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PERCEPTIONS AND ENACTED IDENTITIES WITHIN THE HIV PREVENTION COUNSELING CONTEXT

by

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STATEMENT OF DISSERTATION APPROVAL

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ABSTRACT

With the present study, I aim to address three major areas that, to date, have been infrequently studied on their own terms, and not at all in conjunction with one another: (1) health and identity, (2) health counseling as a topic of health communication, and (3) the counselor's subjectivity within the counseling context. Extant literature on health counseling posits both counselor and client identities as binary and static and fails to account for, much less endorse or cultivate, the complexity and nuance that characterize the health-counseling situation. I seek to trouble these assumptions and contribute to new ways of thinking about health counseling by focusing this study on an AIDS foundation to assess how counselor and client identities are respectively positioned and how counselors perceive their own and clients' identities, as well as how counselors accomplish particular subjectivities in fluid, dynamic, and complex ways. In order to accomplish this, I utilize a combination of theoretical approaches, including critical, rhetorical, and poststructural, and a range of textual and qualitative methods. This study suggests that not only do counselors perform myriad and multifaceted identities during counseling, even in a context that prescribes rigid positionalities, but that these practices may be a valuable resource for effective health-counseling practices.

In honor of all individuals who have been affected by HIV/AIDS and those who have volunteered time and energy to help the disenfranchised.

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CHAPTER ONE

INTRODUCTION

According to the Kaiser Family Foundation (KFF), more than half (54%) of the adult population aged 18-64 in the United States have been tested for HIV at some point in their lives (KFF, 2013). Twenty-two percent reported being tested within the last year. The U.S. Centers for Disease Control and Prevention (CDC) recommends routine testing for all adults aged 13-64, and 3-, 6-, or 12-month return testing for those who engage in "high risk" activity. Since the development of the first HIV tests in 1985, the CDC has funded HIV testing and counseling at health care and non-health-care sites (Valdiserri, 1997). The majority of HIV tests are administered in health care settings, but the majority of new HIV positive identifications occur in non-health-care testing and counseling sites (CDC, 2010). Non-health-care HIV testing and counseling sites are spaces in which individuals can get tested for HIV and possibly other sexually transmitted infections (STIs), but they do not offer additional medical or health care resources. With backing from the CDC, these sites offer free services to the public or at least to those who qualify based on risk factors. One of the funding contingencies established by the CDC is that sites offering free testing also provide counseling to each client tested. In any health counseling context, issues of identity in relation to health are important features, and they are salient in particular ways in these "nonmedical" settings,

where conventional relations of health care/provider do not directly precede and potentially influence the encounter (Patton, 1996; Scott, 2003; Treichler, 1999). Despite the significance of identity in health contexts, it is relatively understudied (Lupton, 1995). As such, this dissertation aims to uncover the ways in which issues of identity are enacted in the counseling situation.

The AIDS Foundation that the present study analyzed is one of these nonmedical testing and counseling facilities. The AIDS Foundation was established in 1985 at a time when people were apprehensive to approach the topic of HIV/AIDS. The AIDS Foundation began as a crisis hotline for people living with or concerned about HIV/AIDS but quickly grew alongside the epidemic. The hotline still exists, but significant other services have been implemented throughout the years, including: transportation and meal assistance, a food bank, educational presentations, public outreach and programming, and, most pertinent to this study, HIV testing and counseling. The mission of the AIDS Foundation is "through education and services, [help] prevent HIV infection and [empower] people living in the Intermountain region, who are affected by or living with HIV/AIDS, to live healthier and more fulfilling lives" (utahaids.org). Ultimately, the AIDS Foundation "seeks to reduce HIV infection and AIDS and their stigma" (utahaids.org). I have been working closely with the AIDS Foundation for the past two years as a volunteer prevention counselor and I have recently taken a full-time position with the Foundation as a HIV Prevention Coordinator. In this dissertation, I seek to examine where and how identity is relevant in these contexts as pertinent to HIV/AIDS counseling in particular and to illness and prevention more broadly, with an eye toward practical implications.

