices of practitioners or health care workers (Creel et al., 2002; Madden et al., 1997). As discussed in Chapter Two, studies that shed light on these "private contacts" are important for ensuring high standards of professionalism and for the identification and correction of problems in service delivery. Leon et al. (1994) add that programmes need feedback from the field to verify the attainment of quality goals, to make changes and to reinforce good practice.

4.1.5.2 Limitations of methods commonly used to assess quality

There are several ways to assess the quality of a service. With direct methods, the researcher sees or hears a counsellor dealing with the client (via audio, video, observation or through the SCM method). With indirect methods, direct observation of the counsellor-client is not possible. More indirect methods (Beullens et al., 1997) are typically used to evaluate a service. These include: a) client exit interviews regarding their views on the aspects of the service delivered to them; and b) counsellor interviews

regarding their perceptions of the service they provided to clients (Simmons & Elias, 1994).

There are some limitations to the more indirect methods typically used to address effectiveness and quality of a service. Counsellor self-reports obtained through interviews on their own behaviour are problematic because of poor recall, lack of relevant experiences, and/or the expected "observation bias" towards socially desirable behaviour (in this case towards the measure of competence or wanting to be seen as competent) (Herrera, 2003; Madden et al., 1997; Simmons & Elias, 1994). With regard to exit interviews conducted after the service has been provided, although the feedback is from the perspective of the actual service user, the account of provider behaviour is second-hand, from an untrained source and unexpected (Madden et al., 1997).

These various methods yield valuable information from important perspectives, but this information may not be the same as observations of the actual service or behaviour. Madden et al. (1997) suggest that the SCM provides data that would be difficult or impossible to obtain through other methods. Simulated client studies have merit for health care environments, operating under patient-practitioner confidentiality and thus subsequently concealed from view and review (Hazelkorn & Robins, 1996; Lerman, 1996). In addition, these studies offer an opportunity for research into what goes on behind closed doors (Lerman, 1996) and allows one to observe the practice of health care from within a naturalistic, non-reactive research setting (Herrera, 2001). Specifically, the SCM "offers a chance to record unselfconscious actual practice from the point of view of the client in a first-hand fashion" (Madden et al., 1997, p. 1469).

4.1.5.3 Argument for using the simulated client method in this research

The social constructionism framework that I adopted for this research tends to be philosophically linked to more naturalistic, discursively focused research strategies (see Holstein & Gubrium, 2004; Potter, 2004). Both EM and CA studies rely on naturally occurring data as methodology. Ritchie and Lewis (2003) describe naturally occurring data as that which is an enactment of social behaviour in its own social setting. Holstein and Gubrium (2004) argue that the benefit of naturally occurring data is that such talk appears to be less staged than that which appears in an interview. Naturally occurring data allows for a view of life in its situated particulars instead of an idealised and decontexualised reconstruction of social life made by the research subjects and/or the researcher that emerges through other methodologies, such as the interview (ten Have, 2002, 2004). The videotaped sessions of counselling interactions that I inherited from the counselling evaluation and chose for this study, fall under the rubric of naturally occurring data.

Silverman (1997) acknowledges that naturally occurring data or counselling *in situ* is never uncontaminated or pure as it has to be recorded and transcribed, but that it usually gives us a good idea of what participants do outside a research setting and to see how counselling actually proceeds. Holstein and Gubrium (2004) concur that simulations are not real – that they are a bit of a biased response. He argues that if you adopt the view that data are products of interpretive practices, then they are neither preformed nor ever pure. Every data collection situation – "no matter how formalised, restricted or standardised relies on an interaction between participants who are constantly engaged in interpretive practice, that is, involved in meaning construction" (Holstein & Gubrium, 2004, p. 55).

Kamenga et al. (2001) highlight a limitation of naturally occurring data in that the presence of the simulated client or the videotape may alter the natural way a counsellor interacts with his or her client. The EM approach adopted for this study would suggest in reply that once people get over the intrusion of the camera or the "non-realness" of the situation, common-sense methods and resources that people use in counselling interactions like this, will eventually emerge and come to the fore.

4.1.5.4 Ethical considerations when using the simulated client method

Shaw (2003) argues that SCM is a novel and innovative tool for gaining insight into an interaction in that it "allows one to come face to face with the invisibility of practice" (p. 67). I have argued along these lines, in this chapter and in the rationale for doing this study in Chapter Two, that the analysis of client-counsellor interaction is important for the development and improvement of VCT policy, programmes and practice. But is this the most ethical data-collection method available given that in order to do these studies it may be necessary to intrude into the ongoing flow of the therapeutic work of client and counsellor (Simmons & Elias, 1994; McLeod, 2003)?

The use of standardised clients in research challenges key ethical principles of non-maleficience and autonomy, which are central to good ethical scientific practice. In fact, Herrera (2001) points out that to succeed, the SCM client deliberately has to ignore informed consent in the clinical setting, where strict prohibitions against deception and involuntary participation are the norm. So, providers are deceived as to the identity and motives of the simulated clients and in most cases are given false information (Madden et al., 1997). Some ethical guidelines suggest that researchers may be justified in not

getting consent under circumstances such as this where doing so would be impractical or frustrate the purpose of the study (CIOMS, 1991). Others suggest that minor deceptions that have no ill effects are acceptable in research, and while the possibility of harm in SCM studies is small, it is not entirely negligible (Madden et al., 1997).

Various authors suggest that the valuable information obtained through SCM studies and not easily obtained through other methods, might be balanced against the minimal intrusions of the practitioner not always knowing that he or she is being covertly observed (Hazelkorn & Robins, 1996; Herrera, 2001). Huntington and Schuler (1993) propose several strategies that researchers could use when conducting SCM studies to minimise the potential risks to participants. Several of these strategies were observed in our application of the methodology in the Richter et al. (1999) evaluation. These included: informing the management and staff upfront that we were going to use the method – variations of this are to inform staff that the method will be used, but not the exact time when this is likely to happen – and obtaining informed consent from the service providers, and if possible the participants in the study.

In addition, harm to the simulated client must also be considered as they could experience psychological stress as a result of participation in the research (Huntington & Schuler, 1993). We took several steps in the research to offset these potential harms to the simulated client's research participation. Even though students were not tested as part of the simulated client experience we felt that it was important that students knew their HIV status before participating in our study to reduce the risk of the person being preoccupied by not knowing and/or testing during the simulated client period.

Secondly, the training we conducted to prepare students for the site visits was also

important in helping students realise that they were simulating the life (and HIV status) of another person and that this was a different situation to their own life. Both the training and the regular debriefings we held were useful in supporting the simulated clients as they managed their roles in the context of their real lives.

4.1.5.5 Conclusion

The use of simulated clients in health research has elicited strong ethical debates about the procedure. There are always risks in conducting research involving human subjects. Researchers have to balance the possible risks of the method against the risks of not conducting the study and relying on incomplete data about an important phenomenon (Herrera 2001, 2003). In the context of this evaluation, the simulated client component of the study offered a rare insider's perspective into the practice of counselling in the South Africa context. Though there may be some controversy associated with the method, the SCM has the potential to generate unique and essential information on actual health care provider practice and this is critical in framing both future practice and programmes.

This PhD research differs in a number of ways from the national counselling evaluation from which it emerged. First, the evaluation used multiple methods to assess the quality of counselling across the country. This PhD research zooms in on a sub-set of the original data set (viz. phase three, which involved a detailed investigation of exemplary counselling sites, that looked at, amongst other things, counselling practice through videotapes of simulated client practice). Secondly, by adopting a qualitative approach the PhD hopes to provide a detailed and more nuanced account of client counselling practice than the aggregate evidence typically provided by such large evaluations.

Thirdly, the PhD differs substantively in the philosophical approach to the nature of social reality, and the nature of research. It adopts a social constructionism approach and draws on elements from both ethnomethodology and conversation analysis to explore HIV/AIDS counselling in its own setting, as naturally occurring data.

4.2   THE RESEARCH PURPOSE AND PROCESS

The second part of the methods chapter now moves to a discussion of the research sample, and the research purpose and process and I outline how the social constructionism approach is anchored in the methodological procedures and tools of EM and CA. I conclude this chapter by addressing issues relating to data management and analysis as well as the issues of reliability and validity I considered when conducting this study.

4.3   THE SAMPLE

From the site visits, 68 videotaped recordings of pre- and post-test counselling sessions with simulated, role-playing clients were produced. There were 22 English recordings in the sample of 68 recordings. The remainder of these recordings were primarily in Sesotho, isiXhosa and isiZulu.

While the data was in video format, I decided to transcribe the videotapes so that I could have detailed verbatim transcripts of the counselling sessions for the analysis. Riessman (1993) points out that the transcribing experience – the process of converting spoken language into written text – has particular significance for discursive studies such as this one.

This decision to work with transcriptions of the videotapes rather than simply analysing the videotapes as I watched them was guided by other studies that I reviewed. Several authors argue that for studies that rely on talk and text, transcriptions have a dual function: they are used to locate particular phenomena, but they can also be shown to support analytical claims made about the recorded practices (Peräkylä, 1997; ten Have, 2004). These were useful functions that I wanted to draw on in this study.

Two research students fluent in Sesotho, isiXhosa, isiZulu and English transcribed the tapes for analysis. Decisions about how to represent intonation, rhythm, overlapping speech, and other aspects of the text (Riessman, 1993) were informed by a modified version of the original Jefferson's notational system used by Silverman in 1997 (see Appendix V). The students and I worked through a few English videotapes together so that they could learn and eventually master the transcription conventions.

While no transcribing method is ever complete (Gale, 1991), the type of transcription conventions used by Silverman referred to several features of talk considered useful for this study. Guided by Silverman's conventions, and informed by methodological aspects of both EM and CA, I used the transcription conventions to the level of specificity required for my analysis i.e. to understand how clients and counsellors negotiate their prevention and support talk, how they generate meaning through their talk, and in this process construct both the interaction, and themselves, in distinctive ways. As such, transcriptions of micro-level talk-in-interaction typical to many CA studies in the field may not be evident here.

Finally, I am first and foremost a practitioner, not an analyst of the calibre of many noteworthy scholars in the CA/EM fields. At best, I would describe this PhD effort as

an honest attempt by a practitioner to adopt a new analytical framework to understand client and counselling talk – my level of skill in transcription and in other aspects of discursive analysis will improve as I expose myself to further training and conduct more studies using this approach.

After the interviews were transcribed they were translated from isiXhosa, Sesotho or isiZulu into English by the students. Each student translated a transcript, and once complete, handed this over to her colleague for back-translation. These translations and back- translations were then compared for consistency. Discrepancies or ambiguities were discussed until agreement was reached about the best possible translation. Towards the end of the study, as an additional verification step, I sent the final extracts used in the analysis for a final round of transcription, translation and back-translation to a professional company who specialises in providing this service. Very small differences in translation emerged from this process, though the quality of the transcribed text did improve.

4.3.1   Sampling strategy

4.3.1.1 Purposeful sampling

The sampling strategy used for the PhD was two-fold. I started off using a more purposeful sampling strategy to help work through the large available data set. As I moved closer to the analytical stage of the process, I leaned towards a more theoretical sampling approach. I outline my reasoning behind using both of these approaches.

I used a purposeful sampling strategy to select tapes for review for my PhD. Purposeful

sampling consists of detecting cases with certain characteristics within a wide range of situations in order to maximise variation, and to have all the possible situations covered (Gobo, 2004). The majority of cases in the evaluation sample were non-English (46 of the 68 tapes). This reflects the reality on the ground that the majority of counsellors are non-English-speaking, lay counsellors. In order to ensure that I had variation of cases, as well as to ensure that I obtained an accurate picture of counselling practice in South Africa, both English and non-English counselling videos were selected from the original sample.

Counselling in South Africa is conducted by both professional and non-professional or lay counsellors. This was an important aspect that I wanted to explore as I wanted to see the extent to which the professional background of counselling shaped the counselling interaction. Guided by similar concerns of data variation and completeness, I also purposely selected videotapes of counselling from both professional and non-professional counsellors.

Lastly, I was also interested in different settings in which counselling took place i.e. medical and non-medical settings. I speculated that these settings might shape the counselling encounter in some way or another (cf. Silverman, 1997), and so I sampled for setting as well.

4.3.1.2 Theoretical sampling

The entire sampling process was guided by a theoretical sampling approach. Mason (1996, in Gobo, 2004) writes that theoretical sampling involves "constructing a sample which is meaningful theoretically because it builds in certain characteristics or criteria

which help to develop and test your theory and explanation" (p. 94). For Glaser and Strauss (1967) the purpose of theoretical sampling is to discover concepts, their hypotheses and their inter-relationships and in so doing achieve theoretical completeness. Theoretical sampling is defined as "sampling on the basis of concepts that have proven theoretical relevance to the evolving theory" (Gobo, 2004, p. 446). Relevance means that the concepts are deemed to be significant because they are repeatedly present or notably absent when comparing incident after incident, and are of sufficient importance to give the status of categories (Strauss & Corbin, 1990).

Mindful of theoretical sampling, I started with one case (for example, a lay counsellor, who was English-speaking, from a medical site). Further, relatively similar cases were chosen together in order to maximize the chances that aspects of the phenomenon will emerge clearly (Rennie, Phillips & Quarttaro, 1988). So, I would stay with the lay counsellors in medical settings to assess particular patterns across these particular groupings of interest. Also, in keeping with theoretical sampling, cases were chosen as and when I needed them in order to check and/or refine emerging conceptual categories from the data (Charmaz, 1995). For example, I would choose a lay counsellor from a non-medical site if I wanted to explore if the emergent finding from counsellors in medical sites had relevance for this group.

The external descriptions of the cases (lay counsellor from medical site, etc.) eventually fell away. At this initial stage, they helped me to order and structure how I approached the data and helped ensure that I was being as representative as possible. As the analysis deepened, I was guided less by these external descriptors, as I was by the conventions of theoretical sampling and the discursive approach to analysis that I used.

4.3.2   Method

As discussed in Chapter Three, this study is informed by social constructionism and methodologically anchored by elements of ethnomethodology and conversation analysis. Drawing on Chapter Three, the following methodological principles informed the data management and analysis stage.

4.3.2.1 Talk and text as social practices

This study draws on critical discursive approaches that view language as the vehicle through which participants jointly construct the social reality of HIV/AIDS counselling, and each other. This is a study of texts and talk as social practices, with talk considered the very action through which local realities are accomplished. The emphasis is on the discursive accomplishments of clients and counsellors and is not a study of the thoughts, emotions and attitudes presumed to be behind, and expressed through the talk (Holstein & Gubrium, 2004).

4.3.2.2 Focus on social order

Drawing on ethnomethodology, this descriptive study explores how the social order of a counselling interaction is achieved. This study accepts that clients and counsellors are active agents, equipped with a number of resources as members of society. These resources refer to the capacity to speak, to know, to understand, to make sense of unfolding events, and to act in ways that are sensible in that counselling context (ten Have, 2004). Social order is made possible through a set of routine, normative ways of being that all participants in an HIV/AIDS counselling interaction are equipped with.

To this end, the study is interested in how clients and counsellors use their common-sense resources, practices and methods to maintain the social order of the counselling session, and to ensure that their respective objectives are met.

4.3.2.3 Focus on conversation interaction

This is a study that focuses on interaction. In particular, this is a study of the institutional context of an HIV/AIDS counselling interaction. Institutional interactions are those that normally involve the participants in specific goal orientations or tasks, which participants work at together to bring to completion (Heritage, 2004).

4.3.2.4 The unit of analysis is interaction

Using tools from both ethnomethodology and conversation analysis, I focus on client-counsellor interaction and on the collaborative, constantly emerging structure of the counselling conversation. I use elements from both of these approaches to focus on how speakers construct the ongoing event, and their social selves. I use conversation analysis to see how basic sequences of talk are organised, and note where deviations from these interactional sequences occur and what impact this has on the unfolding conversation. I adopt Maynard and Clayman's (1991) view that turn-taking is not a mechanistic or formulaic event. I analysed and looked at how participants used turn-taking, and made other interactional moves, in order to be able to participate in the interaction.

4.3.3 Aims of the study and research questions

The aim of the study is to provide a detailed description of how the interactional tasks of VCT are achieved, and how these tasks are achieved against the backdrop of theoretical frameworks that shape counselling practice. More specifically, I wanted to explore:

1. How the interactional tasks of information, advice and support are constructed by participants.
2. How the information, advice and support goals of VCT are discursively accomplished.
3. How these discursive accomplishments and constructions impact the unfolding interaction.

4.4 DATA MANAGEMENT AND ANALYSIS

Data management and analysis is a continuous and iterative process (Ritchie & Lewis, 2003). Guided by Janesick (1998), three stages to data management and analysis were followed. These were: 1) managing the data corpus into workable and manageable units; 2) making sense of the data through descriptive accounts and interpretation of the data; and 3) developing an account of the data.

4.4.1 Step 1: Data management

4.4.1.1 Reading through the texts

Silverman (2000) acknowledge that all researchers approach fieldwork with some orienting ideas, foci and some conceptual orientation that lead them to ask the particular research questions that they ask, and approach research in the way that they do. Institutional interactions, such as AIDS counseling, normally involve the participants in specific goal orientations or tasks, which participants work at together to bring to completion (Heritage, 2004). HIV/AIDS counselling is characterised by three core tasks – information, advice and support. Using this as a starting point, I read through the transcripts, looking at how clients and counsellors constructed information, advice, and support talk of VCT. Ritchie, Spencer, O'Connor, Ritchie and Lewis (2003) see this as a necessary step in becoming thoroughly familiar with the dataset in building the foundation of the analytic structure.

In reading through the texts, the three interactional tasks of counselling were not always evident in such a clear-cut way. Often, in practice, counsellors could be doing all three of these, or at least two of these at the same time. While the three tasks did overlap, there were clear instances of the participants doing information, advice and support talk. These appeared to be marked by distinct communication formats and discursive features. At this early stage, following Willig (2001), I tried to read for the discursive effects of the text (for example, I asked myself how the information, advice and support segments come across as text, or I asked myself what the texts were doing or how they read).

4.4.1.2 Coding

Reading and re-reading was followed by coding sections of the text for information, support and advice. I started with one case and read each transcript with a view to

looking for evidence of information talk, advice talk and support talk. Information talk was evident when the counsellor explained something, educated or provided information to the client. Information could be about the medical aspects of the disease, treatment, or sexual risk and prevention. Advice talk was identified as moments when the counsellor gave advice, made a suggestion, or offered a solution or possible action to a client problem. These advice segments usually contained language that indicated that advice was being given: ("should", "why don't you", "consider", "try", "suggest", "advise", "you could" etc.). Like information talk, advice often centred on issues related to medical aspects of the disease, treatment, sexual risk and prevention. Support talk was identified as moments where the counsellor dealt with the client's psychosocial issues, including emotional problems and concerns as presented in their talk.

The coding stage involved collecting as many instance of information, advice and support talk as possible. The goal was to produce a body of instances that were as exclusive as possible, rather than setting limits on the data corpus. Large sequences of text were coded in order to capture the local context as fully as possible. To retain the integrity of the session overall, and not to break up the data too much at this stage, this level of coding was done per individual transcript.

The next step involved sorting or ordering the data into larger sections of information, advice and support talk across the transcripts. This initial clustering of material allowed for an "intense review of content" (Patton, 2002) that was important for the next stage of analysis.

4.4.2   Step 2: Developing descriptive accounts and interpretation of the data

4.4.2.1 Choosing exemplars

At this stage, I worked with the information, advice and support data separately. After the intensive review of the content under each of the interactional tasks, it became apparent that counsellors used several discursive strategies to construct information, support, and advice talk. At this stage I was able to extract exemplars that demonstrated these strategies. Exemplars often illustrated the features of particular information, support or advice strategies evident in the talk of clients and counsellors. Gale (1991) suggests that exemplars are methods used to describe scholarly claims – these are detailed examples that demonstrate the validity of a phenomenon.

4.4.2.2 Moving into description and interpretation

I started to identify exemplars and developed a descriptive account of each of the discursive strategies that was evident in the talk. I drew extensively from Willig (2001) and Potter and Wetherell (1994), as I moved into this description and analysis phase.

4.4.2.3 Reading for the action orientation of texts

Drawing on these writers, and the constructionism and discursive leanings of this research, as I worked through the exemplars I was interested in the action orientation of talk. Willig (2001) defines analysis of text using an action orientation as involving a focus on "the way in which things are said as well as on what is said" (p. 93). I used this action orientation approach to describe and analyse each the strategies that was being used by the counsellor to give support, share information and to give advice. In doing this descriptive and analytical task I asked myself several questions:

1. How would I describe the core elements of the strategy? What are the particular discursive features of it? What is the evidence of such a strategy being employed? What makes it possible to be heard as such by the client? How does the client orient to the particular strategy?

2. How is the subject (person, object, thing or topic being dealt with or discussed) being constructed in the talk? How are objects (person, thing or object seen as the focus for feelings action and thought) being constructed? Overall, what effect do these constructions have on the interaction?

3. What is gained from constructing the subject/object in this way in the text? What functions does it serve? (What does this particular construction allow the person to do?)

4. How is the strategy discursively accomplished i.e. what are the interactional rules on display, what discursive resources, methods and practices do participants use? Who does what, who takes and retains the initiative, who decides what the next topic will be, who participates, and to what effect?

5. What is the impact of these discursive moves on the unfolding interaction?

4.4.2.4   Reading the detail

In conducting a discursive analysis of a text, the task is not to look beyond the apparent messiness of interaction to discover general patterns or any laws beyond it; rather the analysis is focused on the specific detail of interaction and how that detail is precisely related to the activities that are being performed (Potter, 1998).

In working through the exemplars, drawing on conversation analytic tools, I paid particular attention to the fine details of the text. I paid close attention to the

conversation organisation of the text such as turn-taking, adjacency pairs as well as the detail in the discourse – the pauses, the repairs, word choice, variability in and between different texts; details of hesitations, repair and so on.

4.4.3   Step 3: Developing an account of voluntary counselling and testing interaction

The descriptive and analytical notes that emerged from the clients' and counsellors' talk in steps 1 and 2 were the start of the narrative that appears in Chapters Five and Six. I read and reviewed other CA and EM studies on counselling communication and interactions to help deepen my descriptive account and analysis. In writing up this account, I stayed grounded to the data. Holstein and Gubrium (2004) suggest that it is not so much the "case of letting the data speak but of empirically documenting the meaning-making process through ample illustration and reference to talk – the complex discursive activities through which respondents' meaning is produced" (p. 155).

4.5   ISSUES RELATING TO QUALITY AND CREDIBILITY

Adhering to the constant comparison method, once I had identified exemplars from the smaller subset of cases, I went back to the larger dataset and reviewed other cases in order to systematically collect evidence that related to a particular strategy. I started to look within a strategy, and across several cases, noting the range of discursive tools and resources used in that strategy (Ritchie et al., 2003).

Silverman (2000) and Gobo (2004) suggest comprehensive treatment of the data. Comprehensive data treatment involves actively seeking out and addressing deviant cases. Once I had developed a provisional analytical scheme of the various interactional

tasks of counselling, the scheme was compared to other cases, adapted and modified. The provisional scheme was constantly confronted by negative or deviant cases that did not support my emerging theory about the interactional resources and strategies used in a counselling session.

As discussed earlier, theoretical sampling guided how cases were chosen. Gobo (2004) suggests that using a theoretical sampling strategy allows you to sample types of actions or events, incidents and not people. As I tried to develop the counsellor and client strategies for dealing with information, advice and support, the further selection of cases was driven by their relevance to the phenomena under study and the need for representativeness of emerging concepts. Data analysis ceased when conceptual categories began to saturate, i.e., new categories and their related aspects stopped appearing in the data (Mullen & Taylor, 1994).

The final PhD dataset consisted of twenty-seven VCT interactions ranging in length from 15 to 26 minutes. This was the final sample of cases reviewed at the point at which data saturation was achieved and analysis ceased. In Table 1 below, I illustrate the twenty-seven cases with reference to the earlier categories that I used to sample purposefully from the larger, original dataset and organise the data.

Table 1: Counselling Profession and Language Spoken (N= 27)

	English	Non-English
Lay Counsellor	7	7
Professional Counsellor	9	4

Table 2: Counsellor's Profession and Settings (N=27)

	Medical Site	Non-Medical Site
Lay Counsellor	1	13
Professional Counsellor	6	7

In social science research, one is concerned with the generalisation about the nature of the process – in this case the nature of HIV/AIDS counselling. Theoretical sampling allows one to make such generalisations. As Peräkylä explains, results from qualitative studies such as these are "generalisable as descriptions of what any counsellor or other professional, with his or her clients, *can* do, given that he or she has the same array of interactional competencies" (Peräkylä, 1997, p. 216) as the participants in this study.

As discussed in Chapter Three, ongoing personal reflexivity as I analysed the data was important in helping me filter and digest my own assumptions about good and bad counselling and at the same time, remain open to discovering what interactional resources clients and counsellors used in interaction, and what functions these served in the counselling session. Analytic induction from a social constructionism perspective allowed me to stay connected to and grounded in the data, but also simultaneously to use my experience of HIV/AIDS counselling at various points in the data analysis process.

CHAPTER FIVE

INTERACTIONAL TASKS OF VOLUNTARY

COUNSELLING AND TESTING

INTRODUCTION

Informed by social constructionism, and anchored by ethonomethodology and conversation analysis as methods of enquiry, this study seeks to provide a detailed account of how the interactional tasks of VCT are achieved, and how this is accomplished against the backdrop of the theoretical frameworks that shape counselling practice. The results of the study are organised into two chapters. In this first analysis chapter, I focus on how clients and counsellors organise their talk as they orient towards the information, advice and support goals of the VCT interaction. Goals or tasks take place in the context of the theoretical frameworks that shape the interaction, and so in this first analysis chapter, I will address these issues where appropriate. In the next chapter, I stay with the interactional tasks but foreground the theoretical frameworks that shape VCT, illustrating how these are often in conflict with each other, thus resulting in dilemmas of orientation for interactants.

As discussed in the literature review, there are three core interactional tasks that characterise an HIV/AIDS counselling session: 1) giving information; 2) giving advice and 3) offering support to clients. Counsellors accomplish these tasks through their turns of talk, questions that are asked, and statements that are delivered. Clients, in return, have a dual orientation in the interaction: they answer counsellors' questions and

listen to counsellors' advice and information but also ensure that their individual goals, needs and issues are addressed (i.e. their feelings and concerns about taking the HIV test and the implications that this would have for their life, and others in their life, etc.).

5.1   GIVING INFORMATION

Information-giving is a routine part of health-counselling consultations and can affect the responsiveness of patients towards the desired health outcome (Rollnick & Nick, 1992; Poskiparta, Kettunen, & Liimatainen, 2000). The delivery of accurate, technical information regarding the virus, disease progression, modes of transmission, risk-reduction strategies as well as coping and illness management information, is a well-characterised feature of pre-test counselling.

A number of writers using a conversation analytical approach in exploring HIV test counselling in the United Kingdom and the United States report on the distinctive features of HIV/AIDS information talk (Peräkylä, 1995; Peräkylä & Silverman 1991a; Silverman, 1990; Silverman, 1994a; 1994b; Silverman, 1997). This PhD dataset of voluntary counselling and testing practice in South Africa reveals a similar structure and similar discursive features (typical characteristics of information-giving in the context of HIV/AIDS) to this earlier work.

The following extract is from the beginning of a pre-test counselling exchange. The counsellor has moved into an information-delivery mode regarding the transmission of the HI virus.

Extract 5.1

27. Co: The HIV then my child is a virus that causes the AIDS disease
28. Cl: Yes
29. Co: AIDS
30. Cl: Yes
31. Co: This virus enters a person's blood a person then has red blood (.) has white blood that you cannot see with your biological eyes it is like this glass
32. Cl: Yes=
33. Co: =Yes it is internally spread through out the whole body=
34. Cl: mmm
35. Co: this one which is red then is the one that circulates air inside the body
36. Cl: Yes
37. Co: This one which is white then is the one then that is the immune system the antibodies that keep fighting all the time fighting there inside the body if there is a disease that attacks (.) the immune system releases the ammunition that is going to fight with this disease which is there
38. Cl: Yes
39. Co: By the time it's coming outside but the immune system has done its work internally
40. Cl: Yes
41. Co: Yes (.) but then this virus that is called HIV if it enters a person it enters and goes to stay with the antibodies
42. Cl: Yes
43. Co: It just stays there
44. Cl: mmm

As with the studies conducted by Silverman and colleagues, in this exchange a certain uniformity and asymmetry marks this as an information-giving interaction. Both participants orient to what could be norms that govern information-giving: the counsellor provides authoritative information about HIV and AIDS through the delivery of information statements; the client is a passive recipient of this expert knowledge who maintains the structure of the communication format by either listening or by providing response tokens or continuers ("mms" and "yes's"). These response tokens or continuers indicate several interactional norms – the client's consent in passing the opportunity to provide a full turn or to initiate repair to the counsellor's

statement, and in so doing, keep the interaction intact and moving forward (Peräkylä, 1995; Silverman, 1997).

In the remainder of this information-giving section, I would like to place less analytical focus on what appears to be a typical structure of an information communication format in VCT as this has been well established in the literature. Instead, I would like to examine *how* information contexts are created and oriented to participants. In doing so, I draw on Peräkylä's (1995) description of context in talk as an awareness of "what is said, when it is said, and how, and by whom, and to whom" (p. 32) to show how participants jointly (or not) construct an informational interaction and what functions this may serve for one or the other in the interaction.

5.1.1 Information-giving reigns supreme

In the extract that follows, it has already been established that the client's ex-girlfriend is HIV-positive and that he is concerned that he may be HIV-positive too. We join the conversation at this point.

Extract 5.2

13. Cl: their tests they then found out then that she is [positive
14. Co: [she has a virus
15. Cl: Yes, it then meant then that it was something that I was not very bothered about because anyway it had been a while for us no longer in a relationship then with her
16. Co: Yes
17. Cl: But then it was something that I did not care about then but then I said today let me come then and ask what
18. Co: Uhum
19. Cl: what do you do when it's like this
20. Co: Okay do you have information about the virus?
21. Cl: (.) No I sometimes just hear even just a little from the radio and the news
22. Co: Yes=

23. Cl: =saying it's a virus but then no I know that no I do have the knowledge but then

24. Co: Yes=

25. Cl: =No, it does not worry me a lot [because then

26. Co: [No no it

27. Cl: [I do not have a virus

28. Co: Let me not waste your time my child as you have said that

29. Cl: [Yes

30. Co: [there is something that you are rushing for

31. Cl: Yes

32. Co: let me just get into teaching you what a virus is

33. Cl: Yes=

34. Co: =Yes so that when we continue with what we are doing by then we be knowing what we are doing

35. Cl: Yes *ma*

36. Co: the HIV then my child is a virus that causes the AIDS disease

37. Cl: Yes

38. Co: AIDS

39. Cl: Yes

40. Co: this virus enters a person blood a person then has red blood (.) has white blood that you cannot see with your biological eyes it is like this glass

41. Cl: Yes=

42. Co: =Yes it is internally spread through out the whole body=

43. Cl: mmm

44. Co: this one which is red then is the one that circulates air inside the body

45. Cl: Yes

46. Co: This one which is white then is the one then that is the immune system the antibodies that keep fighting all the time fighting there inside the body if there is a disease that attacks (.) the immune system releases the ammunition that is going to fight with this disease which is there

47. Cl: Yes

The key moment in this extract is the question that the client poses to the counsellor in turn 17, and completes in turn 19. The client frames why he has come in for counselling, when he says: "But then it was something that I did not care about then but then I said today let me come then and ask what what do you do when it's like

this?" "What do you do when it's like this" refers to his current predicament: finding out that his ex-girlfriend is HIV-positive and the implications that this has for his own status. Given that the question follows immediately after explaining this situation, it might be read more as a request for guidance, advice or support. The counsellor responds to this question by checking how much the client knows about HIV/AIDS (cf. turn 20).

The client admits to not knowing much, but then justifies his lack of knowledge by saying: "…. but, then no I know that no I do not have the knowledge but then no, it does not worry me a lot because then I do not have a virus" (cf.. turns 23, 25 and 27). CA practitioners observe that people either accept or refuse an invitation, offer or proposal and refer to the client's response to the counsellor's knowledge enquiry as a "dispreferred" action (Schegloff, 1968). Rejections of an invitation, offer or assessment can be marked as dispreferred by a speaker, indicating the problematic nature of the action in one way or another for the speaker.

Kitzinger (2000) notes that refusals are normatively done in certain ways in interaction: they are usually delayed, indirect and accompanied by palliatives or accounts, and that simply saying no is experienced as rude or hostile (p.179). The client provides an account for his refusal but there are several "no's" in his explanation for why he doesn't need any information (at least three are evident in those turns) marking it as a strong refusal. But in response, the counsellor doesn't acknowledge the refusal, and elects instead to create an informational context (cf. turns 28, 30, 32). A typical information-giving exchange characterises the remainder of the interaction (turns 40-47). Heritage (2004) suggests that there is a direct relationship between institutional roles and talk on the one hand and discursive rights and obligations on the other. In a display of the

asymmetries of participation that characterise institutional interactions, the counsellor wrests the initiative from the client in ensuring that information-giving (and not support or advice) shapes the remainder of the interaction (in spite of client resistance to this path of action).

What does this tell us? For counsellors, when asked by the client to give advice, support or guidance on their problems, giving information is their first response to this request. Heritage (2004) explains that institutional interactions such as counselling normally involve participants in specific goal orientations that may be tied to their institution-relevant identities. Given that an information response was the first and most immediate response of the counsellor in this extract, it could be argued that counsellors feel more competent giving information as compared to giving advice and dealing with client troubles. Giving information is critical to counsellor identities and counsellors feel more competent when in this mode in that it allows them to take on a particular construction – i.e. of counsellor as expert.

Two additional discursive moves in the interaction reinforce the construction of counsellor as expert in this exchange. The first refers to the way that the counsellor frames her role in this informational context. She says: "… let me just get into teaching you what a virus is" (turn 32). The counsellor as technical expert emerges strongly in lines 40-47. The counsellor displays a distinctive, functionally specialized and superior knowledge that shows her expert status (Heritage, 2004), with the client taking on a more passive, receptive role in response. Second, the asymmetrical structure of the information formats – which allows counsellors the initiatory and expert role – affords them a knowledgeable identity (Silverman, 1997) and combines to bolster counsellor competency.

While information-giving constructs counsellors as expert, another function of information-giving in the context of HIV/AIDS is evident in these extracts. In response to the client's request for help, the counsellor provides information. It is possible that information-giving may be constructed as doing something for clients. The following few lines from the beginning of the extract discussed later in this chapter (cf. page 129, extract 5.6) confirms the construction of information-giving as being able to do something and being able to help clients:

Extract 5.6
24. Co: Okay (.1) You see my brother then=
25. Cl: =Yes
26. Co: I do not have help that I can give you (.) but I will just give you the information that I have
27. Cl: [Yes

Counsellors may believe that the specialised medical information that they give is critical in the context of the epidemic – that it may be the mechanism through which they could influence clients towards some of the desired prevention outcomes of the intervention: to take the test, to reduce HIV risk, to change risk behaviour, and so on.

Giving information is constructed in this extract as critical to counsellor identities (it constructs them as expert) but it is also central to how they consider and conceptualise their roles (i.e. giving information is constructed as important and necessary, and can help clients).

5.1.2 Giving information: a "balm for client troubles"

This extract builds on the idea that information-giving is constructed by counsellors as doing something in response to clients' requests for help. The client has tested for HIV, but was too distressed to continue with the counselling, and left the session. He comes now, to another hospital for post-test counselling and to discuss the meaning and implications of this positive result. In the following extract the client's troubles colour the initial turns of the interaction:

Extract 5.3

15. Cl: (.3) Eh actually (.3) when I was home at the hospital there (.) they told me I wanted to do a blood test so they there is this thing called I do not know if it's pre-test counselling then (.1) they then counselled me there then they told me then about AIDS there what it is they also told me what HIV is they also told me about a condom and its importance (.) that I need to start using it because since I started having ( ) I have never used a condom

16. Co: Okay

17. Cl: Yes so yesterday then my results came out when they came out I was found to be positive

18. Co: Okay

19. Cl: As I am positive during the time I was doing the pre-test counselling they had said even if they say I am negative even if they say I am positive but I need to wait for counselling so it means I was confused confused worried about many things (.) I just went home so today I decided to come here because my friend said here you are able to help so I came I was lazy to go back to the hospital so I then said maybe here we can be able may be to (.) may discuss with you

20. Co: <u>Okay</u> Sipho I hear you so as your results said positive how do you feel?

21. Cl: Well (.) the whole body is just numb it is neutral I do not know myself I do not know where I belong (.) I do not know if I am still the one, I am no longer the old me who knows himself (.) even the mind many things have changed especially I am having many worries so that is just the thing that worries me the most=

22. Co: =Okay can it be that you know the difference between HIV and AIDS?

23. Cl: Yes they did explain a bit when I was doing the pre-test

99

24. Co: Do you mind if I explain it to you again?

25. Cl: No you can explain it to me again =

26. Co: =Okay Sipho a difference between HIV is that HIV this is a virus that comes before AIDS (.) AIDS is now a virus that has already entered your body it means a difference between HIV and AIDS is that you will not see a person who is HIV positive they are like you and me

27. Cl: mmm

28. Co: they do not have the they do not have signs and symptoms but the one who has AIDS has those signs because they are not the same as a person who is HIV it means a person who already have AIDS than the one who is HIV positive and then it is important for a person who is HIV positive to also use a condom (.) they use a condom to prevent this virus (.) for instance in order not to infect other people like let's say you have two partners you have sex with both of them so if you are using a condom you are preventing this virus from passing it to another person and remain here in you

29. Cl: mmm

30. Co: So HIV gets into a person's body through sex, it enters through this thing the blood (.) for instance if I say through sex if you have sex with a person when they are HIV positive they have this virus (.) you have sex with them and you did not use a condom the moment you have sex with them you are able to pass this virus to them

The emotion-filled talk in turn 19, frames both the client's predicament ("…. I am confused confused worried about many things…") and his agenda ("… I just went home so today I decided to come here because my friend said here you are able to help so I came I was lazy to go back to the hospital so I then said maybe here we can be able maybe to (.) may discuss with you").

The counsellor acknowledges the client's disclosure and checks to see how the client is currently feeling (cf. turn 20). The client admits that he still feels distressed and distraught over his diagnosis and that finding out that he is positive has resulted in a loss of his former identity (turn 21). The counsellor hardly waits for that turn to be complete (there are no pauses between turns 21 and 22) and says: "=Okay can it be that

you know the difference between HIV and AIDS?" The "okay" at the beginning of the counsellor's turn acts as a full stop to the client's emotional outpouring in the previous turn, and enables the counsellor to set up an information context with her enquiry about the client's level of HIV/AIDS knowledge. In this action, the counsellor communicates that while she hears the client's distress she feels unable to do anything about it – suggesting that unlike the dominance of the counsellor's information-giving identity, the corresponding care-giving or support-giving identity of the counsellor may not be as well developed or well functioning. Her competence and identity come from providing information, and so in response to the client's distress, worry and confusion, she provides information to serve as a "balm" to these feelings and emotions.

The informational context here is similar to the previous extract, with one difference. In the previous extract, the client's request for help was more open-ended and there was space for the counsellor to choose how best to respond to the client's request to do something (i.e. either through providing information, advice or support). In that context, the counsellor chose to respond with information.

In this extract, the client's talk is replete with talk about his troubles. In response to this, the counsellor elects to give information. It's possible that counsellors offer information-giving as a potential "balm for client problems", and that client's orient to it in this way. First, the client gives permission to the counsellor to *repeat* the HIV/AIDS information that he has already received in his previous counselling session (he mentions this in turn 15 and confirms this in turn 25). The permission for the counsellor to give information following distress may serve an important interactional function for participants. The goals of VCT require participants to negotiate tricky interpersonal topics such as emotional responses to an HIV-positive diagnosis,

sexuality, intimacy and death. In this context, information-giving might be a resource that both participants draw on when confronted with such awkward and difficult subject matter.

For counsellors, there is a uniform and rote way in which they deliver information, almost as if they were following a script (cf. turns 26 and 28). This allows counsellors to dispense the information, but to do so in a way that allows them to distance themselves from the particular worries and problems of the individual sitting in front of them, and the difficulties that these problems pose for the interaction (note the depersonalised way in which the information is delivered in this turn – not to this particular client, but to a depersonalised other: "the person" or "a person" or "another person").

The medical language, and the rote way in which it is delivered, may function to create distance and keep things "certain" or controllable in a time of uncertainty and distress. Interactionally, information formats require less from the client too; all he needs to do is keep the wheels of the interaction turning with a few response tokens or continuers. Hunt (1989, in Li & Arber, 2006) discusses various strategies used by symptom-control nurses to deal with emotionally charged or distressing situations through talk. The biomedical format (similar to the information-giving format discussed here) was used in conjunction with the psychological format (similar to the support format discussed later in this chapter) as a primary method of coping with uncertainty and emotionally laden conditions such as pain and other distressing symptoms.

Similarly, Wilkinson (2000, 2004) and Wilkinson and Kitzinger (2000) in their work with cancer patients, noted that talk about unpleasant experiences and negative emotions can often be hard for both interactants to engage with. In their data they

found that there is often a striking juxtaposition of strong negative emotion and a statement about "thinking positive". In this data on VCT, providing information in response to clients' troubles might function in a similar way as thinking positive does in the context of cancer talk. Information-giving may help to manage talk about unpleasant emotions and difficult emotions – such that it becomes easier for participants to deal with, and lighten the potential conversational burden created by this kind of talk (Wilkinson, 2000).

The remainder of this segment (not shown here) supports the notion that information is a useful resource for both clients and counsellors in helping clients get away from their troubles and helping counsellors deal with client troubles by providing the "balm of information". The tone of the interaction in the remainder of the session becomes lighter; there is laughter from both as they discuss the risk of transmission through kissing and toothbrushes. The worry, confusion and identity upheaval framing the opening turns of the interaction (turns 17-21) seem remote.

There is a further function that information-giving serves as illustrated by the extract. Turnbull (1992) suggests that conversation conveys more than just facts; it conveys important information about the interpersonal world of participants too. He explains that because people are aware of the implications of their talk, they tailor what they say to establish, maintain or redefine desired images of themselves, others and their social relationships. Goffman (1967) developed the term "face" to describe the efforts participants in a social situation make towards protecting their own and others' self image.

The concept of "face" is encapsulated in the CA concept of preference organisation or the understanding that participants have of how to conduct themselves in a social situation. For example, if someone asks a question, the other person is likely to provide an answer. Further, participants in a social interaction have the option of dispreferring an invitation, assessment or offer from another or they could accept the assessment, invitation or offer and in so doing mark the action of the speaker as unproblematic. Silverman (1997) suggests that in this way, preferred and dispreferred action formats become a resource through which either party can mark their actions as problematic or not.

The interaction in turns 21-24 demonstrates how both clients and counsellors strive to protect "face" in the interaction. By agreeing and giving the counsellor permission to inform him about HIV/AIDS again, the client averts a threat to face for both the client and the counsellor. For the counsellor, the image of herself as a knowledgeable, technical HIV/AIDS expert is upheld, and the client maintains his "face" or self-image as a helpful, agreeable client who shares the same values as the counsellor. By acceding to the counsellor's request, he communicates to the counsellor that they both share the same values about the importance of information-giving in the context of HIV/AIDS counselling, even if he really wants emotional support for his troubles.

Information-giving acts as a resource for both participants when dealing with client troubles in that it may function to keep both client and counsellor "safe" in the face of the conversational burden created by talk on client troubles.

5.1.3   Need to make sure you received the information

This extract reinforces the high premium that counsellors place on information-giving as an institutional task central to HIV/AIDS counselling, and expands on the idea of the routine-ness of HIV/AIDS information delivery within the context of a pre-test counselling session.

Extract 5.4

18. Cl: Yes it's a friend of mine, yes he said you assist here
19. Co: Okay (.) what is it that made you to go and not wait to get counselling there?
20. Cl: Eh I can just say that I was very confused (.) not being not being able to concentrate I saw that counselling was not going to be of help because my mind was not was not relaxed
21. Co: mmm
22. Cl: it was not relaxed I was thinking about many things
23. Co: Okay
24. Cl: Yes
25. Co: by the way you said before they took blood they did pre-test counselling isn't it?
26. Cl: Yes they did that to me
27. Co: Did they tell you about HIV and AIDS?
28. Cl: Yes they told me
29. Co: They told you everything also their differences neh?
30. Cl: Yes yes
31. Co: Uhm
32. Cl: They told me
33. Co: I believe that this person who was doing pre-test counselling told you that if you can find your results positive that does not mean that you are going to die (.) you are still going to live for a long time isn't it?
34. Cl: <u>Yes</u>
35. Co: Yes because HIV is not curable but its symptoms are the ones that can be treated neh?
36. Cl: mmm
37. Co: and you can have can stay for a long time living with that virus

38. Cl: mmm

39. Co: if you can just use a condom all the time when you have sex and collect tablets on a due date for collecting tablets from the clinic or from the doctor (.) exercise and eat healthy food neh you will not have a problem

40. Cl: mmm

41. Co: Just take this thing like a disease which is the same as others if you think well isn't it TB was also incurable (.) as time went on a cure was found so also with HIV as time goes on the cure will be found but until it is then you will keep doing these things that I am telling you that you have sex with a condom your life will not change you will keep living the way you have been living so do not be confused the thing that changed is just that when you have sex you are now going to use a condom

42. Cl: Okay

43. Co: you are now going to be a person for tablets so do not be confused there is nothing eh you see

44. Cl: mmm

45. Co: that you can say is difficult as such

The counsellor confirms that the client did receive counselling and the information that goes with it. But unlike the previous counsellor, who asked for permission to repeat the information to the client (and in so doing is able to construct information-giving as something that the client wants too), this counsellor uses a different information delivery strategy. Like a teacher she asks a series of checking questions about the information that the client should have received (turns 25, 27, 29 and 33), and through checking ensures the correct information is provided (turns 7 and 9). The mechanism is different but the intention around its delivery seems to be the same. In both cases the HIV/AIDS information is *repeated*. The question then is what is so important that it needs to be repeated and what function does this repetition serve for counsellors in the interaction?

Information-giving serves two useful functions for counsellors. As discussed in the previous extracts, the identity of counsellor as expert is their primary identity, and in this extract participants construct the interaction such that this identity is able to be expressed. But, by reviewing more closely the content of the information-delivery messages that counsellors feel compelled to provide, a second function emerges. This extract shows that through giving information counsellors are able to impart a message of hope and encouragement (cf. turns 33, 35, 37, 39 and 41), to normalise HIV infection and AIDS and to instil a sense of coping and manageability of an unpredictable and eventually chronic condition. Burnard (1992) defines hope as the capacity to care for another person and to affirm that we believe in their ability to overcome problems and adversity. He adds that to counsel within the field of HIV/AIDS suggests hope as one needs to maintain optimism in HIV/AIDS counselling given the lack of a cure and the typical course of the disease. In these extracts, information-giving is the mechanism through which hope can be dispensed and received.

Let's return for a moment to two of the extracts discussed thus far, to further explore the notion of information-delivery being a mechanism through which hope is dispensed to clients. We return to the last segment of the extract that we have been discussing:

Extract 5.4

41. Co: Just take this thing like a disease which is the same as others if you think well isn't it TB was also incurable (.) as time went on a cure was found so also with HIV as time goes on the cure will be found but until it is then you will keep doing these things that I am telling you that you have sex with a condom your life will not change you will keep living the way you have been living so do not be confused the thing that changed is just that when you have sex you are now going to use a condom

The segment below is from Extract 5.3, where the client gave the counsellor permission to repeat HIV/AIDS information, and some similarities in the content of the information messages are evident:

Extract 5.3

28. CO: so these are the things that will make you sick, thinking all the time, that you are HIV positive, just take HIV like any other illness, like TB and cancer were once incurable, but now they are curable, so what I can tell you is that, have hope, hope belongs to an individual, just tell yourself that you are like any other human being, anyway, you are the only one who knows that you're HIV positive, you are not written here, that you are HIV positive

The two extracts show a similarity in the interactions between clients and counsellors within the context of HIV/AIDS: through the language of information-giving, a sense of hope, of coping and manageability of HIV/AIDS is constructed. We can see in the two extracts similarities in what Peräkylä found in his 1992 ethnographic study of hope work in patients. He looked at the role of emotion talk in the construction of counsellor identities and argued that conversation was important in constructing the hopefulness of the situation in terms of helping clients to feel better and get better.