Statement of the Problem

I assert that HIV prevention counseling occurring in nonmedical settings, like the AIDS Foundation, constitutes a unique opportunity to assess the construction and function of identities and illness conceptualizations as relevant to health care messages. In order to examine these issues, the present dissertation intends to address the following research questions:

RQ1: a) How do conventionally employed counseling protocols and policy in nonmedical HIV testing and counseling sites position counselor and client identities?

b) How does the physical space of a counseling encounter construct counselor and client identities?

RQ2: How are counselor identities/self-perceptions performatively operationalized within the counseling interaction?

RQ3: How do the prevention counselor's perceptions of the client and his/her identity play a role in constituting counseling enactments and approaches?

Rationale

With the present study, I aim to address three major areas of study that, to date, have been infrequently studied within current scholarship: (1) health and identity, (2) health counseling as a topic of health communication, and (3) the counselor's subjectivity within the counseling context. I seek to extend and refine extant knowledge regarding health counseling, specifically with respect to assessing the perspectives and choices of counselors during health care encounters. Moreover, I intend to examine identities in a

health-counseling context, thus connecting those areas of inquiry. Although the topic of health and identity has been addressed by some scholars, I hope to bridge a gap between praxis in health encounters and more theoretical, specifically poststructural, conceptualizations of identity and performance. In particular, I wish to uncover the ways in which poststructural understandings of identity are relevant to and can be mobilized in the context of HIV prevention counseling.

Literature Review

Identity

Historically—and still among some scholars today—identity has been understood as a fixed and stable category. Identity is typically taken up as an innate, immutable essence (Davidson, 2001; LeDoux, 2003; Rose, 2000; Wright, 1999). Scholars maintain that "'identities' themselves […] appear at least potentially to be explicable in biological terms, and increasingly in terms of their genetic make-up" (Rose, 2000, p. 6). Thus, some scholars argue that specific characteristics and personality traits that compose one's identity can be traced to genetics and are essentially biologically determined. However, Spivak (1986) contends that although there is an operational benefit to the essentialist view of identity, insofar that it can productively mobilize identities for political gain, such a view does not fully account for the complexity of an individual's sense of self.

Other theories stress the development of personal coherence but maintain that one's sense of self is achieved ontogenetically (Erikson, 1980; Helms, 1984; Phinney, 1989, 1990; Phinney & Alipuria, 1990). These models are rooted in an assumption that people are motivated by an "accrued confidence to maintain inner sameness and

continuity" (Erikson, 1980, p. 89). Thus, these theories purport that there are developmental stages to one's identity but that this development occurs in a linear and passive way.

Demographic categories are another way that scholars tend to discuss identity. Often, identity is conflated with a person's race, gender, or class. Some models of identification complicate the notion of identity being a singular aspect of a person. Models of biculturalism (Domanico, Crawford, & Wolfe, 1994; Szapocznik, Kurtines, & Fernandez, 1980) and acculturation (Birman, 1994) add layers to the immutable theories of identity, but still purport a stable concept of identity by simply stacking fixed categories on top one another. Although these models begin to demonstrate the multilayered nature of culture and identity, they maintain a construction of identity as distinct components that can be mixed and matched.

Most scholars today, however, understand identity not as fixed, but rather as shaped—if not constructed—by social and/or cultural context. Dissatisfied with the idea that identity is a static state, scholars began to theorize identity as a mutable concept, continually in flux (D'Augelli, 1994; Gergen, 1991; Lodi-Smith, Geise, Roberts, & Robins, 2009; McLean, Pasupathi, & Pals, 2007; Zurcher, 1977). Theories of identity in this vein, like the "looking-glass self" (Cooley, 1998), purport that people essentially understand themselves based on the perceptions of others. This theory gained traction with symbolic interactionists, who maintain that through communication we work to construct meaning about the world around us, including ourselves. Perceptions of the self are crafted through our understandings of how particular others and generalized others view us as individuals (Goffman, 1999; Mead, 2009; Shrauger & Schoeneman,

1979). Thus, identity is part of a dynamic process whereby multiple perceptions and understandings come into play.