Information dissemination is constructed in Extracts 5.2, 5.3 and 5.4 as a critical component of HIV/AIDS counselling activities. Both clients and counsellors orient to it as important. Its importance and centrality is evident in the various circumstances under which it is offered and received in these extracts: it is the first and immediate response to a client request for help (Extract 5.2); it is offered even if dispreferred (Extract 5.2); it is offered as a "balm for client troubles" (Extract 5.3); it is repeated in spite of the client having been informed (Extract 5.3); and it is provided again through a series of checking statements (Extract 5.4).

In the dataset of counselling interactions, there are two of the twenty-seven cases where counsellors do not orient so strongly to information-giving as a routine and integral part of an HIV/AIDS counselling interaction, and show more flexibility in its application in counselling contexts.

This section has highlighted, amongst other things, the routineness of the information-giving role for counsellors. This almost rigid application of the interactional task of giving information is not as striking with respect to the advice-giving and support formats of HIV/AIDS counselling. This sense that one *must* give information and that one gives it, irrespective of the receptivity of the context to it, suggests something about the function that this performs for interactants. Silverman (1997) argues that information formats work as a home base in HIV/AIDS counselling and that, as was evident in these South African extracts, locally and collaboratively participants avoid certain forms of interaction and choose others.

I have provided evidence through these extracts that participants jointly construct these information-giving exchanges, irrespective of the immediate context of the interaction. I suggest that given the busy nature of hospital and clinic settings where most counselling takes place, and perhaps coupled with the pressure to do something in the face of this compelling disease, giving information may be constructed as doing something, as a mechanism for soothing away client troubles and a tool through which hope can be dispensed and received.

5.2   GIVING ADVICE

Both information and advice are commonly used strategies in health care consultations, aimed at increasing patient self-reflection and behaviour change (Rollnick & Nick, 1992; Poskiparta, Kettunen & Liimatainen, 1998; Poskiparta et al., 2000). This section of the chapter will focus on advice strategies identified by Heritage and Sefi (1992), Kinnell and Maynard (1996) and Silverman (1997) in exploring the strategies that HIV/AIDS counsellors employ in an effort to influence or persuade the client to change risk behaviour.

As discussed in the literature review, VCT is framed as both a public health intervention and a counselling activity – activities that conceptualise advice in very different ways. From a public health perspective, advice segments are identified as those in which the professional describes, recommends or suggests a preferred course of action to clients (Silverman, 1997). Vehviläinen (2001) adds that advice-giving "contains a normative dimension in that it recommends a course of action that the advice-giver prefers and that it comes with an expectation that the recipient will treat the advice as relevant, helpful or newsworthy and accept it" (p. 373). The "judicious use of commonsense or technical advice" (Feltham, 1995, p. 18) is a common feature of the behavioural approach – one of the approaches to VCT – that frames its prevention goals. The second model that shapes VCT is a counselling approach that involves a strong orientation to the client's autonomy and to the obligation to respect the client's experience. From this perspective, advice-giving is not promoted. As with the information component, I analyse the discursive strategies that participants draw on as they participate in advice talk, and I attempt to understand what implications this has for the unfolding interaction.

5.2.1   Making appeals

In the dataset a range of communication strategies are revealed that fall along a continuum, from directive (where the counsellor uses explicit language to indicate what he/she thinks the client should do) to non-directive (where the counsellor uses more subtle strategies to influence client behaviour change). The appeals strategy falls within a set of categories characterised by their directness. Through using particular discursive resources (closed questions, multiple questions, questions that increase the moral stakes) the onus for social action is placed on the client.

In general, appeals are evident in counselling talk dealing with HIV testing, sexual behaviour and disclosure. All appeals have at their core a request directed at the client to act in a particular way as hoped for by the counsellor. The following extract is quite lengthy, but I include it, in that it neatly captures how the counsellor progressively uses various discursive devices to get the client to accept her advice.

Extract 5.5
50. Co: Okay (.) tell me if you have this test and you will be eh tested HIV positive (.) will you tell your partners that you have HIV?
51. Cl: (.3) I don't know but um (.3) I don't think um okay it is not easy you see because (.) mmm in the farm that I am staying in (.) my father is having a supermarket there and and and and a bottle store(.) so he is a very famous person around and I also sometimes help eh because I dropped out of school. I didn't want to go to school (.) and if if I tell them it is something that will have maybe a bad reputation on on my father's business.
52. Co: Okay (.) so you don't think you will tell them?=
53. Cl: =No.
54. Co: (.2) But tell me will you be willing to use condoms?
55. Cl: mmm. (.2)You mean if I am tested positive?=

56. Co: =Even even if you are not tested (.) if you tested negatively (.) will you be willing to use condoms?

57. Cl: mmm I don't know I will see.

58. Co: (.1) Do you (.) why don't you want to use condoms? Why are you unwilling to use condoms?

59. Cl: Well before the reasons were that eh all my girlfriends were (.1) from protective families and were healthy so I didn't think. (.) Even now I don't think they could be dangerous.

60. Co: But with your previous or your ex girlfriend being HIV positive and she could have been infected a lo::ng time before you started having sex with her (.) so she could have infected you and you could have infected a::ll these other ladies. (.) Because the virus stays very long in your body befo:::re you get sick from HIV.

61. Cl: Uhum=

62. Co: =and before eh it goes to AIDS. So you could have been infected a long time ago and you could have infected your prev your ex girlfriend or she could have infected you.

63. Cl: (.2) Ja I don't know. (.) I don't know.

64. Co: (.3) but are you willing to use you are not willing to use condoms? You are not su::re?

65. Cl: I am not sure ja I am not sure.

66. Co: You see the condom keeps not only the sperm out of the body but it also protects YOU against the female if the female should have any sexually transmitted diseases. So (.) you should think of yourself and of any other children that you might want to have (.) in later life (.) that you should rather protect yourself with this condom which we call the barrier contraceptive and mmm(.) it is 99. 9% safe.

67. Cl: (.) Ja (.) but I don't know but most of my friends tell me that it is not safe (.) because they also say that it can be left in my girlfriend (.) and maybe that that might cause dangers to her I don't know.

68. Co: But the thing is you must be taught how to use the condom (.) Um (.) we can give you a leaflet because you cannot just put the condom on to you if your penis haven't isn't erect. You have to put it on once the penis is erect and HOLD the condom down at the base before you start having sex and then it is quite safe (.) and then before your penis goes slack again you just pull out and then take off the condom and then it is quite safe.=

69. Cl: =But mmm I also hear that it it burst so I don't know.

70. Co: That is also another (.) problem of not putting it ON correctly. (.) If you put the condom on you have got to keep the TIP (.) and you keep the tip with your one finger

so that you don't pull it tight across the penis (.) so there is space for the (.) semen to go into.

71. Cl: I see (.) I see (.) maybe then I can (.1) use them (.) if I find that maybe I am positive or negative =

72. Co: =But I think (1) don't you think it is important to START using them now already (.2) even if you haven't been tested yet (.2) because you don't know what is happening (.) because you see (.) even if you are tested pos negatively now (.) there is a period we call the window period (.) and for three months you MIGHT have be HIV infected but you might not show up it might not show up in your blood the antibodies.

73. Cl: mmm

74. Co: So only after another three months you can be sure that you have the virus.

75. Cl: I see (.2) so you suggest maybe I start using it?

76. Co: It will be better for yourself if you start use the condom straight away.

The counsellor creates the context for this discussion on sexual risk and disclosure in the opening turn by directly asking the client if he will inform his sexual partners of his HIV status. There is a reasonableness and openness implied in this question, a construction of the client as free to choose to disclose or not (cf. turn 50). The client admits to some disclosure ambivalence and indicates concern about the consequences of disclosure for his significant others. The client confirms the counsellor's follow-up question on disclosure with a clear dispreferred response, "no", in turn 53.

In response, the counsellor maintains the order of the interaction by displaying "negative politeness" (Turnbull, 1992). By a show of negative politeness (through not directly challenging the dispreferred response) the counsellor demonstrates respect for the client's right to be free to do as he chooses. Instead she downgrades her advice by shifting the topic from disclosure to discussion about condom use, an action which may be perceived by both as easier to achieve and more within the client's control than disclosure.

While she downgrades the topic under discussion, she upgrades her advice strategy. The "are you willing" question, or variations of it, becomes a regular feature of her advice strategy (cf. turns 54, 56, 58, 64). VCT involves talking about difficult topics: sex, illness, sickness and death – all topics that are not easy to address in ordinary conversations (Peräkylä & Silverman, 1991b; Silverman & Peräkylä, 1990). Counsellors need to accomplish this task through their turns of talk – either through the questions they ask or the information, advice and support statements they deliver. The simplest way of getting people to speak is by asking questions. By answering questions on these difficult topics, participants produce talk on these topics (Peräkylä & Silverman, 1991b). The counsellor's "are you willing" question achieves this effect in this extract. Through repeatedly employing this question, she does two things: 1) she gets the client to account for his decisions and thoughts on condom use or lack of it; and 2) she manages to obtain a positive uptake of her advice – from ambivalence regarding condom use in turn 57 to a tentative, but much stronger statement regarding their use in turn 71: "I see, I see. Maybe then I can (.3) use them if I find that maybe I am positive or negative."

Turns 54-57 show the counsellor stepping into an advice sequence on condom use before she has actually engaged the client's views on the matter. Other CA studies show better uptake of advice where client perspectives are elicited before advice is given (Heritage & Sefi, 1992; Kinnel & Maynard, 1996; Peräkylä, 1995; Peräkylä & Silverman, 1991a; Silverman, 1997). The counsellor displays an awareness of the client's resistance to her advice and responds with a "why are you *un*willing" question that invites the client's explanation for his reluctance to use condoms in turn 58. The counsellor counters the client's reason for lack of condom use with her assessment of his behaviour in turn 60.

The counsellor also shifts mode in this instance and in all three turns (60, 62, 64) she adopts a more authoritative stance in the interaction. This has the effect of the client moving from earlier expressing an unwillingness to use condoms to possibly thinking about it, as indicated by: "I am not sure ja I am not sure" (turn 65). Sensing this shift, the counsellor employs two additional discursive moves. First on three occasions after this (66, 68 and 70), each time dealing with the client's resistance to condom use, she displays her functionally specialised and superior knowledge about condoms that reveals her expert knowledge on that matter (Heritage, 2004).

The second discursive move she employs is to upgrade her condom use advice as something the client should consider for his own health and protection (note the emphasised YOU in turn 66). Thirdly, she ups the moral stakes of the advice by suggesting that even if he won't do it for himself he should think "of any other children [he] might want to have in later life".

The combination of the discursive strategies employed by the counsellor in this extract all work to place responsibility on the client as social actor and eventually lead to the client orienting to the counsellor's appeal to change in behaviour. The uptake of the counsellor advice comes in turns 71 and 75 where the client indicates that he will start using condoms irrespective of the outcome of the test. There are some noticeable shifts in the way that he responds to the counsellor's advice on condom usage in these lines, as compared to earlier on in the extract. In the earlier extracts his ambivalence is clearly expressed: "I don't know, I will see" (turn 57); "Ja, I don't know, I don't know" (turn 63); and "Ja, I am not sure, ja I am not sure" (turn 65). In turn 71 he seems to be agreeing with the counsellor, and he shifts from his earlier view when he suggests that

he will use them if he tests positive or negative. In an earlier segment, turn 51, he thought that he would only use them if he were positive.

The last two turns of this segment (73-74) illustrate the difficulty that counsellors may have in implementing two competing discourses on advice-giving. Up until that point, the counsellor has successfully negotiated the interaction to this point where the client is ready to take up her advice on condom use. He asks for her final confirmation on the new behaviour, and one senses the final permission from the counsellor that that this is a good thing to do: "So you suggest maybe I start using it". In this instance, a simple "yes" or "no" would suffice. Instead, the counsellor's reply is a less affirmative one. She says: "It will be better for yourself if you start using the condom straight away", placing the responsibility for this behaviour back on the client. Counsellors display an interactional difficulty in establishing what should be done when – when to speak with authority and be the expert and when not to. In this instance, having worked so hard to get the client to the point of considering condom usage, a clear "yes" would have made the intended behaviour change clear, and also affirmed the client's shift in position on condom use. The more tentative counsellor reply serves to undermine the work that she had done in getting the client to consider and take up the advice about condom use – and illustrates the tensions inherent in doing both prevention and support in VCT.

Information-giving formats, appearing as they typically do at the beginning of the pre-test counselling session, are interactionally less demanding for both participants. Given their position, they almost lay the foundation, in terms of both timing and their interactional properties, for the more difficult task of giving advice in VCT. In this data, the client rejected or showed some ambivalence to counsellor advice statements on several turns (cf. 53, 57, 63 and 65), thus forcing the counsellor to downgrade and then

upgrade her advice on a couple of occasions. Various authors (Heritage & Sefi, 1992; Kinnel & Maynard, 1996; Peräkylä, 1995; Peräkylä & Silverman, 1991a; Silverman, 1997) in their work on HIV/AIDS counselling communication formats all show that rejecting advice is an action that could potentially threaten the face (and authority) of the counsellor. Advice-giving requires particular interactional work on the part of the counsellor (Vehviläinen, 2001). In their analysis, and as illustrated here, participants organise and revise their utterances so as to manage rejections of advice in a way that preserves preference for agreement in the interaction (Silverman, 1997).

The "are you willing" strategy is effective in getting the client to consider their behaviour. There are several elements of the strategy that might contribute to its success. First, the strategy makes use of a question as its core discursive tool. Questions create a moral obligation for the recipient to provide an answer in that the basic social rules of conversation are to answer when asked a question (Peräkylä & Bor, 1991). Conversation analysts point out that one of the advantages of advice formats that use questions as their base is that, because of the nature of question-answer adjacency pairs, clients are required to speak (Silverman, 1997). This is especially important for topics like safer sex, and for discussions of sexual risk and decisions around testing.

Second, the nature of the question ("are *you* willing?") requires both an answer and an account or explanation from the client. As Turnbull (1992) points out, explanations invariably have a connotation of blame, a sense that one is being brought to task for an act of moral violation (e.g. why are you unwilling, and if not, what is your reason for being unwilling?). In responding to counsellor appeals to act in a particular way, clients have to offer an explanation for their conduct and account for themselves as moral beings. Silverman (1997) also suggests that questions imply categories through which

the person is being defined. The "are you willing" question constructs clients in a particularly moral way and makes them accountable for their behaviour and social action, thus placing the onus for responsibility squarely on the client.

5.2.2 Prescribing rules for living

In contrast to the appeals strategy, the "prescribing rules for living" strategy foregrounds the counsellor as social actor in the interaction who provides clear recommendations for what the clients needs to do to live their lives in the context of HIV/AIDS. Both this and the previous strategy have a strong persuasive element to them ("you must", "you should") and draw on the professional authority of the counsellor as the mechanism for influencing client behaviour. The advice is often framed and emphasized with the personalized "I", for example, "The advice that I give you is", "I will ask you to be ready", and "I will ask you to use a condom". Like the previous strategy, this strategy is evident in counselling contexts of HIV testing, sexual risk and disclosure of HIV status to others.

Extract 5.6
28. Co: [You see (.1) the first one then that I have to advise you on is that (.2) I know that it's it's not easy to go and test yourself
29. Cl: Yes
30. Co: I then want to give you ammunition for to be ready for the thing that
31. Cl: [the results
32. Co: [For your results and other things so that even if you go there to test you need to go there ready you know that you are prepared for anything
33. Cl: Yes
34. Co: First of all, when w::e say that you are HIV positive or negative (.) I will ask you to be ready (.) hmg (.) firstly you must move on (.) you still date (.) you understand and you will still carry on dating (.) and my first advice is from now on I would like you to use a condom

35. Cl: Yes

36. Co: You see use a condom another thing the second one if you come to hear that your results are positive

37. Cl: mmm

38. Co: Or they are negative (.) let me emphasize on the positive (.) to be ready to continue with your future because when you discover that you are positive (.) that's not the end of the world do you understand. You can still carry on it is like that as I have already stated as a first point. Secondly, you will stick to one partner

39. Cl: Yes

40. Co: Another thing then you are going to (.) another one if there are certain things that you are doing those that you enjoy you are drinking you like to freak outside and just take just others that you are in love with (.) and satisfy yourself

41. Cl: mmm

42. Cl: the thing of stopping do you understand and stick to one partner (.) and you must use a condom (.1) and the other thing that I told you is that if you see this thing that you are positive

43. Cl: mmm

44. Co: you can have this (.) you eat balanced food (.) this balanced food means that you eat food that has high proteins [do you understand

45. Cl: [mmm

46. Co: and another thing that I want to advise you on (.) you see a problem is this thing of this child of yours needs to be helped they should be brought in and tested (.2) It's your choice I do not want to make them test or not make them test do you understand

47. Cl: mmm

48. Co: I was telling you what I wanted to advise you on that you go to your girlfriend (.) your ex-girlfriend and then talk now about this thing (.) the thing that you wish to go and have a test do you understand (.1) and then you will hear from her what it is that she is saying ((Cl clears his throat)) because it's not easy the thing of just saying I have heard now the thing that you are [HIV positive

49. Cl: [( )

This segment starts off with advice on HIV testing. The counsellor frames her advice regarding testing using two interesting discursive devices (cf. turns 28 and 32). In both these turns she refers to the activity of testing as something the client will be doing in the future. This future orientation when talking about testing is striking, as the

immediate task in the context of a pre-test counselling situation *is* to discuss the client's fears and concerns about testing and not defer it to another time.

The second discursive feature that is noticeable is that the counsellor depersonalises the testing experience in her utterance: "I then want to give you ammunition for to be ready for *the thing*". The client completes the counsellor's turn by understanding that the thing refers to the results of the test (turns 31 and 32). The future orientation to her advice continues in turn 34 with the counsellor's statement: "…. I will ask you to be ready".

These discursive features (a future orientation, depersonalising the topic of testing) are both non-personal and distancing devices which enable the client to hear the advice as merely generic information being dispensed by the counsellor, not as personalised advice which may require a more detailed response, reflection and discussion from him. Observe how the client orients to the advice as information (note the "yes" responses in turns 29, 33 and 35). These are display responses typical of an information interaction discussed under Extract 5.1 in the beginning of this chapter. These unmarked acknowledgements or minimal response tokens merely have a continuative function in the interaction. Silverman (1997) suggests that they serve two functions in the interaction: a) they do not acknowledge the advice-giving as newsworthy to the client; and b) they do not constitute an undertaking that the client is likely to follow the advice. In fact, Silverman continues, they can be heard as a form of resistance because implicitly, such responses indicate that the client is refusing to treat the talk as advice (p.190). What do advice statements generally require? More than a "yes" or an "mmm", and some engagement with the advice that is being offered or suggested.

The third device that the counsellor uses in the advice sequence is the numbering of the items (firstly, secondly) that she wishes to discuss. This numbering technique is used by the speaker for retaining the floor and is a typical feature of information formats (Peräkylä & Silverman, 1991a; Silverman, 1997). The interactional task for the client is to do what he can – through the use of minimum encouragers – to help the speaker maintain the floor. His response throughout the extract indicates that he hears the advice as information, and provides the response continuers necessary for the conversation to continue, but shows little engagement with the counsellor's advice. Writers have shown that unmarked acknowledgements ("mmm", "yes", "right") in an advice sequence are indicative of the client refusing to treat the talk as advice or as newsworthy or as not undertaking that the advice will be followed (Heritage & Sefi, 1991; Kinnell & Maynard, 1996; Peräkylä & Silverman, 1991a; Silverman & Peräkylä, 1990; Silverman, 1994a; Silverman, 1997).

There are additional aspects to the delivery of this advice strategy that are worth discussing. The authoritative "I" (counsellor who is competent, who has authority and perhaps who knows best) is used in the beginning of the segment: ("… I will ask you to be ready", "I would like you to condomise"). All of these advice sequences draw on the authority vested in the counsellor as a way of influencing behaviour change in the client. As discussed, this appears to have minimal effect on the interaction as the client orients to this advice as information and does not engage with it further.

In response to the non-committal response from the client, the counsellor adjusts her strategy midway in the segment. She starts to personalise her advice by using "you" to refer to the client in the advice sequence. This personalisation of the advice does not appear to shift the client response, appearing in a context where the advice has been

delivered in a depersonalised way and offered as information. He maintains the minimal-response continuer style typical of an information exchange.

A closer look at the counsellor advice assessments in turns 34 and 38 reveals additional features of the structure of this advice strategy. First, both utterances start off with the counsellor attempting to normalise the client's condition and instil the belief that the client can and will cope should he test positive.

> Turn 34: "you must move on, you still date, you understand and you will still carry on dating"
>
> Turn 38: "carry on with your future …its not the end of the world (.) you understand. You can still carry on (.) it is like that…"

Attempts to normalise the client's situation appears to be a common features of HIV/AIDS counselling talk (it was evident in the information segment, it appears here under the advice component and it will emerge again in the next section that deals with providing support). Under the information section in this chapter, Hunt (1989, in Li & Arber, 2006) showed how symptom-control nurses dealt with emotionally charged or distressing situations in their talk through the production of ordinariness and normality in the context of imminent death. This may work in a similar way in the context of HIV/AIDS. In the context of an overwhelming and devastating disease that leaves people feeling out of control, evoking ordinariness and normality may help to fashion control in a context that feels distinctly out of control and overwhelming.

Normalising could also be viewed as a hope-building strategy. In each of the instances in this extract, the normalising statement is immediately followed by the counsellor

advice recommendation (cf. turns 34 and 38). The normalising and hope-building part of the strategy provides a positive context into which the advice could be introduced. By placing the normality and manageability of HIV in the first part of the sequence alongside the advice, an overall context of coping and managing HIV infection is created in the interaction. Also, by organising it this way, alongside the normalising and hope-building part, counsellors may also be aiming to encourage greater client uptake of the advice.

Structurally this advice as information sequence reads as a sermon (the message of hope and belief that one can conquer it is followed by a clear recommendation on a course of action from an influential other) and constructs counsellors as those who have an important message to deliver and clients as those in need of such a message, and mere recipients of this message (note the client's one word response in turns 29, 33, 35, 37, 29, 41 43, 45, 47 49).

The two normalising statements followed by recommendations are followed up with a sequence where the moral stakes are upped. As shown in Extract 5.5, the retreat to a moral space regularly features as a strategy in getting clients to talk about their sexual risk behaviour. Invoking a moral context seems like a fall-back position resorted to when other advice manoeuvres are met with resistance or simply not taken up by the client.

The construction of an ill-disciplined, immoral client emerges for the first time in utterance 42 (cf.: the client who "freaks outside, who takes people to satisfy himself"). The rules for living in a time of HIV/AIDS seem clear: if you do all these "terrible" things ("… you enjoy yourself, you drink, you freak outside, you take people you are

dating to satisfy yourself…") then you must accept the responsibilities that come with that ("… stop and stick to that one partner, and you must use a condom…"). In both the previous appeals strategy and the current rules-for-living strategy, the advice is eventually upgraded and framed in moral terms.

In the previous extract, in combination with the other discursive moves employed by the counsellor, the client showed signs of implementing the counsellor's advice. In this advice strategy, where advice seems to be delivered as information, even when the moral stakes are upped, the client doesn't treat the advice as newsworthy and responds with an unmarked acknowledgement "yeah" in turn 34.

5.2.3   Conclusion

At the core of this strategy was the counsellor as the authority figure; one who is able to use this authority to influence the client to change his behaviour. As a result, not enough responsibility is placed on the client as a social actor in the advice strategy. It reinforces the point that in making decisions about behaviour change "not only do people not do what they know; they do not necessarily do what they are told; nor do they necessarily trust the 'authorities' who provide the instructions and suggestions" (Keeling, 1993, p. 307). This, coupled with the fact that the advice is delivered as information, creates a context where the client is able to treat the advice as information and not as advice on how to change his behaviour.

There are some similarities in the roles of the counsellor in the information-giving and the advice-giving formats. In both, the counsellor is in an initiatory role and the client is in a more responsive one. In both the information extracts and advice extracts the

counsellor is afforded a knowledgeable identity. In the information-delivery segment this is realised in the production of specialist knowledge, and in the advice sequence it means a warrant to ask questions and to sometimes evaluate the answers (Silverman, 1997). In performing both these tasks, counsellors command a specialised body of knowledge, and have a clear sense of purpose of the encounter. Subsequently, in allocating the counsellor the initiatory role and the knowledgeable identity, we put the professional firmly in control in these interactions (Parsons, 1951 in Silverman, 1997).

As these data extracts show, counsellors use a range of strategies to influence clients' HIV/AIDS risk behaviour. These range from strategies that place the onus of responsibility on the client, to those that see the counsellor as the social agent, capable of influencing change through the power of his/her authority and professional position. The strategies have had different effects on client uptake of behaviour. What these data on advice point to are some of the difficulties inherent in influencing change in others' sexual behaviour. It also confirms the limitations of more traditionally didactic health-promotion techniques that rely on instructing, explaining and exhorting people to change their behaviour (Carballo & Miller, 1989).

Some of the counsellor-driven information, advice and advice-as-information strategies appear to engage the client minimally. In these sequences, the bulk of the discursive space in the interaction is taken up by counsellors, with the client doing little but keeping the interaction moving along. In contrast, the more directive strategies where the client is foregrounded as a social actor rather than the counsellor, resulted in more engagement and participation from the client regarding risk behaviours. This engagement and reflection on behaviour is what the epidemic requires.

5.3 PROVIDING SUPPORT

Clients come to VCT with a range of psychosocial problems or troubles. These include concerns about their own risks of infection, mortality and morbidity, and the likely impact of an HIV-positive result for themselves and significant others in their lives. Through the provision of support (i.e. encouragement, enhancement of morale, maintenance of sociability together with practical assistance), these psychosocial problems are addressed by counsellors (Chester, 1987 in Silverman, 1997). In VCT, the provision of psychosocial support should comfortably co-exist alongside the HIV-prevention and risk-reduction goals of the intervention. This is not always the case in VCT practice, resulting in a more complicated interactional activity for both participants. Offering support is not just a straightforward matter of providing encouragement and support on client issues, but occurring in the context of preferred prevention outcomes, support inevitably becomes less open-ended but more directive in favour of these preferred prevention outcomes. Carballo and Miller (1989, p. 118) capture the character of HIV/AIDS support in the context of prevention: "To offer support, is to encourage individual action and responsibility but also to assist people to consider the feasibility of their behaviour and the implications for lifestyle and social relations."

Several writers adopt a more critical stance in analysing how psychological support has come to assume such a central place in modern societies and human life (Foucault, 1977, 1980, 1981, 1984, 1986; Miller & Silverman, 1995; Rose, 1991, 1992; Silverman, 1997). Rose (1991, 1992) and Silverman (1997) argue that the discourse of psychology is pervasive and evident in the popularity of the confessional from the ubiquitous reality talk shows to the range of more private settings where people share their problems.

We have become a counselled society, where psychologists and their techniques have become indispensable: it is to psychologists that people turn to when they "seek to comprehend and surmount the problems that beset the human condition – despair, loss, tragedy and conflict – living their lives according to the psychological ethic" (Rose, 1991, p. 351). These writers argue that psychological ideas have become routine ways of applying thought in and to the world, making the world thinkable and practicable in certain ways. These techniques are forms of power used to interpret and regulate the population using much more subtle mechanisms like the confession rather than overt discipline (Foucault, 1980, 1984).

Gail Jefferson (1974) coined the term "troubles talk" to refer to talk about difficulties, misfortunes, loss and other painful, upsetting or unpleasant events. Garfinkle (1967) and Heritage (1984) describe how clients' troubles – which they frame as socially constructed realities – are talked into being in counselling settings. By using a range of discursive strategies, troubles are made topics for public consumption in the confessional of the counselling room (Silverman, 1997). These writers suggest that "troubles talk" is a socially significant aspect of counsellors' work through which counsellors fulfill their professional responsibilities. Troubles talk constructs clients and counsellors in a particular way. By dealing with troubled clients, counsellors feel resourceful, competent and like they have helped the client, and in so doing they fulfill their professional responsibilities.

Drawing on the work of Miller and Silverman (1995) and Silverman (1997) on troubles talk in HIV/AIDS counselling settings in the United Kingdom, in this last section I explore how troubles talk is both talked into being and managed by interactants in these South African transcripts. In encouraging clients to talk about their troubles,

counsellors draw on a range of techniques: asking questions, engaging in directive conversation, talking and listening, summarizing and paraphrasing, in order to elicit information and knowledge about clients' lives, perspectives and troubles and to guide the clients towards mutually agreeable definitions and responses to their troubles.

The troubles talk, or support strategy, differs structurally to the information and advice strategies. A marked difference in these interactions is in the relative levels of symmetry in client and counsellor talk. While counsellors still lead the discussions and frame the agenda, clients are given more space to talk in comparison to the previous two strategies. Counsellors draw on various discursive tools to elicit clients' troubles and encourage clients to talk. Clients cooperate by creating a support interaction that is marked by reflection on their troubles, disclosure and mutual working through of issues and decisions. In these support interactions, compared with the information and advice interactions, counsellors assume a less dominant, authoritative identity in the interaction with a willingness to hear from clients and discover what they consider important.

5.3.1   Constructing talk about troubles

Through a series of questions, not shown here, the counsellor in the next extract invites the client to talk about his "troubles". For the client, these revolve around his discovery that his ex-girlfriend and the mother of his child, is HIV-positive. His main concern, identified earlier and being alluded to again here (cf. turn 28 and turn 30), is that his baby might also be infected with HIV.

Extract 5.7
    27. Co: When last have you seen your ex girlfriend?

28. Cl: Um (.3) this past this past weekend as I went to see the baby. We are not on good talking terms=

29. Co: =Yes

30. Cl: and I couldn't ask her whether it is true if she is HIV-positive or not=

31. Co: =mmm

32. Cl: . = I just came and test myself.

33. Co: Okay and the ba::by? Was the baby well or ill?

34. Cl: The baby is well. She is she is she is quite healthy. I mean she looks healthy yes.

35. Co: Okay. Look Sipho I think that what you are feeling about your baby the concern about your baby (.) that that's perfectly normal and mmm you know anybody in this situation would feel concerned about their baby. But I think that for now seeing that your baby is well. I think that for now perhaps you should focus your attention on yourself (.) and I would like to just come back to you and how you are managing your feeling (.) and how are you coping with these fears. (.) eh you have said to me that your main concern is about being rejected by the community.=

36. Cl: =Yes that is [true

37. Co: [Uhm but yesterday (.) in addition to that yesterday you walked out because you felt that you did not want to (.) you couldn't sit in a counselling situation and talk.

38. Cl: Yes [exactly

39. Co: [I would just like to bring you back (.) eh to that point and time when you received the news that you were HIV-positive. (.) I would like to ask you what did you feel?

40. Cl: (.2) Well (.2) I expected it.

41. Co: You expected it=

42. Cl: =Yes because of my ex girlfriend's status.

Miller and Silverman (1995) and Silverman (1997) define troubles talk as encompassing three types of talk: a) serious problems that the person may have that might necessitate professional intervention; b) those aspects of people's lives considered undesired and perhaps warranting change in behaviour or perspectives; and c) aspects of a person's life that may be considered mildly annoying.

While the above definition captures the range of "troubles talk" that could take place in counselling, it leaves a lot unsaid. Mostly, it leaves unstated the "productive expressions of power" inherent in negotiating troubles talk as illustrated by Extract 5.7: who defines what "serious problems might need intervention", who decides what is "undesired" and what warrants "change in behaviour and perspective"? In this instance, the counsellor does. She uses her professional authority as counsellor to construct a particular form of client troubles – i.e. concerning feelings and coping – and places this on the agenda:

35. Co: Okay. Look Sipho I think that what you are feeling about your baby the concern about your baby (.) that that's perfectly normal and mmm you know anybody in this situation would feel concerned about their baby. But I think that for now seeing that your baby is well. I think that for now perhaps you should focus your attention on yourself (.) and I would like to just come back to you and how you are managing your feeling (.) and how are you coping with these fears. (.) eh you have said to me that your main concern is about being rejected by the community.=

The counsellor acknowledges, at the start of her turn in 31, that the primary concern for the client has to do with his baby, and his potential HIV status. She then follows this up with a reflective statement or summary that both acknowledges and normalises the client's feelings and concerns about his baby. Summaries of what has just been said are also intended to move the conversation on in a particular direction and may serve the function of keeping the conversation going (Wilkinson & Kitzinger, 2000) in that particular direction.

This is powerfully illustrated in turn 35. Her reflective statement works well for the counsellor. In the first part she aligns herself with the client through her acknowledgement of his feelings and normalisation of his concerns. Having done this, the summary also allows her to neatly introduce her own agenda on troubles talk with

minimal disruptions in the interaction, ensuring easier uptake of her agenda insertion (cf. client response in turn 36-42 where the feeling agenda is engaged with by the client). Silverman (1997) sees these as "productive expressions of power" that operate in subtler, more persuasive and more seductive ways – the counsellor uses her professional authority to shape the social interaction to focus on her particular construction of the client's troubles being about feelings and coping. Foucault (1977, 1980) points out that knowledge and power operate through micro-political processes of social interaction – these are sites of power and discipline. Drawing on these aspects, particular and distinctive social realities and human subjects are produced in the process (Miller & Silverman, 1995; Silverman, 1997).

Silverman (1997) and Miller and Silverman (1995) propose that through the micro-political process of interaction, counselling is able to function as a "discourse of enablement". This is a professional strategy for inciting/stirring preferred forms of troubles talk and encouraging preferred forms of change in clients' lives. It is also a vocabulary and theory about troubles, their social contexts, and how they are best remedied. A key institutional discourse that is jointly constructed by clients in this and the extract that follows is about participants being able to manage and cope with feelings and concerns pertaining to HIV disease. This extract illustrates how through the use of reflective techniques and through a display of her authority, the counsellor is able to insert her agenda into the session. This agenda creates a particular social reality about client troubles where client troubles (their feelings and fears) have to be discussed, managed and coped with. This construction is a collaborative process involving participants, all of whom act within available discourses to define, contextualize and remedy client troubles (Miller & Silverman, 1995; Silverman, 1997).

5.3.2 Managing feelings and coping with fears

Extract 5.8 continues with the extract of talk introduced in the previous segment. This advances the argument in the previous extract and shows how through using various discursive tools the participants collaboratively construct a context about troubles talk being about feelings and coping and how best to manage feelings.

Extract 5.8

35. Co: Okay. Look Sipho I think that what you are feeling about your baby the concern about your baby (.) that that's perfectly normal and mmm you know anybody in this situation would feel concerned about their baby. But I think that for now seeing that your baby is well. I think that for now perhaps you should focus your attention on yourself (.) and I would like to just come back to you and how you are managing your feeling (.) and how are you coping with these fears. (.) eh you have said to me that your main concern is about being rejected by the community.=

36. Cl: =Yes that is [true

37. Co: [Uhm but yesterday (.) in addition to that yesterday you walked out because you felt that you did not want to (.) you couldn't sit in a counselling situation and talk.

38. Cl: Yes [exactly

39. Co: [I would just like to bring you back (.) eh to that point and time when you received the news that you were HIV positive. (.) I would like to ask you what did you feel?

40. Cl: (.2) Well (.2) I expected it.

41. Co: You expected it=

42. Cl: =Yes because of my ex girlfriend's status.

43. Co: Uhum

44. Co: So so (.2) ((sigh)) I was already you know worrying about many things just before the result

45. Co: mmm=

46. Cl: =and it didn't change the result didn't change (.) anything my worries instead it was they reassured my worries that yes my worries are real

47. Co: mmm

48. Cl: because the results are positive.

49. Co: Okay (.) so do you feel that to a certain extent that you had prepared yourself for bad news?

50. Cl: Yes yes I was was in between bad and good

51. Co: mmm

52. Cl: (.2) but when I received the results the only thing that first came to my mind was (.) death because I know the AIDS is a (.1) killer disease.

53. Co: umm

54. Cl: AIDS ja

55. CO: Okay. When you first, so your first response when you heard that result was "I am going to die now"?=

56. Cl: =Ja

57. Co: Is that the way you feel (.) sti::ll now that you have had a chance to think?

58. Cl: (.) Well mmm in a way yes.

59. Co: mmm=

60. Cl: =because I I feel like (.2) now I know that I am going to die sooner.

61. Co: mmm

62. Cl: ((Talks very softly)) (It is having to live alone with that knowledge that also) ( )

63. Co: Okay (.) so it is the knowledge that you are going to die sooner than you thought or planned?=

64. Cl: =mmm yes and also my plans that I am thinking.

65. Co: mmm

66. Cl: My longtime long-term plans that are going to be (shattered).

67. Co: mmm

68. Cl: I don't I think I will find strength any more to, to, to continue with my long-term plans knowingly that I am going to leave them halfway or earlier than that.

69. Co: (.2) mmm. Ja (.) Sipho an HIV-positive result has a ma::jor impact on a person's life (.) and very many people that receive positive results have similar thoughts to what you are thinking. (.3) Um you speak about this um and I notice that your leg is shaking and I am wondering although you say that it concerns you and you expected it (.) I am wondering what else it is that you are feeling?

70. Cl: (.5) I have quite mixed feelings actually (.) Quite a lot of things that=

71. Co: =Ja

72. Cl: when I think (.) then I think of them and I think of my status

73. Co: mmm

74. Cl: it just (shuts) everything down them down and my family at home it is not easy for me to tell them. Or (.) it is going to be difficult when they find out for themselves when I start becoming sick.

75. Co: Yes

76. Cl: And I don't know how they are going to take that (.1) knowing that I have been quiet for some time. Because you see my father is eh my father is running a small business in in the community and now he is old and he wanted to retire.

77. Co: mmm

78. Cl: So I dropped out of school yesterday willingly (.) and so that I could do something so he has started teaching me how to run it,

79. Co: mmm

80. Cl: the business so when he dies then I can take over but now that he can find out my status knowing him I am sure he is going to throw out that proposal and I am sure I am going to be (.) denied many other things (.1) that I had access to before because of my status. So that is why I don't know where to go and what to do. I'll have to keep it inside of me till I die.

81. Co: Uhm (.4) Sipho you have said quite a lot (happened) to you about what is concerning you what's worrying you (.) and then it seems to me that the major thing is that as a result of your HIV/AIDS-positive status you feel there is a lot you are going to lose. You are losing your it seems as though you are losing perspective that you are going to live a long life. It seems as if you think that people are going to reject you. People are going to view you differently. People are going to expect different things from you. And that people are even going to deny you access to certain things.=

82. Cl: = That's right=

83. Co: = That is a very heavy burden to carry to carry for anybody.

84. Cl: Uhm ((Nods his head)) (.3) I don't know seriously (.) I don't know what to do. Will you maybe suggest that I tell them at home or keep quiet? (.2) because I don't think I don't feel like there is someone I can trust that I can tell.

85. Co: I was going to just ask you um, if there is anybody you feel that can be there for you. Um, I don't know if you have answered that question for me?

86. Co: Okay. Look Sipho, I think that what you are feeling about your baby.

As shown in the previous extract, the counsellor structured the conversation to talk about feelings and coping (turn 35) and the client responds to this construction by talking about his feelings (cf. turns 36- 42) when he found out that he was positive. The counsellor uses numerous formulations in this extract to get the client to talk about feelings and coping.

Luckner and Nadler (1997 in Brown, 2003) distinguish between paraphrasing and summarizing. Paraphrasing is where the counsellor re-states in her own words what she thinks the client has said (an example of this is evident in turn 49) and summarizing can be viewed as the way in which the counsellor "gathers up" the gist of what has been said so that confirmations or revisions can be made (see turn 81 for an example of this).

Ethnomethodologists regard summaries and paraphrases as formulations. Formulations refer to the manner in which a participant may use some part of the conversation as an occasion to describe that conversation (Garfinkle & Sacks, 1970). Formulations are described as activities like explaining, characterising, explicating, translating, summarising or furnishing gists of the talk thus far or reflecting (Garfinkel & Sacks, 1970; Heritage & Watson, 1979; Heritage & Watson, 1980).

The aim of a formulation is to establish a collaborative and jointly accepted statement of what is being talked about, to demonstrate understanding and to have that understanding attended to and endorsed (Brown, 2003). How this works is evident in the following lines:

36. Cl: =Yes that is [true
37. Co: [Uhm but yesterday (.) in addition to that yesterday you walked out because you felt that you did not want to (.) you couldn't sit in a counselling situation and talk.
38. Cl: Yes [exactly
39. Co: [I would just like to bring you back (.) eh to that point and time when you received the news that you were HIV positive. (.) I would like to ask you what did you feel?
40. Cl: (.2) Well (.2) I expected it.
41. Co: You expected it=
42. Cl: =Yes because of my ex girlfriend's status.

43. Co: Uhum

44. Co: So so (.2) ((sigh)) I was already you know worrying about many things just before the result

45. Co: mmm=

46. Cl: =and it didn't change the result didn't change (.) anything my worries instead it was they reassured my worries that yes my worries are real

The overlapping turns of client and counsellor talk in turns 36 and 37, and again in turns 41 and 42, demonstrate the mutual understanding between client and counsellor about the nature of the client's troubles. In conversation, since formulations act as a participant's "publicly aired" understanding of a preceding section of talk, they are deeply implicative for subsequent talk (Heritage & Watson, 1979). Structurally, formulations function much like question-answer adjacency pairs in conversation (Heritage & Watson, 1979). The sequential nature of the formulation is evident in the formulation-decision pair. And like, questions and answers, they work to engage participants in conversation, to create an interaction that is characterised by client disclosure, discussion and reflection on their troubles (cf. 37, 39, 41). The length of the client utterances in these client turns illustrates the effectiveness of the formulations in encouraging client disclosure about their troubles, and works to create a jointly reflective space in which troubles talk can be enquired about and responded to (Poskiparta et al., 1998; Poskiparta et al., 2000).

The counsellor uses questions and formulations to good effect in the unfolding interaction. She uses questions to probe the client's emotional state of mind at the time of finding out his HIV-positive status (turn 35); she uses formulations to probe how prepared he felt for the positive result he received (turn 37, 39); and she uses a series of formulations to look at his current emotional and coping state (55, 57, 63). For example, she asks: "Okay. When you first, so your first response when you heard that

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result was 'I am going to die now'? (55) and "Okay (.) so it is the knowledge that you are going to die sooner than you thought or planned?" (63).

These discursive strategies help to translate the general sense of despair relating to his discovery of an HIV-positive diagnosis into more concrete and manageable terms. Peräkylä (1992) observes that through the use of such formulations, the counsellor is able to translate general emotional terms (worrying, bad and good, mixed feelings – see client turns 38, 40 and 50) into a more specific and (manageable sense) that is related to the occasion and its use and its meaning for the individual.

Emotion talk is defined as an activity involving words that attribute feelings and meanings to the shared and lived experiences of participants (Li & Arber, 2006). Doing emotion work may serve particular interactional goals. The emotion work done by clients and counsellors in these turns can be viewed as a resource that is actively employed by people in interaction with others. Through turns of emotion talk in this extract, a troubled/coping client is constructed. But, also through doing this emotion work and by making this available for public consumption, another version of the client is constructed: one who is reflective, who is in touch with, and able to articulate and work through their experiences – one who is eminently psychologically credible.

Frith and Kitzinger (1988 in Li & Arber, 2006) describe emotion work as work that is involved in the managing of emotions and as a participant resource that is actively employed by people in interaction with others. Emotion work functions to manage social interaction and to achieve interactional goals (such as presenting oneself as a caring and competent individual). Through the use of step-by-step formulations that emphasise feelings and coping, a construction of clients' troubles, their fears and

feelings as manageable and within the coping capacities of the clients, is also created. As the implementer of such tools that are able to achieve this interactional effect, emotion work allows counsellors to construct themselves as competent and caring individuals. Further, in these contexts mutual containment of emotions serves to preserve participants as rational and emotionally controlled people and to preserve self-esteem and integrity (Li & Arber, 2006).

There is a clear institutional discourse about coping and managing HIV disease that is constructed in Extracts 5.7 and 5.8. These institutional discourses are made up of vocabularies, concerns and practical interests which are assembled by participants in particular ways to produce particular forms of troubles talk and the contexts of that talk (Silverman, 1997).

5.3.3   Ensuring clients get support

A second major discourse on client troubles that emerges is around ensuring that clients get support and help with the many consequences of an HIV-positive status. The following extract typifies a common occurrence between HIV/AIDS clients and counsellors as they work to create a context where support is identified as a need and strategies framed for getting clients the support they need.

Extract 5.9

16. Co: (.) O<u>kay</u> (.3) perhaps in a while we can go back (.1) and we can talk about those things. (.3) Carry on telling me about your other problems.
17. Cl: Uhm (.) and another thing is that (.1) the only person who knows about it (.) is my boyfriend (.2) and he doesn't want me telling anyone else. (.3) and (.2) my family is

busy like saying that we should get married and someday we should get married (.) and I just don't think that it is the right step to do right now.

18. Co: Uhm (.2) you are in a situation where your family doesn't really know the pain you are going through. (.1) They are expecting you to be happy perhaps?

19. Cl: (.2) Uhm

20. Co: You are pregnant (.1) you are about to be married (.) your mother is expecting you to be joyous and happy (.1) but she doesn't know that you are HIV-positive?=

21. Cl: = No she doesn't

22. Co: She is not able to support you in anyway?

23. Cl: No. The thing is I lost my father when (.) I was fifteen years old (.) and since then my mother has been (.1) divorced from the family (.1) responsibilities. She has been hurt since then and (.2) basically there is no recovery from the loss. My older sister is just is taking care of us (.) since then (.2) basically I don't have anyone to confide to.

24. Co: (.3) You feel because your father died you don't want to tell your mum because you might burden her further.

25. Cl: Exactly=

26. Co: =mmm

27. Cl: (.3) And my boyfriend's mother keeps on phoning me because he is my boyfriend is now sick. (.2) He is having a lot of symptoms that I suspect are HIV-related. So (.2) she keeps on phoning me and asking me what's wrong with <u>him</u>. I don't know what to say to her because I'm not supposed to tell <u>her.</u> But basically I am just worried about my BABY.

28. Co: (.4) Thembi there are so many issues here. (.1) You and your boyfriend are the only two people who know about the crisis that is happening in your li_fe. (.3) There is a lot of pressures on you isn't there (.) from his mom? (.1) From your family?

29. Cl: (.5) ((there is noise from the background)) I have always wanted to have babies (.2) but I am feeling so stressed now that I don't know whether I should keep the baby or not.

30. Co: (.4) ((sigh)) I can see that you are feeling helpless. (.2) Should we talk about what the most important thing (.) to concentrate on right now is (.2) your baby (.) your pregnancy (.) and see where we should be acting and what decisions you could make around that. (.3) Is that the most important issue for you at the moment?

31. Cl: Well (.) maybe and there's a lot of things on mind right now there are a lot of things on my mind (.) that I can't think.

32. Co: mmm

33. Cl: But I do know that if we take it one step at a time maybe (.) I will come to realise the solutions to my problem.

34. Co: mmm

35. Cl: (.4) I don't believe in (.) in abortion. I know that I have always been rebellious and (.3) ever since my father died my mom has been trying to tell me to do the right things but I never ((starts crying again)) (.4) I regret them and the way I have handled my life and the way I have done things (.3) but I don't want to kill my baby.

36. Co: (.5) Thembi (.3) you feel you want to protect your mum on the one hand (.) on the other hand you don't want to confide in her because you feel you are going to disappoint her. (.3) Perhaps if you can get to disclose to your mom (.1) and have her support you (there might be a little answer for you). How do you feel about that (.2) about considering disclosing to your mum?

37. Cl: ((Cl very tearful)) .We don't really have that kind of relationship and (.2) trust that she could help me with things (.) and I am just afraid that I am burdening her more. The fact that (.) me and my older sister are now supporting her and (.) with money and a lot of other things. So if I DIE (.) ((Very tearful)) I am just wondering who is going to take care of her (.) and I can't see her suffering again (.3) it's going to be too much for her.

38. Co: (.4) It will be too much for you to (cope) by telling her ( ). (.2) So at this point and time you would prefer not to tell your mother?

39. Cl: (.3) Yea (.) but at least talk to someone that's why I am here.

40. Co: Uhm.

This extract starts off with the counsellor setting up the supportive context by inviting the client to talk about her troubles. The client admits to not having being counselled, and not having being informed of the implications of a positive diagnosis. In turn 10, where our extract starts, the counsellor checks her response and refrains from discussing the client's lack of information. Instead she invites the client to continue: "Carry on telling me about your problems" (turn 10), illustrating that through troubles talk counsellors get to fulfil their professional responsibilities (Silverman, 1997), and that listening to and helping clients with their troubles is considered important work for counsellors.

But formulations, like any other strategies employed in conversation, are not neutral and can be used for particular agenda purposes in the interaction. Garfinkel and Sacks (1970) and Heritage and Watson (1979) point out that formulations tend to "fix" meanings in conversation or to describe (according to the perspective of one of the parties) what was really meant by something. A formulation may involve the preservation of the relevant features of the previous utterance, the deletion of irrelevant portions, and the emphasis of significant points (Heritage & Watson, 1979) – hinting at the possibilities for aspects of disciplinary knowledge and power in the employment of formulations in interaction. As Brown (2003) asks, whose meaning is being fixed and publicly articulated?