While many scholars place an emphasis on the role of others in the construction of one's sense of self, other scholars focus on the importance of cultural values and priorities and how those fit within hierarchical structures of society. Within the terrain of critical cultural studies, scholars argue that identities are composed of a complex circuitry of racial, ethnic, economic, sexual, gendered, and ideological structures (Fearon & Laitin, 2000; Geertz, 1973; Laraña, Johnston, & Gusfield, 1994). In this framework, identity is malleable and multifaceted. Additionally, these factors are commonly in flux but remain contained under larger structural powers. For instance, identities often intersect and can create what theorists call *hybrid identities* (Anzaldúa, 2012; Appadurai, 1990; Bhabha, 2012; Clifford, 1994). Hybridity as a quality of one's identity is rooted in discussions of globalization and issues of postcolonialism (Dutta-Bergman & Pal, 2005). Therefore, at the heart of this theory are arguments about imperialism and global power differentials.

In this vein, identity is commonly conceptualized as a result of power dynamics (Habermas, 1974; Mantero, 2007; Marcuse, 2007; Mouffe, 1979). Thus, people are regulated by state and ideological apparatuses and subsequently "hail" and "interpellate" others (Althusser, 1984). This model of power and identity maintains that hegemonic forces create social hierarchies which function to define ourselves and others. Plainly, most contemporary scholars note the flexible and multifaceted nature of identity, even if their guiding assumptions and conclusions may differ. In both symbolic interactionist and critical cultural views there is a tendency to conceive identity as mutable but within larger, more fixed structures.

More recently, identity has been theorized from poststructural perspectives, which apprehend both identity and the structures surrounding it as fluid, flexible, and in continual flux. Such a view extends the symbolic interactionist and critical perspectives to an even more fluctuating and complex understanding. To achieve this nuanced position, poststructural theory conceptualizes the subject as an active agent. Foundationally, this perspective views identity and social structures as a perpetual negotiation through discursive formations (Foucault, 1969/2013). From a Foucauldian perspective, discursive fields refer to the relationship between language, social institutions, positionality, subjectivity, agency, and power. In sum, identity is a complex web of constructions between a subject and object. It is important to note that Foucault perceived power as productive (Foucault, 1976/1990), meaning subjects can enact power in order to shift the discursive formation. In this vein, subjects are not powerless to the larger oppressive structures, but are actors within the production.

Poststructuralists aim to deconstruct the entire discursive field in an effort to decenter our assumptions and understandings. As discursive formations get more complex in modern times, identities get even more fragmented and fractured and multiply across different discourses, practices, and positions (Hall & Gay, 1996). This conceptualization of identity makes for a “fluid unpredictability of identity formation” (Drzewiecka & Halualani, 2002, p. 341). Many of the aforementioned theories of identity emphasize the ways in which language and social structures function to universalize or minoritize individuals and groups of people, but poststructuralists aim to combat this polarizing impulse. While other perspectives might recognize the importance of the other in the relation to personal identity, poststructuralists believe that the other is

always already central to the understanding of the self (Sedgwick, 1990), meaning we understand ourselves only insofar as we understand what we are not. For instance, more than anything, masculinity is defined in opposition to femininity. Likewise, it is argued that heterosexuality is only comprehensible through an oppositional understanding of homosexuality (Butler, 2002). Identifying and dismantling these binaries are at the heart of poststructural practice. By pinpointing hierarchical binaries and deconstructing them, poststructural theorists effectively break down indiscriminate assumptions and proffer fuller understandings of our social realities.