The counsellor uses formulations to this effect in turns 18 and 20. From the client's assessment of her problems in turn 17, the counsellor preserves and focuses on certain features of those assessments: a client whose family doesn't know the pain she is in and who expect her to be joyous and happy, but are unaware of her HIV-positive status. She reflects on a client who is alone, in pain and not well understood by those in her environment, and hence one who is in need of support (the remainder of the extract works on getting the client support).

There is a key difference to the formulations strategy used here as compared to the one employed in the previous extract. Here the counsellor generally makes a formulation, and then tags a question on to the end of this statement. See the question tagged on to the end of this formulation:

28. Co: (.4) Thembi there are so many issues here. (.1) You and your boyfriend are the only two people who know about the crisis that is happening in your li_fe. (.3) There is a lot of pressures on you isn't there (.) from his mom? (.1) From your family?

The formulation followed by a question approach occurs five times in the above extract. In addition to turn 28 shown above, the strategy is employed in turns 18, 20, 28, 30. In discussing the previous extract, I mentioned that structurally, formulations are like adjacency pairs in conversation (Heritage & Watson, 1979) – typically, when a formulation is made, a decision is required from the other participant, and like questions they effectively engage participants in conversation. If questions typically function to achieve this effect in conversation, why would the counsellor still tag a question on to the end of a formulation?

By tagging a question on to the end, the counsellor can a) make sure that she receives an answer from the client and b) by the type of question that she tags on, she can ensure that the agenda that she is interested in pursuing is addressed by the client. The second reason points to a much more directive counsellor strategy in dealing with client troubles.

To start with, paraphrases tagged on to questions may have to do with ensuring that the counsellor gets an answer to her questions. Formulations are publicly available and recognised interpretations of what is going on in the interaction (Brown, 2003). Consequently, counsellors can use these publicly available conversational devices to reshape and define clients' troubles or perspectives and ways of dealing with them. Formulations typically result in a decision by the client. As shown in the previous extract, clients normally orient to it in this way, and either agree or disagree with it. I mentioned earlier when discussing advice that questions typically generate an answer when asked. By adding on a question to the formulation, the counsellor makes doubly sure that she gets an answer to her assessment.

As Peräkylä and Bor (1990) state, the public and social effect of a question is for the client to answer it. By using conversational devices, such as formulations and questions, counsellors make sure that particular constructions of client troubles are made public, and are responded to. In turn 18 of this extract, highlighted above, the counsellor in her assessment of the client's troubles, concludes with a tag question with what she thinks is the most important issue for the client: "There is a lot of pressure on you isn't there, from his mom? (.2) From your family?" At this time in the interview, the construction of the client as troubled and alone with her HIV status was being pursued in the talk. The tag question at the end of the formulation pursues this agenda and the client orients to it in this way.

The response to a counsellor formulation would be a client decision. This decision can take the form of a confirmation or disconfirmation, but Heritage and Watson (1979) state that there tends to be overwhelming preference for the confirmations of the formulations as presented. There are two instances in the current extract where client assessments are disconfirmed by the client (cf. turns 33 and 37).

In the first instance, the client doesn't agree with the counsellor's construction of her most important problem being her pregnancy. The client tentatively disconfirms the counsellor's assessment ("Well maybe and there's a lot of things on my mind that I can't think") but then goes on to explore this issue in the remainder of that turn. The counsellor displays a tendency to maintain a positive face and the positive self-image of both herself and the client in the way that she manages the disconfirmation.

Heritage and Watson (1979) explain that disconfirmations may jeopardize the collaborative structure of things. The client maintains the order of things by being

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tentative in her rejection of the counsellor's advice, and then by also immediately following this by constructing herself in clearly psychological terms by using the counsellor's language of coping and manageability. She follows her disconfirmation with: "But I do know that if we take it one step at a time maybe, I will come to realize the solutions to my problem". In this statement, she maintains the collaborative structure even as she tentatively voices her disagreement. She does this by aligning herself with the counsellor ("if we take this one step at a time") and uses the language of the counsellor to construct herself as a client capable of coping and managing.

Rose (1991) would comment that this ability of the client to construct herself in the language of the counsellor would be an example of the capacity of psychological language and judgments to graft themselves onto the ethical practice of individuals – i.e. the way that psychological language influences the way that clients evaluate themselves in relation to what is true or false, good or bad, permitted or forbidden. Rose (1991, 1992) says that counselling has been reconfigured in psychological terms and that to "speak the truth of one's feelings and desires, to share – the confessing subject is identified – one becomes the subject of one's own narrative, in the very act itself one is attached to the work on constructing an identity" (p. 363).

5.4   CONCLUSION

Through the use of a series of formulations, the counsellor invites an immediate context for troubles telling, where these troubles can be understood by the counsellor. These are jointly constructed by both participants and clients orientate strongly to them. Even when there are threats to the social order where clients may not agree with counsellor formulations, these are managed so that collaboration is maintained.

Miller and Silverman (1995), Rose (1991, 1992) and Silverman (1997) observe the strategies that counsellors use to construct conversation on troubles – and that construct clients and contexts where coping is done, and feelings are managed and coped with as creating particular contexts and vocabularies and theory about troubles, their social contexts, and how they are best remedied.

CHAPTER SIX

DILEMMAS OF ORIENTATION

INTRODUCTION

The previous analytical chapter focused on the information, advice and support tasks characteristic of VCT interactions, and drew on the public health and counselling frameworks that inform the interaction. In this final analytical chapter I use two advice segments to foreground the struggle that counsellors experience in implementing their tasks against the background of these two competing theoretical frameworks.

VCT has a clear public health goal. This is evident in its aims: firstly, to prevent transmission of the virus to oneself and others, and secondly, to provide psychosocial support to those infected and affected with HIV/AIDS. A core prevention outcome of HIV/AIDS counselling is behaviour change. A common feature of health care consultations involving nurses, doctors and health workers is the delivery of medical advice and information, controlled by the practitioner and intended to influence or persuade the client to change risk behaviour (Rollnick & Nick, 1992).

These public health goals are achieved through the medium of counselling. The client-centred and humanistic counselling approach popularised by Carl Rogers views the client as competent and best able to find the solutions to their problems. Within this approach counsellors are facilitators in the process and are expected to refrain from offering advice and from the temptation to put the client's life right for him (Burnard, 1992). Further, counselling is open-ended as the outcome of counselling cannot be

predicted nor can concrete goals be set – unless devised by the client at his or her request (Burnard, 1992).

The extracts in this chapter illustrate two examples of counsellors implementing their information, support and advice tasks against and through these two frameworks that shape their practice. The dilemma of orientation that counsellors experience in these extracts involves implementing VCT as a both a directive health care activity with clear prevention outcomes as well as a client-centred, non-directive activity.

6.1 STRUGGLING WITH PREFERRED OUTCOMES AND THE FREEDOM TO CHOOSE

The discursive strategies employed in this extract reflect the struggle counsellors have with this simultaneous orientation to be both directive and open-ended. In this extract, the counsellor makes his preferred recommendations on the course of action that the client should take. The advice is not in the form of an order or suggestion or request, but is offered as information. The information is not neutral, as it reveals the counsellor's advice or position on the matter under discussion. This advice is then followed up with an open-ended question that constructs the client as free to choose and act.

We join the interaction where some facts have already been established: the client has found out that she is HIV-positive, and more recently that she is also pregnant.

Extract 5.10

   35. Co: So what are you going to tell Tshepo then (.) if you do meet him

36. Cl: (.2) No I think I have to tell him I will have to tell him that he is going to be a dad (.) of which I am not sure if (.1) I am going to keep the baby or not that is one of my questions (.) whether it would be the right thing to keep the baby or not (.) because I have fears that (.) ((There is a background noise)) he will also be HIV-positive (.) and then who will take care of him?

37. Co: What do you think if you talk about (.3) abortion to Tshepo what will his reaction will be? What do you think (.) what will he say?

38. Cl: (.2) I don't think he is gonna like it. (.3) I don't think he is gonna like it.

39. Co: Okay will that be Tshepo's first child then?=

40. Cl: =yeah.

41. Co: Okay. Now why do you think he won't like it? If you tell him "lo_ok" and he knows that you are both HIV-positive (.1) and automatically the child (.) there is a possibility that when the child is born that the child might also be HIV-positive

42. Cl: mmm

43. Co: and what do you think if you tell him (.) that you will most probably have a sick child to look after. What do you think his decision will be then?

44. Cl: (.3) mmm I am not sure about that. (.2) I am not quite certain what his reaction will be.

45. Co: Okay. So (.) so what is your decision?

46. Cl: (.1) The thing is right now I can't decide anything?

47. Co: (.) So you are actually confused about it.=

48. Cl: =Uhum uhum

49. Co: (.2) Okay and and okay you know that you are HIV-positive and you are pregnant at the moment (.) expecting the child and you know that the child when he is born (.) most probably the child will also be HIV-positive.

50. Cl: Ummm

51. Co: And knowing that once the child is born you will have a lot of medical expenses with sick children. (.1) How do you feel going on with the pregnancy?

52. Cl: (.6) Knowing that if he is born I am going to have medical expenses too[

53. Co: [That's right=

54. CL: =To be responsible too

55. CL: (.6) Maybe (.1) looking at looking at it from that angle (.) abortion will be may be the the (.) anoth one option that I could take but (.3) Are all babies all babies born HIV-positive?

56. Co: (.) Uhm somewhere or another there is some babies that are not born HIV-positive. They get tested in the first few days (.) and then they are negative and then they do a tested after three months and it's still negative and then after six months or a

year then they suddenly test HIV-positive. So we can't tell (.) I can't say "look your baby will be born and it is not HIV-positive" It is actually a gamble that we take there

57. Cl: mmm

58. Co: and knowing that your child will be sick if it is HIV-positive and it might die of HIV/AIDS at the end so going through all that heartsoreness and all (.) the griefs I would say you have to think about an abortion. (.) It is your decision nobody can make that decision for you. You have to decide on your own. And like you said Tshepo knows about your status and he is also HIV-positive. So you two have to sit and discuss the thing.

59. Cl: mmm

60. CO: Right. Having any children while you are HIV-positive, because most of the pregnancies that will go through eh eh the children might be HIV-positive, might test HIV-positive. So (.) what do you think as as as a person? Do you think it will be right for an unborn child to go through all those stages or what do you think will be the best for that child? ((A phone rings))

61. Cl: (.3) Actually I am not sure I think when I get to speak to him he will maybe he will (.) come up with something that (.) you know I didn't think of or he may tell me things in a way that I didn't think of

We join the interaction in turn 36 as the client introduces her ambivalence regarding whether to keep or abort the baby now that she has discovered that she is HIV-positive. In his turn, the counsellor responds not to her struggle, but with a question regarding how she thinks her boyfriend will react to an abortion. Stepping out of the flow of the conversation to introduce a new question is an indication of the counsellor's need to insert a new agenda question or topic (Ainsworth-Vaughn, 1998).

In this case, the counsellor appears intent on pursuing how the boyfriend might respond to the abortion – and this might be an indirect way of not addressing the client's abortion ambivalence directly. In turn 37, he asks what she thinks her boyfriend's reaction to abortion is likely to be. The counsellor indicates that her boyfriend is not likely to like the idea. The counsellor changes the topic again (turn 39)

and this seems to function as a filler question, to allow him to gather his thoughts and decide on his approach to the matter.

His primary strategy in dealing with the abortion ambivalence of the client emerges from this point. His strategy (cf. turn 41) is to construct the boyfriend as the object (the person seen as the focus for feelings, thought and action) of discussion. He asks: "Okay. Now why do you think he won't like it? If you tell him "lo_ok" and he knows that you are both HIV-positive (.1) and automatically the child (.) there is a possibility that when the child is born that the child might also be HIV-positive…" By constructing the boyfriend as the object of the discussion he is able to offer his advice in the form of an argument that the client could make in support of abortion (and counter her boyfriend's resistance to the idea). In posing the question and then immediately following up with a proposed answer, the counsellor reveals his "preferred answer" to the client's abortion dilemma, but without directly owning it as his advice on the subject.

I introduced Goffman's (1967) idea of face in the previous chapter to describe the lengths to which participants go in a social situation towards protecting their own and others' self-image and that people are concerned with how others see them and manage this carefully in their interactions. The counsellor's strategy here could be viewed as a face-saving tactic on his part. By asking the question and then providing the answer to that question, he offers the advice as a solution to the client's problems. In doing so, he constructs himself as a helpful person and also by identifying with the client (they are both concerned about how to deal with the boyfriend) he hopes to reduce the chances of the client rejecting his advice. The counsellor also tries to save face by not directly addressing the client's thoughts about abortion expressed in line 36, but uses her

boyfriend's apparent resistance to abortion (introduced by the client), to put forward his own views on abortion. In doing so, he preserves the relationship and attempts to save the positive image of both the client and himself in the interaction.

There are similar discursive features to the advice sequences in turns 41, 49 and 51. In these instances the counsellor's views for a preferred course of action are made clear and then ended off with an open-ended question designed to elicit client views on the problem. In turns 49 to 51, the counsellor makes a strong argument for abortion:

49. Co: (.2) Okay and and okay you know that you are HIV-positive and you are pregnant at the moment (.) expecting the child and you know that the child when he is born (.) most probably the child will also be HIV-positive.
50. Cl: Ummm
51. Co: And knowing that once the child is born you will have a lot of medical expenses with sick children. (.1) How do you feel going on with the pregnancy?

The way that the counsellor's assessment is framed (it makes clear what course of action the client should take) nullifies the open-ended question – that implies that the client is free to choose how to act – tagged on to the end of it. The first part makes it difficult for the client to feel free to make her own decisions on this matter. This discursive move might point to the difficulties that counsellors have with being non-directive and client-focused in a context where a set of preferred outcomes is obvious to them.

This strategy indicates two things in the interaction: the first is the ambivalence that counsellors have with being directive, with telling people what to do. On the one hand the counselling framework that shapes VCT suggests that counsellors should not give advice, that they should not tell people what to do. On the other hand, VCT takes place

in the context of preferred prevention outcomes – to prevent infection and limit the spread of the disease to others. The tagging of an open-ended question at the end of a directive advice assessment might be a way for the counsellor to manage this tension, and rein in this directive side with a more open-ended question that attempts to move the conversation in a client-centred direction.

The strategy also points to the fact that advice-giving requires particular interactional work on the part of the counsellor (Vehviläinen, 2001), as discussed in the previous chapter, under the interactional task of advice. Various authors (Kinnel & Maynard, 1996; Peräkylä, 1995; Peräkylä & Silverman, 1990; Peräkylä & Silverman, 1991a; Silverman, 1994a; Silverman, 1997) in their work on HIV/AIDS counselling communication formats show that rejecting advice is an action that could potentially threaten the face (and authority) of the counsellor. In their analysis, and as illustrated here, participants organise and revise their utterances so as to manage rejections of advice in a way that preserves preference for agreement in the interaction (Silverman, 1997). Tagging an open-ended question at the end of a directive on what the client should do, may also be a way for the counsellor to attempt to manage the interactional difficulties of advice-giving.

In turns 41 and 49 to 51, the counsellor positions himself as the client's friend, concerned about her relationship and wanting the best for her. The tone is conversational and casual and is couched in the language of ordinary conversation or friendly advice. "Now why don't you think he won't like it…" (turn 41). And then, like a good friend, the counsellor provides an answer to the question she has posed, and finally, even suggests what she could say: "If you tell him "lo_ok" (turn 41). The friendly tone and construction of the friend who is concerned that the client

understands the implications of her pregnancy and HIV status is evident again in turn 49.

The friendly counsellor strategy in turn 41 does not elicit a positive response from the client, but further ambivalence. This is followed by the professional counsellor voice, which pushes the client to make a decision: "Okay. So (.) so what is your decision?" (turn 45). Following turn 45, the client displays a form of indirect resistance to the counsellor's assessment by asserting her knowledge and competency, by questioning the counsellor's position that all babies are born positive to HIV-positive women (cf. turn 55).

55. CL: (.6) Maybe (.1) looking at looking at it from that angle (.) abortion will be may be the the (.) anoth one option that I could take but (.3) Are all babies all babies born HIV-positive?

Kitzinger (2000) in commenting on the dispreferred literature in the conversation analysis field suggests that refusals to an assessment (in this case the counsellor's abortion agenda) are normatively done in certain ways: they are usually delayed, indirect and accompanied by palliatives or accounts (p179). The client's response carries several discursive features that mark it as dispreferred: there are several pauses or hesitations in her speech before she asks her challenging question at the end. In an earlier turn (46), when pressed by the counsellor to make her decision on abortion, she offers another refusal. In an attempt to alleviate the interactional fallout from the refusal she provides a reason for this, which suggests that she is simply not ready. Kitzinger (2000) observes that it is common for people to present accounts that suggest that it is not that they are choosing not to accept the invitation, it is that they cannot (they are unable rather than unwilling), and it is also common for refusals to be qualified or mitigated in some way.

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The counsellor maintains the rules of the social interaction by answering the client's challenging question, but assumes the professional, somewhat officious counsellor voice in delivering the medical and authoritative information regarding determining babies' HIV status (cf. turn 56):

56. Co: (.) Uhm somewhere or another there is some babies that are not born HIV-positive. They get tested in the first few days (.) and then they are negative and then they do a tested after three months and it's still negative and then after six or a year then they suddenly test HIV-positive. So we can't tell (.) I can't say "look your baby will be born and it is not HIV-positive" It is actually a gamble that we take there

In addition, there is a shift in footing from the authoritative "I" in earlier segments to an impersonal recommendation in the form of "we". "We" acts as an impersonal recommendation in that it allows the counsellor to draw on the membership categorisation of counsellor and allow the counsellor to be heard as speaking in their organisational capacity (Kinnell & Maynard, 1996; Silverman, 1997). The friendly counsellor is replaced by the professional counsellor who cannot tell, and who actually takes a gamble with patients like her who are undecided about what to do. The effect of such an impersonal recommendation is to distance the speaker from the very advice that he is giving. Situated in the counsellor's response to the client's show of knowledge and competency about mother-to-child transmission, the impersonal counsellor voice reporting on the risks of HIV transmission from mother to child functions by allowing ambiguity in what is being said (Silverman, 1997).

In the same turn, the counsellor also upgrades his abortion advice. In an earlier turn he had softened his advice from "automatically" to "there is a possibility that….you will

most probably have a sick child to look after". This advice is now upgraded to: "…most probably the child will be HIV-positive."

In his lengthy explanation that follows (turn 58) he acknowledges that there is a chance that the baby may test negative. In this extract as with the two previous advice strategies that have been discussed, the moral stakes are upped and the advice is framed in distinctly moral terms. The counsellor has just acknowledged that there is a chance that the child may be negative. He says:

58. Co: and knowing that your child will be sick if it is HIV-positive and it might die of HIV/AIDS at the end so going through all that heartsoreness and all (.) the griefs I would say you have to think about an abortion. (.) It is your decision nobody can make that decision for you. You have to decide on your own. And like you said Tshepo knows about your status and he is also HIV-positive. So you two have to sit and discuss the thing.

This is the first time that he directly states his advice on the matter ("I would say that you have to think about having an abortion…"), and he immediately displays his discomfort with being so direct by following that statement with: "I would say you have to think about an abortion. It is your decision nobody can make that decision for you. You have to decide on your own" (turn 49). In the remainder of that extract he suggests that she and her boyfriend need to sit down and discuss the matter: their HIV status and what to do about the pregnancy. This statement reflects the open-ended, client-driven nature of the counselling approach. Again the struggle and tension between the two orientations is revealed. This statement is followed by a directive, closed-ended question that once again ups the moral stakes in the interaction:

60. CO: Right. Having any children while you are HIV-positive, because most of the pregnancies that will go through eh eh the children might be HIV-positive, might test HIV-positive. So (.) what do you think as as as a person? Do you think it will be right for an unborn child to go through all those stages or what do you think will be the best for that child?

6.1.1   Conclusion

The counsellor showed great difficulty in operating from a supportive, counselling position and strong investment in an advice position. When confronted with resistance from the client, he backs down to an "it's your choice position" in an attempt to construct his advice as a suggestion and the client as being free to choose and make her own decisions on the matter.

As the session proceeds and as a way of dealing with client resistance, he ups the moral stakes of his advice. Like others in the extracts before this, the context in which HIV risk and behaviour change are discussed is a distinctly moral one. Evoking a moral context to deal with behaviour change, routinely and regularly appears when all other attempts seemed to have failed.

6.2   BALANCING   PREFERRED   OUTCOMES   WITH   CLIENT-CENTRED   SKILLS

This next extract differs from the other advice sequences in this dataset in a number of ways. First, I have illustrated throughout that VCT takes place in a moral context that both participants orient to. Second, in all three of the previous strategies counsellors upped the moral stakes or upgraded their advice by framing it in moralistic terms. This seems to be a fallback position for dealing with the difficulties of changing client sexual

behaviour. In this case, the context (sexual risk behaviour) and the task (behaviour change and uptake of advice) is the same as in the previous extracts discussed. What are different are the strategies that the counsellor employs to negotiate the moral terrain of another person's sexual behaviour.

Third, in this extract the counsellor seems more conscious that she carries these two sets of responsibilities: that she has a set of preferred outcomes, but that this needs to be done against a client-centred background that encourages the client and gets him to reflect and consider what these preferred outcomes will mean for him. The overall task of VCT is to get clients to consider their risk for HIV and the responsibilities that this brings up for themselves and others. The question is how do counsellors do this? The following extract seems to suggest a way forward.

Extract 5.11

61. Co: Um (.) in terms of what you mentioned in terms of your girlfriends. Eh are you sexually active with your girlfriends?

62. Cl: Yes yes

63. Co: Do you practice safer sex?

64. Cl: You mean using [condoms?

65. Co: [Using condoms=

66. Cl: =No I actually never used a condom before (.) and it never came to my mind that I should use a condom. I always have girlfriends that are coming from straight (.) strict families and they do not have the opportunities of going out and and sleeping around.

67. Co: Uhm

68. Cl: Up until this (last) incident of my ex girlfriend's status

69. Co: (.2) So you feel that you have no reason to fear that they might be infected?

70. Cl: Yes (.) no I had no reason to fear about the about the chances of them being unfaithful

71. Co: Okay um (.) Sipho the reason I ask about safer sex is that now that you know you are HIV-positive (.) firstly you would want um to prevent other people from becoming infected (.) which means that if you have sex it is important that you use a condom.

But secondly (.) um I don't know if you know that even if you are HIV-positive you can still become re-infected if you have unprotected sex with an infected person. So in order to protect your own health. You didn't know that? In order to protect your own health it is important that you use a condom as well. So both for your health's sake and for the health of your partners it is very important (.) to practise safer sex.

72. Cl: Okay (.) I understand

73. Co: Okay the second thing that I need to discuss with you I said to you a little bit earlier that there is no need to tell anybody now. Eh there is an exception to that eh in that it is very important that you do tell your partners (.2) your sexual partners (.) How do you feel about that?

74. Cl: (.2) It is going to be very difficult to tell my sexual partners. As I said there is two (.) three of them (.2) I mean I am sure you can also understand

75. Co: Yes

76. Cl: the feeling that they are going to think that I infected them. Which will be equal to I have killed them because (people hear that when you are HIV then you are going to die soon). So

77. Co: Uhm

78. Cl: That's what I am afraid of what they might do. I will never know how they might react too (.) but definitely I am going to be accused. Maybe they can even go to an extent of I don't know (.) maybe I am (.)

79. Co: Yes. (.1) It is very frightening to think of what might happen (.) if you tell people and they don't keep that information to themselves. And I am sure that just hearing the news that you are HIV-positive yesterday and me now telling you that you need to inform your sexual partners that that must be very difficult for you?=

80. Cl: =Yes no it is quite tough. I think maybe (.) I don't know I think eventually maybe I will have to tell them.

81. Co: Uhum

82. Cl: But I am afraid because when I start using a condom they are obviously ask me why I am using a condom now when you have been sleeping without a condom. So maybe I will have to tell them eventually. I'll see.

83. Co: Okay. If you start to use a condom now and your girlfriends ask you why (.) um obviously you don't feel that you are ready to tell them at the moment that you are HIV [positive

84. Cl: [yes=

85. Co: =So what do you think you are going to tell them?

86. Cl: I don't know actually I will have to think because (.) I think it is going to be easier because each of them knows that I have got others too.