Within the poststructuralist paradigm, some scholars view identity as a product of cultural performance(s) (Butler, 1990; Conquergood, 1992; Madison, 2012; Muñoz, 1999; Turner, 1982). Along these lines, performance theory purports a view of everyday performances and enactments of identity as a way of knowing and better understanding the world around us (Turner, 1982). Performance scholars view identity not as something someone *is,* but rather as something someone *does* (Butler, 1990). Therefore, agency is central to the performance perspective of identity. Subjects make active choices about how to enact an identity, and these performances demonstrate the constructedness of different structural expectations. It is not a matter of simply responding to being hailed and therefore being interpellated as something, but rather it is the choice to enact that interpellation on behalf of the actor that brings an identity to fruition.

> In opposition to theatrical or phenomenological models which take the gendered self to be prior to its acts, I will understand constituting acts not only as constituting the identity of the actor, but as constituting that identity as a compelling illusion, an object of *belief.* (Butler, 1988, p. 520)

Thus, identities only exist to the extent that they are performed. That is not to say that one can perform away issues of marginalization or inequality. Rather this perspective suggests that identity is not fixed but hinges on the performance of various discursive elements (Munoz, 1999).

Under the rubric of performance, the concept of performativity is key. At a base level, performativity refers to the power of an utterance not only *to mean* something but also *to do* something (Austin & Caton, 1963; Butler, 1997). The classic example of this is "I proclaim you man and wife": this sentence not only has symbolic meaning but also functions to restructure how people are addressed socially, legally, and politically. Confessions tend to have a similar performative power (Scott, 2003). When someone chooses to make declarations about him/herself (i.e., coming out as gay or lesbian, disclosing drug use, admitting infidelity, identifying with a religious organization, etc.), that person discursively reformats understandings and conceptualizations. For instance, admitting a homosexual act can disqualify a person from donating blood (Bennett, 2009). Clearly, confession can result in dramatic shifts of attitude and behavior on behalf of the subject and those interacting with him/her. Likewise, how a subject chooses to enact a confession or disclosure plays into the equation as well. Someone might admit to an aspect of his/her identity but actively perform that identity in a way that is contrary to conventional perceptions. Performance scholars recognize that through citational understandings, a subject can subvert or disidentify with particular aspects of him/herself (Muñoz, 1999). Ultimately, performativity has clear links to issues of identity.

Poststructural and performance perspectives are particularly germane to the present dissertation. While poststructural conceptualizations reside in the blurry and

opaque margins of discourse, I maintain that they provide holistic and deep understandings of the world around us. A major aim of this study is to mobilize and operationalize poststructural and performance theory in a practical manner within the purview of HIV prevention counseling. In describing, extending, and complicating understandings of the counseling situation I hope to help enrich counselor perspectives of the counseling context.

Health and Identity

In the health literature, identity has been taken up extensively with respect to how demographic markers are relevant to health encounters. Broadly speaking, these studies implicitly subscribe to the idea that identity is fixed, at least to the extent that demographic characteristics and culture are interchangeable. Studies have, for instance, examined how the race/ethnicity of the patient impacts the health encounter (Bhopal, 1998). Generally, these studies have identified discrepancies among different racial populations and their reported trust of health care providers (Armstrong et al., 2008; Gallo, Smith, & Cox, 2006; Meredith, Eisenman, Rhodes, Ryan, & Long, 2007); compliance with medical advice (Allen, Kennedy, Wilson-Glover, & Gilligan, 2007; Peterson et al., 1997); and access to care (Govindarajan & Schull, 2003; Williams & Mohammed, 2009). Scholars have also examined how gender plays into health encounters. These studies show that gender does play a role in patient-caregiver interactions in regard to building rapport (Gross et al., 2008); expressing personal concern (Gabbard-Alley, 1995; Stratton, Saunders, & Elam, 2008); and an overall preference from female patients to see female doctors (Bean-Mayberry et al., 2003).