87. Co: Uhm
88. Cl: So it is easy to say that "it is for your safety because I have got those other people but I think it is going to be easy.
89. Co: okay=
90. Cl:=yes

The interaction starts in turn 61 with a series of closed-ended, direct questions about the client's condom use. The questions are framed in a factual, straightforward way (see turns 61, 63) requiring a "yes" or "no" response from the client. The simple repeat and clarification of the client's words in turn 65, leads to a detailed client explanation for his lack of condom use with his partners (turn 66). The client frames his own assessment of his behaviour in clearly moral terms by implying that he only sleeps with *good girls*. "… I always have girlfriends that are coming from straight (.) strict families and they do not have the opportunities of going out and and sleeping around", he explains in his turn.

In response to the client's explanation for his behaviour the counsellor does not offer an assessment of her own (a possible judgement of his/her behaviour or situation). Instead she uses a reflective statement that remains neutral, but goes straight to the heart of the client's risk: "So, you feel that you have no right to fear that they might be infected"), which the client agrees with in his turn (turn 68). Following Silverman (1997), empathy and reflection are understood in this counselling context not as the psychological ability of the counsellor to tune in to the private meanings of the client, but more as the social ability to pick up on the behavioural cues present in what the client is saying and doing.

The counsellor acknowledges this response but doesn't challenge the client's view that he feels safe because his girlfriends are of a particular social standing. Instead, she shifts direction and offers the client an explanation for her enquiry regarding his sexual practices and behaviour in the preceding turns. In doing so, she makes explicit the routineness of talk about sexual behaviour that characterises much of HIV/AIDS counselling. While talk about sexual matters might be a routine task for counsellors, it is not something that clients might expect when they go for an HIV test.

The counsellor's discursive accomplishments in turn 71 make explicit that she has a clear prevention agenda, and she is unapologetic about stating this. First, in a display of her professional authority she offers an explanation for the routineness of talk about sexual matters. Second, she makes clear what she thinks the client's responsibilities to himself and to others are now that he is infected: "… now that you know you are HIV-positive (.) firstly you would want um to prevent other people from becoming infected (.) which means that if you have sex it is important that you use a condom. But secondly (.) um I don't know if you know that even if you are HIV-positive you can still become reinfected if you have unprotected sex with an infected person…" Lastly, she operates from the safety of her authoritative, expert position in the explanations for why he should use condoms: to avoid reinfection and to protect his own and his partners' health. The information is offered as neutrally as possible and the delivery seeks to appeal to a reasonable, responsible adult who will do the right thing. In sum, she takes control and takes charge of the awkward and difficult task of talking about dreaded issues of sexual intimacy and risk. Silverman (1997) acknowledges that all HIV/AIDS counselling involves talking about sex, illness and death – introducing such awkward and dreaded topics which are usually avoided and tentatively approached seems to be easier if the counsellor is firmly in control.

At the end of this segment, she adds to her clear prevention agenda with the following statement:

71. So in order to protect own health. You didn't know that? In order to protect your own health it is important that you use a condom as well. So both for your health's sake and for the health of your partners it is very important (.) to practise safer sex.

Coming as it does against the backdrop of the various discursive strategies she has employed thus far, the advice comes across as reasonable and achievable and is oriented to as such by the client, who responds with: "OK (.) I understand"(turn 70).

In her next turn (cf. turn 73) the counsellor upgrades her earlier advice. She admits that there is an exception to client autonomy when it comes to one's sexual partners:

73. Co: Okay the second thing that I need to discuss with you I said to you a little bit earlier that there is no need to tell anybody now. Eh there is an exception to that eh in that it is very important that you do tell your partners (.2) your sexual partners (.) How do you feel about that?

Disclosure is a difficult topic for most counsellors to deal with. She is clear about her position on disclosure and this is stated in an unambiguous way for the client. In his response the client admits that it is going to be difficult, and appeals to her understanding of his predicament: "I mean I am sure you can also understand". This seems to be an appeal for understanding from the counsellor.

She uses another reflective statement (turn 76) to acknowledge that what she is asking (to disclose to sexual partners) is difficult. This allows the client to expand on the difficulties he anticipates in disclosing to his sexual partners. In the closing parts of this

extract (turns 74-80), there is a shift from the client's earlier stance that he has no HIV risk from his sexual partners. Turn 66: "=No I actually never used a condom before (.) and it never came to my mind that I should use a condom. I always have girlfriends that are coming from straight (.) strict families and they do not have the opportunities of going out and and sleeping around".

Through a series of turns, the client eventually constructs himself as capable of doing the right thing by disclosing to his partners. In framing his intentions to act (turn 78) he uses the counsellor's earlier words about doing the right thing for his own sake and the sake of others in his life. Silverman (1997) suggests that the most powerful indication of client uptake of advice is when clients use counsellors' words to frame their actions:

85. Co: =So what do you think you are going to tell them?
86. Cl: I don't know actually I will have to think because (.) I think it is going to be easier because each of them knows that I have got others too.
87. Co: Uhm
88. Cl: So it is easy to say that "it is for your safety because I have got those other people but I think it is going to be easy.
89. Co: okay=
90. Cl:=yes

The counsellor has been directive – and deliberately so – in dealing with the client's responsibilities to himself and to others now that he is infected with HIV. She has balanced her preferred prevention outcome agenda with some client-centred skills. She effectively used reflective statements at various points in the extract (65, 69, 79, 83). By repeating words, phrases or sentences of the client's (and commenting on behavioural and social cues she was observing) she provides a resource to keep the conversation going, and to communicate. The aim of a formulation is to establish a collaborative and jointly accepted statement of what is being talked about, to demonstrate understanding

and to have that understanding attended to and endorsed (Brown, 2003). The talk itself is a show of involvement and willingness to interact and gives evidence of the counsellor's own participation (Tannen, 1994), and interactionally, this allows her to advance her prevention agenda.

6.2.1   Conclusion

This case has shown a much more client-oriented approach to advice-giving. Through the deployment of a number of strategies the counsellor has created an interaction that could be characterised as one of engagement and self-reflection, where the client is able to explore his moral obligations to himself and others, with helpful prodding by the counsellor. Through reflective statements, and the use of probing questions towards the end, the client is able to formulate his own advice, and the counsellor is able to draw on the client's views, feelings and concerns which are critical to the uptake of any change in behaviour.

The discursive strategies used in this extract result in an interaction that feels less like a moral judgement as was constructed in some of the earlier extracts, and more like one where responsibilities and rights in the context of HIV/AIDS can be considered, discussed and achieved.

CHAPTER SEVEN

DISCUSSION

INTRODUCTION

The aim of the study was to provide a detailed description of how the interactional tasks of VCT are achieved, and how these tasks are achieved against the backdrop of the theoretical frameworks that shape counselling practice. More specifically, I wanted to explore how clients and counsellors work towards the completion of the interactional tasks of information, support and advice. Informed by social constructionism and drawing on various tools from ethnomethodology and conversation analysis as methods of enquiry, I analysed a sample of client counselling interactions in South Africa, with this aim in mind. My intention in grounding this study in EM and CA was to adopt an "ethnomethodological distance" (Peräkylä & Vehviläinen, 2003) in describing practitioners' unfolding actions in counselling practice – and to see what new or different insights might emerge regarding VCT practice from my normative accounts of what counselling should and ought to be.

In keeping with the requirements of the methodology, the analysis chapter has developed a descriptive, inductive account of "how" the interactional tasks of VCT are managed by interactants. In this discussion chapter, in reflecting on the research questions that framed this study and the subsequent results discussed in Chapters Five and Six, I'd like to move beyond the "hows" of the interaction to offer some explanations for the findings that emerge. I would like to revisit some of the key debates and literature on VCT in the light of the picture of VCT practice that emerged

from this study. In particular, I would like to consider what implications and consequences these issues might have for counselling policy and practice in South Africa in the final concluding chapter of this thesis.

I discuss the findings and the implications for each of the interactional tasks of VCT first, and then move on to more general considerations of how counsellors are able to achieve the goals of the interaction against the backdrop of the two competing constructions of VCT as both a public health intervention and a counselling encounter.

7.1   THE ROLE OF INFORMATION-GIVING IN VOLUNTARY COUNSELLING AND TESTING

Previous studies, locally and elsewhere, which explored HIV counsellor perceptions of their role, showed that counsellors use primarily a prescriptive, didactic and disease-centred approach in their work, with strong applications of information-giving (and advice) aimed at patient compliance and behaviour change (Buskens & Jaffe, 2008; Delaney, 2002; Fawcett, 2001; Richter et al., 1999, Stein et al., 1997). These findings reflect the normative health promotion view on the role of information and advice – i.e. that these activities are used in the interests of client compliance and behaviour change in the context of HIV/AIDS counselling.

Previous studies that have focused on counsellors' perceptions of their role have indicated that counsellors identify strongly with their information-giving role and feel most proficient when giving advice and making clients see things (Fawcett, 2001; Nulty & Edwards, 2005). Similarly, Silverman (1997), using a more discursive approach to analyse HIV/AIDS counselling, confirms that interactively, information-giving acts as a

"home base" around which much of the activity in the session revolves. In keeping with these studies, this study confirmed the centrality of information-giving relative to the other interactional tasks of VCT such as advice-giving and support.

By adopting a more discursive analytical approach and by analysing VCT in its natural environment through simulated client, videotaped counselling sessions, this study was able to move beyond reports of the importance of information-giving in the context of VCT to describe in detail how these informational contexts are created in practice. Significantly, this study was able to provide additional and useful insights regarding the functions of information-giving within the context of HIV/AIDS counselling, and to show in detail the impact that these functions have on emerging constructions of each other, and on the unfolding interaction.

The data on the role of information-giving in the context of HIV/AIDS added new perspectives on the role of information-giving in the context of counselling people at risk for HIV or those who have AIDS. The long-held view is that information alone does not contribute to behaviour change (Rollnick & Nick, 1992). In the contexts explored, information-giving was constructed not so much as a tool to fashion patient compliance in the service of behaviour change, but it acted as a powerful mechanism through which a range of interpersonal tasks could be achieved.

This study showed that the giving and receiving of information was constructed by both participants as a critical component of VCT and was intimately connected to both client and counsellor identities. Like several other CA studies (Peräkylä, 1995; Peräkylä and Silverman 1991a; Silverman, 1990; Silverman, 1994a; Silverman, 1997) these South African transcripts revealed a similar uniformity and structure to information formats –

i.e. participants oriented to certain norms that govern information-giving: the counsellor provides authoritative information about HIV/AIDS through the delivery of statements, with the client assuming a more passive role in the interaction.

The centrality of the information-giving role for VCT was also evidenced in the way that participants created informational contexts under a range of conditions: it was the immediate and most natural response to a client's request for help; it was provided when clients did not ask for it or appear to want it; it was repeated when there appeared to be no need for it; and it was offered in an attempt to ease client troubles. Given the variety and diverse range of informational contexts that were constructed in these client-counsellor exchanges, it appeared that information-giving was important and valued in and of itself, for itself, irrespective of the immediate conditions that surround it and that may justify its meaning and importance in the interaction.

7.1.1   Functions of information-giving

The answer to understanding the centrality of information-giving in VCT can be found in the broader contexts that shape HIV test counselling. In the face of an overwhelming, devastating and compelling disease such as HIV/AIDS, where a cure and effective technologies to prevent the virus continue to elude us, where treatment is increasingly available in these contexts but not easily accessed, information-giving enables counsellors to *do something*. The role of information-giving as a pivotal tool in the prevention response to HIV/AIDS is best captured in the words of the counsellor in Extract 5.6 who explains that she does not "have help that I can give you (.) but I will just give you the information that I have". The informational strategies used by counsellors suggest that they believe that the specialised, technical information they

impart to clients may be an important tool at their disposal in their response to the epidemic, and working in the contexts that they do. Counsellors, although trained to do what they do, show in these extracts that they are people too. As suggested by ethnomethodology, counsellors have a range of resources at their disposal that help them manage the clients and the interactions that they encounter. This data suggests that both in their professional roles and as ordinary members of society, counsellors draw on information-giving as an interactional resource in the context of a disease that threatens to overwhelm us.

In the broader context of the disease, information-giving assumes an additional interactional function for both participants. The data showed that beyond a possible (but limited role) in trying to use information to educate and inform people about HIV and risk (and hopefully change their behaviour) information-giving was constructed as a powerful tool through which hope could be dispensed by counsellors and received by clients.

Typically, information exchanges and advice-giving tend to be linked to behavioural and medical interventions, and are not normally considered a part of counselling activities or encounters (Rollnick & Nick, 1992). Considering some of the hope-giving functions of information, it is ironic that an activity – such as information – normatively defined as "bad counselling" (Burnard, 1992) is used by counsellors to construct hope and to alleviate client distress. Attempting to provide hope to clients through normalizing the client's situation appeared to be a common feature of AIDS counselling talk in this study (and appears in both advice and support talk too). As in other contexts where people work with chronic conditions, (Hunt, 1989 in Li & Arber, 2006), and in the context of an overwhelming and devastating disease such as AIDS,

the production of ordinariness and normality may help to create control in a context that feels overwhelming and out of control. The analysis suggests that information, advice and support are all constructed as ways of creating hope and normality for clients.

Linked to the "*doing something*" function of information-giving, the findings suggest that the way that information is dispensed, (in a rote fashion, with the counsellor in an expert position, dispensing technical, authoritative and medical information) acts as a resource for both participants in the interaction. In sum, the information-delivery mode serves to help counsellors keep things certain and controllable when dealing with client uncertainty and emotional distress in the context of HIV/AIDS. For the client, the passive role afforded them in this format keeps them safe from the interpersonal difficulties of HIV/AIDS and risk. In this sense, information-giving is as much a counsellor mode of coping with HIV as an attempt to empower clients – it offers both participants a respite from the emotionally demanding tasks associated with HIV/AIDS counselling.

While these two functions operate in the interests of client issues and concerns, information-giving plays an important role in helping counsellors too. Previous South African studies (Fawcett, 2001; Nulty & Edwards, 2005) have described that counsellors felt a greater sense of control when they were in the factual or information-delivery mode and generally found it more difficult when dealing with client emotions. This study confirmed these observations and showed the interactional difficulties counsellors faced when dealing with client distress and emotionally charged talk. Further, information-giving formats afford counsellors a knowledgeable and expert identity, and for these reasons counsellors may place a greater premium on it, than the

advice and support aspects of their role. The fact that counsellors turn to information-giving as a first response to client needs and requests, may also say something about the levels of competency they feel doing this as compared to the sense of their competencies in their advice and support roles. Clients appear to pick up on this and do what they can to keep information formats going – and counsellors comfortable in their knowledgeable and expert identities.

7.2   SUPPORT GOALS AND FUNCTIONS

The support goals of VCT are mostly linked to the counsellors' ability to improve personal coping in clients by helping them gain emotional and social support, including facilitating disclosure to significant others (Baggeley, 1997; Lie & Biswalo, 1994, 1996). This study was able to develop a detailed account of how counsellors worked to achieve these support outcomes.

7.2.1   Coping and manageability

Many writers suggest that HIV/AIDS counselling has an important role to play in helping clients accept and cope better with their HIV status (Campbell & Rader, 1995; UNAIDS, 2001). In this study a key institutional discourse was constructed around manageability and coping with HIV disease. This construction is a collaborative process involving participants drawing on a range of reflective tools to create a particular social reality where client troubles (their feelings and fears) are discussed, managed and "coped with' (Miller & Silverman, 1995; Silverman, 1997). "Coping" appeared to be narrowly defined in these extracts – along the lines of "an acceptance of being HIV-positive and having a positive attitude towards making the most of each day" (p. 38).

The results show that the discursive tools employed by counsellors work in several ways: to translate the general sense of despair relating to clients' discovery of an HIV-positive diagnosis into more concrete and manageable terms. This finding echoes what Hunt (1989, in Li & Arber, 2006) showed in looking at how symptom-control nurses dealt with emotionally distressing situations. That study showed that nurses relied on the biomedical format (similar to the information-giving format) and the psychological format (similar to the support format) as a primary method of coping with uncertainty and emotionally laden conditions such as pain and other distressing symptoms.

Doing emotion work may serve particular interactional goals. Through turns of emotion talk in this extract, a troubled client is constructed. But, also through doing this emotion work and by making this available for public consumption, another version of the client is constructed: one who is reflective, who is in touch with, and able to articulate and work through their experiences – one who is eminently psychologically credible.

Through the use of step-by-step formulations that emphasise feelings and coping, a construction of clients' troubles, fears and feelings as manageable and within the coping capacities of the client is also created. As the implementer of such tools, that are able to achieve this interactional effect, emotion work allows counsellors to construct themselves as competent and "caring" individuals (Li & Arber, 2006) operating within a medical mode.

Finally, HIV/AIDS evokes fundamental existential anxieties about life and death – and these have to be managed in the interaction by participants. Given the overwhelming nature of the anxieties, for which counsellors are not adequately prepared, it seems as if

these anxieties are medicalised by counsellors in the interaction – with clear medical advice and injunctions to cope better, to manage and to be in control. As with information-giving, this support and coping talk may also function in the context of creating greater order, manageability and control over a virus and a process, over which participants may feel the reverse. The coping and manageability talk evident in both the information-giving and support modes of counselling in this study may work in similar ways to the "positive talk" examined by Wilkinson (2000) and Wilkinson and Kitzinger (2000) in their work with women with breast cancer.   Talk about coping and manageability may well be a device that helps participants deal with the difficult interactional tasks of dealing with clients' distress and troubles, such that issues become easier for listeners to deal with, rather than a potential conversational burden (Wilkinson, 2000).

7.3   THE ROLE OF ADVICE IN THE CONTEXT OF VOLUNTARY COUNSELLING AND TESTING

This study showed that through the interactional tasks of information and support, counsellors are able to assist clients with both the practical and psychosocial problems that they may be experiencing. But in addition to these supportive goals, counsellors have to meet the public health goals of the intervention by getting clients to consider and address any risk behaviours for HIV/AIDS, and the implications this may have for others in their lives.

Carballo and Miller (1989) summarise the complexities of this task when they suggest that: "… we need a type of psychosocial counselling that complements HIV prevention and risk reduction, that not only encourages individual action and responsibility but,

more importantly, one that allows individuals to assess the feasibility of that behaviour and the implications for lifestyle and social relations" (p. 118). While this is a goal of the whole VCT encounter, the interactional task of advice – which involves imparting authoritative information, explanation, guidance, and clarification of options – is the point in the interaction when these risk-reduction goals are most evident (Sketchley, 1989 in Burnard, 1992).

7.3.1   The interactional complexity of advice-giving in HIV/AIDS counselling

This research showed that as an interactional activity, advice-giving (as compared to information-giving and support) is much more demanding for both participants. This is a complicated task in the context of AIDS counselling for several reasons. The first is because VCT involves talking about and finding solutions to difficult topics – existential anxieties about sex, illness, sickness and dying – all topics that are difficult to address in ordinary conversations (Irinoye, 1994; Peräkylä & Silverman, 1991b; Silverman & Peräkylä, 1990). A key task for counsellors is to find ways of getting clients to address these difficult topics in the context of advice on these matters.

Secondly, advice-giving taps into the awkward terrain of the counsellors' normative views of the clients' behaviour. Alasuutari (1995) defines these normative views as expressing an opinion on how someone should go about doing something, or someone reprimanding someone else or urging someone else to do something. Counsellors have to manage their normative views at the same time as they have to manage the clients' behaviour – the data showed that some strategies were more effective than others in helping counsellors achieve this balance, and that invariably in managing this task, counsellors upgraded their advice and framed it in distinctly moral terms.

And thirdly, counsellors have to manage this interactional task against the backdrop of two competing theoretical frameworks on the role of advice-giving in the encounter. Wood (1994) captures this tension on advice, when from the perspective of a counselling profession he suggests that: "The moment the counsellor becomes a directive educator, a person who instructs the client for the good of society, or according to their own judgements of what constitutes normative and responsible behaviour, then the premise of therapeutic intervention is lost" (p. 12). Rollnick, Mason, & Butler (1999) take a different stance to this from a health consultation point of view and suggest that talk about behaviour change is governed by personal values on both sides and these "revolve around one's desirability of controlling one's health and a vision of what a good life is" (p. 36). In the midst of these two competing discourses on advice, how do counsellors manage the complexities of this interactional task?

7.3.2   Establishing what works when giving advice

The data from this study showed that counsellors draw on a range of discursive tools to helps clients consider their behaviour. These are employed with varying levels of success with respect to client uptake of behaviours, and range from those strategies that construct the counsellors as the one responsible for behaviour change to those that place the responsibility for change directly on the client. A number of the advice sequences attempted to draw on the authority vested in the counsellor as a way of influencing behaviour change in the client. This strategy worked in one instance and not in another. As other studies employing conversation analysis have shown, the effectiveness of the advice strategy depends on the context in which it occurs (Heritage & Sefi 1992; Peräkylä, 1995; Silverman, 1995; Silverman, 1997). As shown in this study, in the "managing client responsibility" strategy in Chapter Five, the client's

circumstances and views on the advice had already been engaged when the counsellor gave her opinion on what the client should do. This kind of approach is likely to yield a better uptake of counsellor advice (Silverman, 1997).

In the "rules for living strategy" in Chapter Six, the advice segment is constructed as information and the client treats it as information and does not engage with it further as it is set up as an information exchange. Within this mode, there is very little engagement with the client's views on behaviour change. The counsellor strategy appears to rest on the view that through the strength of her authority and position as a moral guide she will influence the client to change. But these strategies are not particularly effective in that insufficient responsibility is placed on the client as a social actor who is negotiating HIV risks with him/herself and others. As Keeling (1993) observes, "not only do people not do what they know; they do not necessarily do what they are told; they do not necessarily trust the 'authorities' who provide the instructions and suggestions, and they notice not only the intended content, but also the conflict and confusion in what they see and hear" (p. 307). As others have shown, for advice-giving to be effective, counsellors need to find a way of contextualising the advice, and drawing on the clients' issues and concerns in framing that advice (Heritage & Sefi, 1992; Pospikarta et al., 2000; Silverman, 1997).

7.3.3   Placing moral responsibility for action on the client

As discussed at the start of this section, counsellors have to get clients to reflect on, talk about and act on aspects of their lives not normally subjected to public scrutiny in this kind of way. Questions were successfully employed by counsellors in producing talk on these difficult topics (Peräkylä & Silverman, 1991b). In addition, this study was able to

demonstrate how questions create a moral obligation for the recipient to provide an answer in that one of the basic social rules of conversation is to answer when asked a question (Peräkylä & Bor, 1991). In addition to using questions to ask clients to account for their situation, the nature of the "are you willing" strategy discussed in Chapter Five required both an answer and an account or explanation from the client that constructed the client, and the interaction, in a distinctly moral way.

As discussed in Chapter Five, explanations or accounts for why the client may be willing or unwilling to disclose their status to sexual partners or to use condoms come with connotations of blame in that clients have to offer an explanation for their conduct and account for themselves as a moral beings as they respond to the counsellors' questions (Turnbull, 1992). Silverman (1997) suggests that the actual question – "are you willing" – constructs clients in a particularly moral way and makes them accountable for their behaviour and social action. In this way the strategy works to place the onus for responsibility squarely on the client.

7.3.3.1 Upping the moral stakes

In all the advice extracts, in trying to find ways of getting clients to change their behaviour, counsellors tended to up the moral stakes or upgraded their advice by framing it in moral terms. As Rollnick et al. (1999) comment, advice-giving is not easily done, and its path is delicately steered in the interaction. Often in response to low client uptake or resistance to particular advice from the counsellor, counsellors tended to upgrade their advice in distinctly moral terms. Framing advice in these moral terms seemed to be a fallback position that most counsellors retreated to in the context of AIDS counselling.

Delaney (2002) identified certain "trigger points" that forced the client out of a client-centred mode into a more prescriptive mode of counselling. Contextual triggers were described as those in which there was the potential for harm to self and others, as well as disclosure situations. Taylor (1994) also referred to the moral imperatives of the disease as being those where the counsellor becomes aware that his client is having unsafe sex or has knowingly infected another person. Taylor framed this quite strongly when he said that: "This behaviour amounts to attempted murder and the client should be left in no doubt as to the legal implications of his or her actions" (1994, p. 6).

These writers suggest that HIV/AIDS counselling is constructed as a particularly moral activity in which the task of the counsellor is to help the client consider how best to conduct themselves as moral beings and to consider how their actions place them and others at risk. A critical task of counselling is to help clients both admit these risks and consider actions that would act in their best interests as well as show their responsibilities to others they are in relationships with. While the training of counsellors would ask that they be non-judgmental and remain neutral, this study shows that it is difficult for counsellors to do so under these emotive and trigger-filled circumstances – and they are also not adequately trained to deal with this anxiety. In all instances when the advice was upgraded in moral terms, it was in relation to the triggers mentioned by Delaney (2002): the potential for harm to self and to others directly, or indirectly in the case of disclosure to others. She argues that VCT is a highly emotive issue involving a degree of preferred outcomes that lend an urgency and strong moral overtones to the encounter – these act as triggers and force the client out of a more client-centred mode into a directive mode of counselling.

In some instances the moral upgrade had a positive effect on the interaction; but in others it did not. In the "rules for living" strategy in Chapter Five where the counsellor referred to the client doing all these "terrible" things ("… you enjoy yourself, you drink, you freak outside, you take people you are dating to satisfy yourself…"), she implied that the client must accept the responsibilities that come with such behaviour. In this context, upping the moral stakes had little effect on behaviour change. Similarly, upgrading the advice by framing it in moral terms in the "struggling with preferred outcomes and being free to choose" strategy in Chapter Six, also had a minimal effect on the client's uptake of the advice.

However, in the appeals strategy also in Chapter Five, upgrading the moral stakes of the advice seemed to work. The key issue in determining client advice uptake is the contextualisation of the advice and moral talk, and the extent to which the client's concerns and issues are being recognised and included in the advice formulation. As shown in the strategies where advice seems to be delivered as information, even when the moral stakes are increased, it has little effect on the uptake of the advice in the interaction, as not enough contextual framing of the advice occurs for it to be meaningful to the client.

7.3.4   Balancing rights with responsibilities

In the first section of the literature review I described that a key debate that frames HIV/AIDS counselling is between the rights of the individual and his or her responsibilities to others. Dixon-Mueller (2007) argues that individuals need to find some kind of balance between individual sexual rights and social responsibilities (i.e., not to do harm, to inform others of your status) in the context of HIV/AIDS. This

study showed that this is not a debate in abstract, but is situated at the very heart of VCT practice; clients and counsellors alike struggle with this issue. The analysis of the second case in the Chapter 6 showed that while for the most part in the dataset, counsellors struggled with working under dual and competing public health and counselling frameworks, it is possible for counsellors to find a way of effectively addressing this issue in the interaction.

What stood out about the "balancing preferred outcomes with client centred skills" in Chapter Six is that the counsellor was clear and quite directive about her preferred outcomes (in this instance, disclosure) and communicated this to the client. But, these counsellor–preferred outcomes were complemented with a range of client-centred skills that acted as a resource in the interaction and served to keep the conversation moving forward. Through the deployment of these discursive tools the counsellor created an interaction that could be characterised as one of engagement and self-reflection where the client was able to explore his moral obligations to himself and others, and to discover suitable ways of dealing with these issues.

Motivational interviewing (MI) developed by Miller and Rollnick (2002) in the addictions field, has successfully combined a directive encounter with more client-centred skills. Motivational interviewing advocates for a structured intervention that provides clients with a clear sense of direction on certain behavioural outcomes – but these are balanced with certain client-centred skills such as empathy and reflection. Informed by motivational interviewing, several groups have developed brief HIV-prevention counselling interactions consisting of two 20-minute sessions (Rietmeijer, 2007). The intervention is structured around HIV risk and risk reduction. The model is client centred in that the client is actively engaged in the intervention and the

development of the risk-reduction plans through the use of various skills such as open-ended questions, role plays, alternative listening and non-judgmental and supportive approaches.

This two-session HIV-prevention counselling model with a strong risk reduction focus (the risk-reduction model) has been evaluated extensively in several international and developing contexts, and found to be acceptable to clients and counsellors and feasible for use in busy public clinic settings (Kamb et al., 1998; Metcalf et al., 2005; The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000;). Predominant counselling models in Africa (such as the Egan Model in South Africa and The AIDS Support Organization [TASO] Model from Uganda) are not as specifically structured to achieve behaviour change as the risk reduction model. There have been some efforts to train national, provincial, district and local service providers in South Africa in the prevention counselling model, including in research trials, but there is as yet no widespread implementation.

AIDS is primarily a relational disease, one involving relationships with others, and impacting these very relationships. Yet as Dixon-Muller (2007) suggests, people find it easier to think of individual rights than social responsibilities. As discussed in the literature review, the individual rights perspective has been fuelled by a human rights discourse that has framed HIV/AIDS and counselling since its inception. Feltham (1995) suggests that the disciplines of counselling and psychotherapy may have also contributed to this situation. He suggests that counselling may have "inadvertently exaggerated the merits and extent of autonomy, of individual freedom and choice, overlooking the question of moral responsibility and obligation to others" (Feltham, 1995, p.131). HIV/AIDS counselling requires individuals to address this fine balance

between individual rights and responsibilities and social responsibilities. The data suggests that VCT struggles to achieve this balance partly because VCT has a dual identity – it needs to be both client-centred as well as operate as a public health intervention with a set of preferred outcomes.

7.4 COMBINING THE PUBLIC HEALTH AND COUNSELLING APPROACHES

I have argued in the literature review that the two constructions of VCT – as a public health activity and a counselling activity – create a dilemma of simultaneous orientation for counsellors (Vehviläinen, 2001). The dilemma results in practical difficulties for counsellors who have to find a way of implementing one approach which privileges client experience and perspectives, and is more open-ended in terms of its outcomes, and the other which values the authority of the professional perspective, is directive and informed by preferred public health outcomes. This was confirmed by the analysis discussed in Chapter Six.

Several studies in South Africa and elsewhere show that in practice practitioners tend to adopt a predominantly directive, prescriptive and health advising approach to counselling (Buskens & Jaffe, 2008; Richter et al., 1999; Stein et al., 1997). Also, Bond (1991) found that counsellors experienced some difficulty in implementing two competing outcomes – a more client-centred view combined with externally generated outcomes and goals. Delaney (2002) elaborated on this with her finding that the preferred outcomes of VCT (i.e. to test, to change one's behaviour and to disclose) lend an urgency to the issues being dealt with and that this, together with the moral imperatives of the disease compel the counsellor to reconsider her shift from a client-

centred to a more directive orientation. This is likely to be even more difficult given the calls to revert back to "test and treat", and to lose some of the counselling components of VCT as evident in the routine testing approaches.

The results from this study reveal similar difficulties that the counsellor has with being open-ended and non-directive, in a context where a set of preferred outcomes is obvious to the practitioner. Chapter Six showed how counsellors struggle to adhere to the dictates of both orientations. The tagging of an open-ended question on to the end of a directive advice assessment might be a way for the counsellor to manage this tension, and rein in this directive side with a more open-ended question that attempts to move the conversation in a client-centred direction. Alternatively, it could be construed that tagging an open-ended question on to the end of the directive advice segment constructs the pressure to change as a negotiable option – or constructs the advice as something the client wants.

7.4.1. Considering advice-giving in public health and counselling contexts

A critical practical dilemma for counsellors required to implement these two approaches is most acutely felt in the management of advice in health interventions and in more traditional counselling interactions. In the former approach, the dispensing of advice to clients is considered a core part of the intervention that, if appropriately used, has more benefit than harm (Feltham, 1995). In counselling on the other hand, advice is considered to be anti-therapeutic in that counsellors should not be telling clients what to do under any circumstances (Stein & Brouard, 1994).

Chester (1987, in Silverman, 1997) describes advice as imparting authoritative information, explanation, guidance, and clarification of options regarding where to seek symptomatic treatment, and what to do about safer sex. In this study, most counsellors struggled with their advice-giving role. For example, in "struggling with preferred outcomes and the freedom to choose" strategy, this struggle awareness was most noticeable. The counsellor managed this by giving his advice, and then making it more open-ended by reminding the client that it was up to her to decide what to do.

In other cases, this struggle is more subtly expressed. It appears that counsellors have difficulty in distinguishing between advice, and suggestion or mere confirmation of an intended action that the client should take. The appeals strategy in Chapter Five illustrates this advice dilemma. It comes at the end of a session where the counsellor has worked hard to get the client to take up a particular behaviour. The client gets to this point, and says "I see. So you suggest maybe I start using it?" In response the counsellor gives a somewhat cautious, reply that distances her from the advice that she has worked so hard to get the client to take up. She replies with "It will be better for yourself if you start using the condom straight away". From an interactional perspective it would have been appropriate to acknowledge firmly the client's proposed behaviour change with a clear "Yes!"

Gibson, Swartz and Sandenbergh (2002) address the issue of whether advice should form part of counselling. They point to the operational difficulties in upholding this widely held mantra that counsellors should not give advice. In the context of helping, clients often ask counsellors what it is that they should do, and counsellors often feel that they should give clients some answers or advice. VCT combines two approaches, one that supports and the other that seems to reject the role of advice-giving in the

interaction. As a dual-identified encounter, the role of advice in the context of HIV/AIDS counselling needs to be clarified.

In particular, greater clarity is required on the different types of advice and the circumstances under which advice may be advisable or not in HIV/AIDS counselling. For example, Feltham (1995) suggests counsellors need to be able to distinguish when it would be unwise, incorrect or unethical to give advice (when you deprive the client of using their own decision-making resources) and when it would be useful to give crucial advice and information (when the client is not likely to know certain things or arrive at important conclusions without assistance). Gibson et al. (2002) advocate that in some instances it may be helpful to give a client firm suggestions, including laying down all the constructive alternatives before the client. Finally, Feltham (1995) observes that sometimes people need a sense that there is an authority who knows what needs to be done. In fact, many clients coming in for HIV/AIDS counselling may not be operating from this Western, client-centred perspective that counsellors do not tell you what to do. Mkhize (1994) argues that this approach to advice may not be a universal expectation since "people from many other cultures value and expect advice and even authoritative commands and are confused by the non-directive assumptions of Western psychology" (p. 10).

Central to this process is an acknowledgement that, whether as counsellor or health adviser, persuasion and influence are central features of counselling (Stokes, 2003). Feltham (1995) advocates for a realistic and beneficial acceptance on the part of counsellors that they exert influence and would be wise to be aware of when and how to utilise their power on their clients' behalf. Stokes (2003) highlights an important consideration for HIV/AIDS counselling policy makers and practitioners. He suggests

that there is a need to reflect upon and explore the notions of power and advice-giving in more non-directive counselling orientations, and whether these can comfortably co-exist in both theory and practice.

7.5 VOLUNTARY COUNSELLING AND TESTING WORKS AS A COMBINATION OF ACTIVITIES

Beardsell and Coyle (1996) point out that a limitation of the outcomes and efficacy-based focus of much VCT research is that voluntary counselling and testing tends to be conceptualised as a series of discrete events (e.g., prevention or support) rather than as a dynamic process that consists of related processes. As discussed earlier, while there are clear instances where counsellors can be seen to be engaging in information, advice and support talk, often in practice there is considerable overlap between these three activities, and counsellors can be seen to be doing one, both or all three of the activities at once. In adopting a process approach in looking at HIV/AIDS counselling, I hoped to focus on the individual interactional tasks of counselling, but also to show how VCT works as a whole to give it meaning and shape its character, rather than as a discrete set of prevention or support tasks. As Goss and Mearns (1997) observed, "counselling is a process composed of so many parts, which are so mutually interdependent that it is impossible to consider them separately without losing characteristics essential to the therapeutic relationship, the evolving meaning of all elements and their changing relationship to each other" (Goss & Mearns, 1997, p. 191).

This comment has relevance for this study. I found that the various interactional tasks work collaboratively to inform the prevention and support outcomes attached to the intervention. Like Silverman (1997), I found that information-giving acts as a "home

base" around which much of the activity in the session revolves. Information-giving appears to be the foundation on which the advice and support goals of voluntary counselling and testing are realised. This study showed that the information-giving formats, appearing as they typically do at the beginning of the pre-test counselling session, are interactionally less demanding for both participants. Given their structural position and timing in the session, information-giving works to lay the foundation for the more interactionally difficult and problematic tasks of giving advice in HIV/AIDS counselling.

Kinnel and Maynard (1996), Peräkylä (1995), Peräkylä and Silverman (1991a), Silverman (1997) in their work on HIV/AIDS counselling communication formats all show that advice work is difficult in the context of HIV/AIDS counselling. This study confirmed those findings. In their analyses, and as illustrated here, participants organise and revise their utterances so as to manage rejections of advice in a way that preserves preference for agreement in the interaction (Silverman, 1997).

The structure of the communication patterns regarding information, advice and support, is something that is collaboratively worked through by both participants. Even where there are moments in the advice or troubles talk segments that threaten to derail the interactional order of things, both clients and counsellors draw on a range of resources to keep the interaction moving forward.

The power of VCT as an interactional activity lies not in the discrete interactional tasks but in the way that these come together to create a context for providing hope and support, and in which the more awkward tasks of risks to self and to others can be reflected upon and dealt with. Put differently, this study has shown how VCT works as

an interpersonal encounter (Richter et al., 1999). By drawing on elements of counselling

and combining information, advice, and support, it works to achieve its prevention and

support objectives.

CHAPTER EIGHT

CONCLUSION

The final analysis and write up of this study took place amidst a broader political and policy context where the utility and efficacy of voluntary counselling and testing, the cornerstone of prevention efforts in most high-prevalence, developing countries, was being called into question. I argued that this study, with its focus on VCT in its natural environment, with a particular emphasis on the micro-processes of practice, could provide detailed and concrete descriptions of VCT practice. My hope was that these detailed accounts of VCT practice might assist in understanding how the aims of VCT are actually being implemented and in so doing improve practice and shape these broader policy debates on the usefulness of counselling and testing as a prevention tool. In this concluding chapter, I would like to consider the extent to which this goal has been achieved, to discuss the strengths and limitations of this work, and to consider potential avenues for future research.

8.1   USING PRACTICE TO INFORM POLICY

A central theme in this PhD has been that VCT research has been dominated by quantitative, outcomes-based research that has been consumed with a funding and policy agenda to prove that VCT "works". I have argued in the literature review that this approach has several limitations and as a consequence more than two decades into the epidemic we know less about *how* VCT works to achieve its prevention and support goals. Given the current epidemiological and policy context that questions the role of

VCT in prevention efforts, qualitative research that explores actual practice could inform the broader policy debate regarding VCT.

But is this possible, and how is this possible? As Rist (2005) states, research can contribute to informed policy decision making but the manner in which this is done is not straightforward – there is no "linear relation of research to [policy] actions" and often policy decision making is an "ongoing set of adjustments and mid-course corrections"(p. 548). What this means is that there is no automatic relationship between the findings that emerge from practice-oriented studies such as these and VCT policy on this matter. Acknowledging this reality, I still believe that qualitative research of this kind could and should inform the realities of the VCT policy-making process.

Policy can be defined as a set of instructions from policy makers to policy implementers that spell out both the goals and the means for achieving those goals (Rist, 2005). Typically in the HIV/AIDS field, policies and policy agendas are set by multinational and global funding organisations such as the WHO, UNAIDS, and the CDC. For those on the ground, these policies can seem far removed from their immediate realities and contexts, and mirror the currencies of modern life – money, power and the ability to influence and shape agendas, and sometimes change the world. As implied in Rist's definition, the process is a top-down, uni-dimensional one.

Qualitative research – and in particular that which provides insight into actual interaction or practice – is in a unique position to show how intended policy actually translates into practice, and to highlight the disparities that often exist between well-intended policy far removed from implementation, and contextual realities that ultimately shape a particular activity such as counselling. Qualitative studies of this kind

that focus on practice, can provide the "bottom-up" contextual and implementation insights that are necessary for informing current VCT policy debates, and make the implementation-policy relationship a much more dynamic one. To do this, more studies of this kind need to enter the public domain through publications and other dissemination fora. As social scientists we need to engage more actively with policy makers so that our work and the insights that they generate have a better chance of informing public policy on VCT. Drawing on the results of this study, I make several policy observations and recommendations as highlighted by this study on VCT practice in South Africa.

8.2   DEFINING WHAT VOLUNTARY COUNSELLING AND TESTING IS: A PUBLIC HEALTH INTERVENTION OR A COUNSELLING ENCOUNTER?

The WHO in 1995 clearly articulated the aims of VCT as involving the prevention of infection and the provision of support for those infected and affected by the virus. While the goals of VCT are clear, the frameworks that guide its implementation – as a public health intervention with health-promoting goals and as a counselling encounter – are less clear, and often contradict each other. This study with its focus on actual client-counsellor interaction was able to show how counsellors, in practice, struggle to implement the competing frameworks that guide VCT practice: on the one hand a directive health-education intervention that privileges the authority and expertise of the counsellor, and on the other, the construction of VCT as counselling, which is determined by client needs, and is as a result more open-ended in terms of possible outcomes. In addressing the question of what it is – a public health intervention or counselling activity – the results have shown that while counsellors struggle to

implement these two competing approaches, they orient more towards an interpretation and implementation of their role in more directive and health-advising terms than in non-directive, client-centred counselling terms.

This conceptualization and implementation of their role in public health terms is strikingly evident in their management of advice in the context of VCT. From a counselling perspective advice is not permitted, but from a public health perspective it is considered a desirable and necessary part of the intervention to direct, persuade and guide the client to act in certain ways that would protect their health, as well as the health and wellbeing of others. Operating from a public health perspective, counsellors in this study treat advice as an important and normative part of their work in a context where a certain set of preferred outcomes is known to them – i.e. to get people to change their risk behaviour, to get people to test, to get people to disclose and to reduce transmission risks to others. There is evidence in this study that given that practitioners also operate within a counselling framework, they struggle to know how best to go about implementing this advice, to distinguish it from other forms of client-requested guidance (i.e. a suggestion or recommendation), and to know under which circumstances it is permitted, or desirable for them to step into an advice-giving mode.

8.2.1 Client-centred counselling or utilising client-centred skills?

Since its inception in 1985, VCT or HIV test counselling has been conceptualised as a counselling activity, drawing heavily on Rogers' (1967) client-centred approach to psychotherapy and counselling. Burnard (1992) noted that the client-centred approach used in the context of VCT may not always be client-centred in the way prescribed by Rogers, but that client-centred skills can serve as the broad basis for a broader range of

effective counselling skills for counsellors in a context of HIV/AIDS. Buskens and Jaffe (2008) in their study of VCT in the context of infant-feeding counselling, understand a client-centred approach as being one that takes clients' agendas as being indispensable to the process as they are the ones who need to know their situation and need to commit to the behaviour change. This study showed that advice worked more effectively when it addressed the client's context, and feelings and views on the matter – and in this sense could be considered client-centred. Further, this study demonstrated that employing a range of client-centred skills – such as reflection and empathy – can be balanced with the preferred outcomes of the HIV-test counselling encounter and successfully combined to help clients address risk behaviour. In sum, the counselling framework – and in particular the client-centred approach it draws on – has not been clearly articulated by VCT policy makers.

In addressing the role of VCT in the changing context of the epidemic, we need to revisit a central question. What is it that we are doing? Carballo and Miller (1989) addressed this issue early on in the epidemic when they argued that we needed to define and characterise HIV/AIDS counselling better – particularly its aims as a dual prevention and support intervention. Almost twenty years later, this comment still holds true.

The findings from this research reveal a disjuncture in the intention and the practice of VCT. VCT practice, as illustrated in this study, describes an intervention that is at odds with itself, and that operates under two frameworks that cause difficulties for counsellors. This study suggests that we need to define and frame more clearly what VCT essentially is. Greater clarity is required for practitioners to help them determine whether to implement a client-centred therapeutic approach alongside a public health

prevention agenda, or whether to implement VCT as a public health intervention that uses a set of client-centred skills to advance a set of preferred prevention and support agendas known to the practitioner. This clarification is important for practitioners in that it could free them up from the impossibility of trying to deliver a health intervention within a competing discourse of client-centred counselling as has been the case up until now. As argued by Peräkylä and Vehviläinen (2003), theoretical frameworks tend to describe the best possible situations or the broad aims of the approach but may fail to articulate adequately the actual goals or skills required to organise institutional practice. Clear implementation guidelines that flow from this reconceptualisation of what VCT is and that define its goals more clearly will also be useful in helping counsellors implement policy aspirations and ideas.

Several attempts have been made to develop, implement and test the effectiveness of various models of brief, 20-minute HIV-prevention counselling sessions in many high-prevalence busy medical settings (Kamb et al., 1998; Metcalf et al., 2005; The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). This model is considered client-centred in that the client is actively engaged in the development of the risk reduction plans and the counselling is characterised by a range of client-centred skills (i.e. client views on risk are actively sought and used in the development of context-specific risk reduction plans, and various client-centred skills such as open-ended questions, role plays, alternative listening and non-judgemental attitudes are used). Further, the approach does not necessarily take more time than other VCT counselling models, but could be much more effective in achieving the desired outcome of risk reduction (Rietmeijer, 2007).

Predominant counselling models in this South African sample (and in other parts of Africa) are more loosely designed around the behaviour change goals of VCT than the prevention-counselling model. At present, despite the evidence, there is as yet no widespread implementation of this prevention-counselling model. Based on the findings of this study, more widespread implementation of the prevention-counselling model is recommended in this context. This would need to be accompanied by clear promotion of the prevention counselling approach to VCT, as well as clear guidelines and training on the model to assist programme managers and practitioners.

8.3   REFLECTIONS OF SELF IN A MORAL CONTEXT

While not clearly articulated or outlined in any policy, in managing the dual goals of prevention and support, a core activity that frames this interaction is for counsellors to get clients to reflect on their own behaviour, and consider the consequences of this behaviour for them and for others in their lives. This study has shown that this reflection is essentially a moral activity.   Genetic counselling deals with similar dilemmas as VCT in that it also deals with the tensions of delivering a set of preferred outcomes while operating under a counselling framework. Scully, Porz and Rehmann-Sutter (2007) and Taylor (2004) comment on the inherently moral context that frames their work in this field. In this context – as with HIV/AIDS – individuals have to consider their own risk behaviour, the consequences that this might have for others in their life and the powerful influence of moral emotions such as regret, guilt or shame. Bayer (1989) adds that HIV/AIDS is complicated by the need to motivate and get people to talk about "deeply rooted biological and psychological pleasures that are often reinforced by cultural as well as social dynamics" (p. 94).

As discussed in earlier chapters, HIV/AIDS is often caught between two ideological perspectives: protecting the privacy of those most at risk for HIV infection, and focusing on broader concerns for public health (Bayer, 1989; Taylor, 2004). A key challenge to individuals living in the time of HIV/AIDS is for "individuals to transcend their self-interest and gain a sense of communal responsibility" and that people "recognise the moral obligation to desist from moral acts that may place others at risk" (Bayer, 1989, p. 80). Thus far, it has been a challenge that has not been successfully met.

This study showed that this kind of self-reflection occurs naturally within the parameters of an interpersonal interaction such as counselling. Through its analysis of detailed VCT interactions, this study revealed a range of strategies that counsellors were able to employ – some successful and others not so successful – to encourage a "moral sense of responsibility towards others and an awareness of competing ethical interests within self, as well as between self and others" (Taylor, 2004, p. 140). We need to consider if this morally reflective activity is best placed within the context of an interpersonal encounter such as VCT. Given that the encounter revolves around HIV testing, and involves considerations of risk to oneself and to others, I would argue that VCT is best placed to provide an opportunity for this kind of moral reflection. But as Bayer (1989) and Dixon-Mueller (2007) caution, this kind of moral reflection needs to be distinguished from the "strictures of moralism conveyed in forceful and imaginative ways" in HIV/AIDS (Bayer, p. 95) and that reveal more conservative and religious views on human behaviour and conduct.

The kind of moral reflection required in HIV/AIDS is best described by Taylor (2004) in the context of genetic testing. He suggests a process where the individual is

encouraged to consider what their moral sense of responsibility is towards self and others and to create a moment of awareness of how this reflection can result in competing ethical interests within self, as well as between self and others.

But this mandate to create a morally reflective culture cannot fall on VCT alone, burdened as it already is with all of the expectations related to behaviour change and prevention. This kind of engagement can be done within the brief context of prevention counselling where discussion of risk reduction is complemented with more client-centred skills. But, for this notion of morally responsible selves to take root and to have meaning, and greater impact, then these kinds of discussions need to find expression beyond the confines of the counselling rooms, in the more intimate spaces that drive HIV risk and influence our behaviour – our relationships, our peer groups, our social networks, our families and communities. Bayer (1989) proposes that collectively we must develop a public culture that defines morally acceptable behaviour and that if we are to be successful in this then "a culture of responsibility must take hold and be reinforced among those at risk for acquiring AIDS if it is to shape their private acts" (p. 96). Similarly, Dixon-Mueller (2007) recognises the importance of this collective responsibility we all have to both define and act on a set of normative messages regarding our responsibilities to ourselves and our sexual partners.

8.4   THE ROLE OF VOLUNTARY COUNSELLING AND TESTING IN HIV PREVENTION

Two primary critiques have been levelled at VCT in the broader prevention and treatment policy debates discussed in earlier chapters of this thesis. The first has been that the content and process of VCT as currently practised – with its focus on pre-test

counselling and individual informed consent – is not suitable for busy hospital settings in that it creates a service delivery bottleneck and subsequently limits rather than increases the number of people who get tested and treated. The second critique revolves around the effectiveness of VCT as a prevention intervention, particularly its ability to address people who are HIV-negative but who are at risk.

HIV test counselling has found itself at the centre of various critical debates fuelled by a changing epidemiological context that includes 1) growing public health concerns regarding the scale of the epidemic; 2) the relatively few numbers of people who know their status in many developing, high-prevalence HIV contexts and 3) the increased availability of treatment in many countries in sub-Saharan Africa. The proposed policy solution is to promote a massive scale-up of HIV testing in many developing contexts, and to expand the number of counselling and testing approaches to include more routine testing models, that have the potential for ensuring that a greater number of people know their status, and who could access the prevention, treatment and care services that they need (UNAIDS, 2003).

8.4.1   Unbundling counselling from voluntary counselling and testing

The aims and objectives of this study are limited in scope, and hence not able to comprehensively address the broad critiques levelled against VCT as a prevention intervention. However, the findings of this study, by focussing on VCT practice, do allow for commentary on some of the proposed policy changes and the realities of VCT programme implementation on the ground.

Recent policy documents have suggested that counselling in the VCT package be made advisable but not mandatory (Obermeyer & Osborn, 2007). This study offered support for the idea that VCT works as a combination of its interactional tasks – information, advice and support – and that these roles are interrelated and complement each other. For example, the informational tasks lay the foundation for the more difficult interactional tasks of advice giving. More specifically, this study offered some support for the continued role and function of information-giving in the context of VCT interactions. Information giving, though not directly explored with this focus in the analysis, seemed to have minimal effects on behaviour change, but did have an important role to play in the interaction in creating an interaction where hope could be dispensed and received. In addition, the support element was defined and implemented in more directive terms – i.e. about manageability and coping. But in combination, the information and support functions work at normalising HIV and AIDS and creating manageability and coping for clients contemplating an HIV positive diagnosis and/or living with one.

Making counselling, no matter how loosely defined and unevenly implemented (with its information and support components) advisable but not mandatory, as well as possibly removing it all together, runs the risk of losing an important resource in the fight against HIV/AIDS. Counselling is resource that is particularly important in many high-prevalence, resource-constrained settings, where treatment is available but not easily accessible and available to all who need it. More generally, at a time where effective biomedical interventions such as a cure and vaccine continue to elude us, counselling – and the hope, encouragement, and sense of manageability and coping that it seeks to impart – remains our only hope and an important resource.

This study would argue that to remove counselling completely from the VCT combination could limit the behaviour change goals of the intervention. The risk reduction and behaviour change goals of VCT are inherent to both the pre- and post-test counselling sessions. Koo et al. (2006) note that abbreviated pre-test counselling or streamlined counselling could undermine efforts necessary to manage emotional responses to the diagnosis and to teach behavioural changes necessary for prevention. This study showed that addressing risks to self and others was an important goal that interactants engaged with (with varying levels of success), whether that took place before HIV testing or after HIV testing, once that diagnosis was known.

The broader policy debate which seeks to remove pre-test counselling seems to indicate a policy shift and a reversion back to a traditional public health strategy of "test and treat" when it comes to AIDS (Rietmeijer, 2007). The test and treat approach focuses on those who know their status and are positive. The other side of that perspective is that even in most high-prevalence countries (for example, with an adult HIV prevalence rate of 30%), the number of negative people will always outweigh those who test HIV-positive. Primary prevention – prevention of infection of the at-risk, HIV-negative group – needs to remain a simultaneous goal with treatment in mounting an effective response to the epidemic. VCT in its current form (or adapted) or some other prevention strategies are needed to address this target group.

Indeed the argument for a more medicalised intervention with a focus predominantly on testing and treatment ignores the importance of behaviour change, which is at the core of any prevention efforts in response to HIV/AIDS. Even if biomedical interventions (such as a vaccine or cure) were to become available, the most effective response to HIV/AIDS will continue to lie in the human, behavioural, psychosocial,

cultural and interpersonal aspects that drive the disease (Green, 1989; Irinoye, 1999; Richter, van Rooyen, Solomon, Griesel & Durrheim, 2001). It is human beings who will have to master, adhere to and ensure compliance with either biomedical or behavioural interventions.

This research has highlighted the need for further research regarding the role of counselling in the VCT package. We need more studies that allow us to describe how the proposed changes in the structure and content of VCT – no pre-test counselling, and limited or reduced informed consent – work in practice, and what effect these changes have on the unfolding interactions. Other studies, that specifically address the behavioural change goals of VCT in its current or adapted format, are also needed to inform the VCT policy debate.

8.5   IMPLICATIONS FOR COUNSELLING, COUNSELLOR TRAINING AND COUNSELLORS

The methodology used in the study makes practice visible. By focusing on the micro-analytical level of communication between simulated clients and counsellors, insight into the practice of a sample of client-counsellor interactions in South Africa is provided. Exploring what actually happens in practice – as compared to policy intentions or aspirations of what should occur or what hopefully will occur in practice – allows for a more realistic assessment of the realities of that practice and the conditions that might constrain or inform it.

HIV/AIDS is an overwhelming and devastating disease. Counsellors confront this in a most intimate way on a daily basis – they engage clients on matters relating to sex and

sexuality, and the associated risks, vulnerabilities, fears, as well as illness, sickness and death, and the consequences of all these things for themselves, and for others. Certain studies have pointed to the stress counsellors' experience while performing HIV/AIDS counselling, particularly in high-prevalence countries (Baggaley, Sulwe, Ndovi-Macmillan, & Godfrey-Fausset, 1996; Coyle & Soodin, 1992; Grinstead & van Der Straten, 2000; Richter et al., 1999). This work reminds us that counsellors are people too, and that they tend to be of a similar age and belong to the same risk category as their clients. Further, many counsellors are in the very difficult position of dealing with HIV on a daily basis, while at the same time dealing with their own personal vulnerabilities and anxieties about HIV/AIDS (Baggaley et al., 1996; Richter, et al., 1999).

Given this context, this study has demonstrated that counsellors as ordinary members of society first, try to do the best they can under very difficult circumstances. While trained to do the job of counselling, they bring with them to this interaction a range of resources they have as human beings – including how they make sense of each other or how they fail to do so and how they characterise and connect the worlds they talk about (Baker, 2003). It is against this background that we understand some of the interactional difficulties inherent in HIV/AIDS counselling: counsellors feel most competent in their information-giving and advisory roles; support is very narrowly defined in terms of outlining coping and management strategies; and stepping into an advisory and information role may be a way for counsellors to manage their own anxiety or discomfort generated in the interaction.

These international difficulties also comment on their capacity as counsellors, revealing what their current skill sets are and what might need to be done to improve counsellor

skills. This study suggests that through guidelines and training, the theoretical frameworks of "client-centredness" and "advice-giving" in the context of VCT could be more clearly defined, thus equipping counsellors to become client-centred in a context where there is a set of preferred outcomes that they need to ensure.

Earlier in this chapter, I argued that VCT is well placed as an intervention to allow clients the space to reflect on their own behaviour, living in a time of HIV/AIDS. To do so though, requires a set of morally responsible agents and counsellors – counsellors who are able to engage clients in this kind of morally reflective and responsible activity. Challenging people to do better and be better can be effective when done by a skilled counsellor and we would need to address current training paradigms in order to develop this kind of practitioner.

This kind of detailed work on VCT practice has immediate relevance for training (and reflection of practice) of counsellors. The focus on the details of counselling talk allows for the beginnings of a conversation about practice and the consequences of that practice (Silverman, 1997). For example, using transcripts from this study could be useful in considering how to deliver advice. One could also look at which advice strategies generate a better uptake of decisions in clients, or which strategies encourage better refection on the moral responsibilities of clients living in a time of HIV/AIDS.

8.6   LIMITATIONS OF THIS RESEARCH

8.6.1   Generalisability in qualitative research

In reflecting on the results and implications of this study, I am mindful of the limitations of this piece of research. One of these limitations has to do with the nature of qualitative inquiry (and what can be generalised from such an enquiry). I am aware that the final dataset for the PhD consisted of twenty-seven VCT interactions in a South African context – and that these observations may be grounded in this context, in a particular time and place and so therefore may not automatically be transferable to other parts of sub-Saharan Africa. While this may be so, in social science research one is less concerned about representivity and generalisation of the cases to other contexts, than about generalisation of the nature of the process under investigation – in this case the nature of voluntary counselling and testing (Peräkylä, 1997). The theoretical sampling strategy as well as the strategies of enquiry that were used allow for an explanation of the results from this study to be generalised descriptions of what any counsellor or client can do, given that he or she has the same interactional competencies as the participants in this sample (Peräkylä, 1997). In this sense, this study into VCT practice may have relevance for other counsellors in other contexts beyond South Africa.

8.6.2   Simulated versus actual counselling interactions

While I have made the argument for the utility of SCM on ethical grounds, and pointed to several advantages of the method to HIV/AIDS research in Chapter 3, there are

some limitations to this study that result from using simulated rather than actual counselling counselling sessions as my data.

Following Holstein and Gubrium (2004), I argued that data – simulated or actual counselling sessions – are neither performed nor ever pure. Data are always products of interpretive practices. In other words, every data collection situation – "no matter how formalised, restricted or standardised relies on an interaction between participants who are constantly engaged in interpretive practice, that is, involved in meaning construction" (Holstein & Gubrium, 2004, p. 55). Ethnomethodologists would add that in making meaning, participants would rely on a range of common sense and everyday resources available to all people in situations such as these. In the context of counselling, real or simulated, participants would draw on a range of resources in knowing when to speak and when not to, implicitly knowing who leads the interaction, and who follows and so on. This study, using a combined EM/CA approach attempted to make visible these common sense and everyday resources inherent in HIV/AIDS client and counsellor talk.

But, simulations construct a particular reality that may be different from an actual situation. Some would argue that these are not "naturally occurring" data in that for at least one of the players in each interaction (the simulated client), and perhaps even the counsellor on occasion, the interaction is scripted or acted rather than a "typical" health event. These scripted or acted elements of the simulated client situation, could impact the unfolding interaction and conversational strategies in a number of ways.

Firstly, the constructed rules of a role-play situation may differ from the rules of a session into which a real client enters. In most helping relationships, the professional

frames the agenda and interaction, with the client assuming a more submissive role (Ainsworth-Vaughn, 1998). In several of the video-tapes (not shown in the data extracts as it was not the immediate focus of the analysis), on several occasions the sessions were terminated by the simulated client. These moves may have been more a function of the "role" and a sense that their work was done than an indication of what clients typically do in such situations.

A second important distinction between the real and the simulated client relates to the issues of intention. For the real client their reasons for entering the session may be to get the best possible health care, and to appear to be a good person. For a simulated client, their intentions might involve trying to appear real and convincing in their roles, and to evaluate the counsellor's behaviour. Living in the high prevalence context that we do in South Africa, there may be superimposed levels of complexity on this – some of the simulated clients may have HIV related concerns regarding their own risk and status, and these anxieties may have impacted the emergent talk and strategies that were employed in their talk. In debriefing sessions counsellors often struggled with the evaluative component of their roles - and often felt traumatised by what they judged to be "bad" counselling. Again, their experience of the counselling in their role as clients but also evaluators of practice may have influenced the ways in which clients (and counsellors) conducted the interaction. In sum, the simulation constructed a particular counselling situation, and a range of discursive responses and strategies which may or may not be different from an actual counselling situation. Future studies that explore counsellors from the same settings in a simulated and then an actual counselling situation, would be ideally placed to provide some evidence on how different or similar these constructions are.

8.6.3 Immediate talk is shaped by broader context

Following other CA studies, I adopted a dynamic view of context as something which is both locally produced and transformed at any moment. In this study of VCT talk, I was interested in how participants create contexts that can be heard as "doing information talk or advice talk or support talk"? The analysis showed that very particular contexts emerged or were created when doing information, advice and support talk. How might these immediate contexts been influenced by the broader contexts that shape them? The data for the larger study from which this study was drawn, was collected in 1999 – a particular time and place in our experience of the HIV/AIDS epidemic in South Africa. At this time in our history, ART was not widely available and services and support for people with HIV/AIDS were limited. The talk of counsellors and clients in these transcripts seems to reflect these broader contextual realities. For example, the analysis showed that information-giving plays a central role in these interactions. It is used to impart a sense of hope and to encourage coping and manageability in the face of an overwhelming epidemic. Given the epidemiological and programmatic backdrop against which the data was collected this talk could be considered to be reflective of that.

Almost ten years hence, various factors about the disease have changed – incidence has increased rapidly and there has been a rapid explosion of services and ART is more widely available. A study into client-counsellor talk at this time would be instructive. It would be interesting to see how the combined facts of rising prevalence (both through more incident cases and longer survival), the construction of AIDS as a manageable condition as opposed to a death sentence, and better information about prevention-of-mother-to-child-transmission services, might impact on the unfolding talk and

discursive strategies employed by current day HIV/AIDS clients and counsellors.

8.7 CONCLUSION

As Silverman (1997) and Peräkylä (1995) comment, a focus on counselling talk using tools from ethnomethodology or conversation analysis prevents one from arguing in favour of the therapeutic effectiveness of VCT practice. Instead, as Silverman (1997) articulates, the methodology enables one to show how people interact with each other in the counselling interaction and in the process reveal facets of their practice of which they (and we) might be unaware. I began this study with strong positivist assumptions about the nature of social reality and about counselling. Counselling existed as an objective reality that was either good, bad or somewhere in between. Informed by social constructionism and drawing on tools of EM and CA, was radically different to the more positivistic approach to evaluation that I was used to. Under this framework my approach has been less about imposing an external set of normative standards on VCT practice, and more about being open to the possibility of what is actually in front of me – of seeing and trying to understand what these two people actually do, as they grapple and interact with each other as they complete the business of VCT together.

By focusing on how VCT clients and counsellors perform a conversation interaction – including how they make sense of each other or how they fail to do so – I have seen new things in the old. It's a lesson and orientation that I will take to other aspects of my life – as a person, practitioner, researcher and manager: if you suspend judgement and start with what you have in front of you – not what you imagine it to be, nor what it could and should be – you could be pleasantly surprised.

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APPENDICES

Appendix I: Letter to the Counselling Site

<div align="center">

UNIVERSITY OF NATAL

School of Psychology

P.Bag X01, Scottsville, Pietermaritzburg,

3209, South Africa.

Telephone 0331-260-5680   Fax 0331-260-5809

E-mail: SOLOMON@psy.unp.ac.za

</div>

Dear ....

Thank you for agreeing to participate in this study. This national study evaluating HIV/AIDS counselling nationwide has been commissioned by the National Department of Health (HIV/AIDS Directorate). The intention is not only to determine the impact of counselling services in the epidemic but more importantly to inform the national counselling strategy and associated department planning.

Your site has been selected as one of a number of sites for more in-depth study. The site visit will take place from Monday 31st May to Friday 4th June 1999. These sites have been selected from the entire national sample of sites of counselling services. Each site has been selected to allow for more in-depth study of sites which represent the typical features of the varied settings in which counselling services are rendered.

We are aware that our visit will be to a degree an imposition and will require commitment in time and energy from your organisation and personnel and ask for your cooperation in this regard.

We believe it is important to have an initial opportunity to brief all the staff in the organisation in order to address concerns, explain the purpose of the research and the process we would like to follow. For this, we would like to arrange a briefing meeting at the start of the site visit itself and hope that all personnel will be present for this meeting. We hope to hold this meeting from 9.00a.m until 10.30 on the first day of the site visit. We would also like to meet again more informally towards the end of the work day with all the personnel when we could discuss any issues about the research which people may wish to raise.

We intend collecting information from three areas of activity; management, counsellors and clients. It is important to point out the confidential nature of this study. We undertake to ensure confidentiality of all data collected. At no stage in respect of any written report relating to the study, will any organisation, member of staff, counsellor or client be identified. Findings will be discussed in anonymity through reference to the type of site or nature of counselling activity.

In respect of the three areas, we intend to conduct structured interviews with selected staff and clients and also to videotape a sample of simulated counselling sessions. Confidentiality in respect of counsellor activity is assured.

Our intention is to obtain information on the nature of counselling practices nationwide. In order to make the site visit efficient it would be helpful if you could assist us in the following ways:

- circulate this letter to all staff in the AIDS Unit
- try to ensure that counselling clients have been booked on the days of the site visit
- provide space for us to conduct interviews
- provide a counselling venue where we can set up vide-tape equipment
- provide us with a detailed annual report (if available)

We are aware of the burden this research may place on your organisation and hope that you will assist us in collecting the necessary data which will feed-back into the important area of counselling in HIV/AIDS. We also hope that the visit, although potentially a burden, is experienced as valuable and hopefully stimulating as it does offer an opportunity for the organisation to pause and reflect on its work.

Thank you for your cooperation

Vernon Solomon
for: National HIV/AIDS Counselling Research Team

Appendix II: Initial Briefing Workshop

Purpose

- To introduce the project to all members of staff at the organisation and explain what we will be doing.

- To obtain consent from management, counsellors and other staff.

- For relevant members of the organisation to sign consent and confidentiality forms.

- To answer questions and address concerns of staff members.

- To collect documentation requested in advance.

Introduction

This research is part of a tender that has been awarded to the University of KwaZulu-Natal to evaluate HIV/AIDS counselling services in the country. We have completed an extensive survey of all organisations likely to be doing counselling and have chosen your organisation as one of a number of sites that we consider to be exemplary of what is happening in counselling at the moment. By this we mean that your organisation can serve as an illustration to the National HIV/AIDS and STDs Directorate, among others, of the kinds of things that happen at a site that provides HIV/AIDS counselling.

What we will do

We will be requiring a number of 'bits' of information from the organisation, some of which we have already requested from management (e.g. time spent on counselling as opposed to other activities). We would also like to ask counsellors to fill in a questionnaire which will look at the levels of knowledge they have, the way they feel

about HIV/AIDS, the kinds of counselling they do and their future training and development needs. We will be asking clients to fill in a related questionnaire.

All questionnaires are entirely anonymous. This means that neither counsellor nor clients write any identifying information (e.g. name and address) on them. Once they are completed they will be placed in a box and no one will know that the questionnaire comes from specific people or from this organisation, for that matter. We therefore ask everyone to be completely honest; responses can never be traced back to people and the more frank everyone is the more we will be able to give a valid rendition of counselling in the country.

We will also interview members of management and selected counsellors. These interviews will also be confidential; no one except the interviewer need know who said what. We are not interested in what particular individuals think or say but rather in the general issues that counsellors bring up regarding their training, how they go about counselling, what their needs and resources are, their difficulties etc. The interviews will be transcribed and no identifying information will be included in the transcription. We will also change the identifying information of any person that you may refer to. The interviews with management will cover questions about the organisation in general but the same rule applies; that is, no other person will ever know who said what. It is essential that each person realises that we do not represent any one organisation and it is not in our interests to give anyone this information.

We would also like some counsellors to be video recorded during a counselling session. This will be a mock session in which someone will pretend to be a client and we will ask the counsellor to demonstrate how he or she would go about counselling the client.

This is to try to see what kinds of things people do when counselling and according to what model counselling is done. It is not to see how good or bad a particular counsellor is. The same confidentiality undertaking applies to this videotape data. No one outside of this research project will see it (not even the National HIV/AIDS and STDs Directorate, management of this organisation, other counsellors etc). We will erase identifying information from the transcripts that we make. Those who are given access to the data at a later stage for other research purposes will therefore have no way of identifying individuals or even organisations.

Outputs

Our final product from this research will be a report to the National HIV/AIDS and STDs Directorate. The Department will not know which sites we have visited. They will simply be told the nature of the organisation, e.g. that it was a hospital in an urban area in the Eastern Cape. This report will not contain any identifiable information about individuals or about organisations. It will tell the Department the kinds of counselling that occur, what needs organisations have, how effective the current training and supervision is, the obstacles to effective counselling and what we recommend the National HIV/AIDS and STDs Directorate do to make counselling more effective and easier to implement. Other research outputs (i.e. further data analysis, publications and other reports) may also be produced. The purpose of these outputs is to share our research with others in the field so that they can learn from and make use of any recommendations we may make.

The success of this project rests on the participation of everyone we approach, but we cannot force anyone to participate, nor can we prevent people from changing their

minds should they wish to drop out of the project at some point during this week. Participation is entirely voluntary.

Question and answer session

Having addressed questions and concerns, counsellors taking part in the videotaped mock counselling component of the site visit can sign consent forms. The question of how we can meet the needs and requirements of the organisation should be raised.

Follow up documents requested from management

- History of the organisation.

- Financial statements.

- Annual reports.

- Information on counsellor training, i.e duration of training, training manuals, programme, training schedule for the year.

Appendix III: Individual Consent Form

I, the undersigned

....

agree to participate in the research which will include videotaping a simulated counselling session as well as interviews. I am aware that the research is for the purposes of evaluating the HIV/AIDS counselling services in the country. I am aware of the steps that will be taken to ensure my anonymity. I am aware that the data will be used to produce summary reports for the National HIV/AIDS and STDs Directorate that will not contain any identifying information about myself or the organisation I work for.

I acknowledge that I gave my consent willingly and without being influenced to do so by the researchers or any other person.

Signed: ....

Date: ....

Appendix IV: Counselling Vignettes

Instructions for counsellors:

The following is a simulated counselling session. You have a maximum of twenty minutes to counsel this client. Try to handle the case as if it were any other that you may see, that is, treat it as if it were a real counselling session.

1.   Pre-test counselling scenario

Sipho is a young black male who has just discovered that his ex-girlfriend, and the mother of his baby, has tested HIV-positive. He has several girlfriends whom he believes carry little risk for him as they are all from good families. His father is a local businessman in the community and Sipho works with him in the family business. He presents for pre-test counselling. He doesn't want to test as he feels that he has little or no risk from his current partners. He is worried about his ex-girlfriend's HIV status, but is more concerned about what the implications are for his baby than for himself.

2.   Ongoing positive counselling scenario

Tembi is 28 years old and works in a local supermarket as a cashier. She was diagnosed as being HIV-positive about a year ago through HIV testing in her workplace. She has disclosed to her boyfriend Tsepho that she is infected. While he has been supportive of her, he refuses to go for a test himself, saying that he would rather not know his HIV status. He has also convinced her that it is not necessary for anyone else, apart from the two of them, to know that she is positive. Recently, Tsepho has started to become very

ill, with what Mary suspects are AIDS-related symptoms. His mother is constantly phoning her to try to find out what is going on with him. Tsepho is depressed and angry and constantly picks fights with Tembi. There is pressure from her family that they settle down and get married. To top it all she found out that even though they practice safe sex most of the time, she is 18 weeks pregnant. She arrives to see you very distressed, confused, overwhelmed and not sure what to do about the situation.

Appendix V: Simplified Transcription Symbols

Symbol	Example	Explanation
[	C2: quite a [while Co:　　　[yea	Left brackets indicate the point at which a current speaker's talk is overlapped by another's talk
=	Cl: that I'm aware of = Co: = Yes, would you confirm that?	Equal sign, one at the end of a line and one at the beginning, indicates no gap between the two lines
(.4)	Yes (.2) yeah	Numbers in parentheses indicate elapsed time in silence in tenths of a second
(.)	To get (.) treatment	A dot in parentheses indicates a tiny gap, probably no more than a tenth of a second
_____	What's up?	Underscoring indicates some form of stress, via pitch and/or amplification
::	O:kay?	Colons indicate prolongation of the immediately prior sound. The length of the row of colons indicates the length of the prolongation
WORD	I've got ENOUGH TO WORRY ABOUT	Capitals, except at the beginnings of lines, indicate especially loud sounds relative to the surrounding talk
( )	Future risks and ( ) life ( )	Empty parentheses indicate the transcriber's inability to hear what was said
(word)	Would you see (there) anything positive	Parenthesized words are possible hearings
(( ))	Confirm that ((continues))	Double parentheses contain author's descriptions rather than transcriptions