Disability has also been investigated in relation to health contexts. These studies demonstrate that many doctors feel discomfort when caring for patients with disabilities (Kroll, Beatty, & Bingham, 2003), which is exceedingly unfortunate because people with disabilities often have increased difficulty changing doctors (O'Connell, Bailey, & Pearce, 2003); consequently there is more attention to these issues and caregivers are getting trained about interacting with patients with disabilities (Tuffrey-Wijne, Bernal, Butler, Hollins, & Curfs, 2007). Age is another major category of identity that has been analyzed within the health context. Older patients face a plethora of prejudices which impede on their care and sense of self. Caregivers avoid older patients (Giles, Ballard, & McCann, 2002); view them as less accommodating (Ota, Giles, & Somera, 2007); and even disparage them (Fowler, Fisher, & Pitts, 2008). These studies establish the relevance of identity to health but construe identity in very narrow and generic terms.

The other primary way in which identity has been engaged in the health literature relates to how it is affected by illness. The founding assumption of most of these studies is that identity is socially and culturally constructed and thus variable, although they do tend to assume a coherent identity. The literature tends to fall along two themes. The first major theme discusses identity as a negotiation, or coming to terms with a chronic illness. Several models have been developed to explain how individuals preserve, expand, and/or reform their sense of self in the face of a chronic illness (Asbring, 2001; Bury, 1982; Charmaz, 1987, 1995; Kelly & Field, 1996; Lonardi, 2007; Telford, Kralik, & Koch, 2006; Thornhill, Lyons, Nouwen, & Lip, 2008; Walker, Holloway, & Sofaer, 1999). These models generally discuss identity as a process whereby individuals undergo fairly ritualized steps in constructing a new self.

The final major theme apparent in the health literature is relevant to stigma. A significant branch of health research has analyzed how stigma associated with particular health conditions can affect an individual's perception of her/himself when affected by a stigmatized condition. Consequently, this perception can also cause people to be wary of taking proper care of or even getting checked for certain health concerns (Kosenko, Hurley, & Harvey, 2012; Smith, 2003). Fundamentally, stigmas are "social constructions shared among members to socialize them as to how they can recognize the stigmatized and enact the required devaluation of them" (Smith, 2003, p. 455). Following foundational identity theories, like the looking-glass self, it is plain to see how stigma can affect one's identity. If someone is devalued in the eyes of those around him/her, s/he can easily begin to devalue him/herself and subsequently change his/her own self-concept. Thus, stigma can devalue individuals to the extent of making them feel like outsiders and even inhuman (Goffman, 1986). Consequently, issues of stigma and identity are distinctly interrelated. Much of the health literature regarding stigma addresses strategies to cope (Hatzenbuehler, Phelan, & Link, 2013; Link, Mirotznik, & Cullen, 1991; Link & Phelan, 2014). Withdrawal, secrecy, and education have been identified as major ways in which stigma is managed. Withdrawal refers to taking action to selectively expose oneself only to those accepting of, or also associated with, the stigmatized status (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002). Secrecy refers to purposefully concealing marks that could associate one with a stigmatized label (Goffman, 1986; Herek, Capitanio, & Widaman, 2002). Education, in this case, refers to a strategy of coping with stigma by intentionally disclosing one's stigmatized label in order to better inform others and potentially reorder negative valuations (Link et al., 1991; Peters et al.,

2005). In sum, stigma is potentially the leading impediment to health promotion, treatment, and support (Smith, 2003).

The literature examining identity in relation to HIV/AIDS has reflected both of these trends as well. Like other chronic conditions, there are models for how people negotiate their identity in relation to their seropositive status (Baumgartner, 2007; Baumgartner & David, 2009). These models recognize the shifting nature of identity but still deploy a relatively fixed notion that identity moves along a linear path that is then integrated into one's sense of self.

Perhaps most of the literature in this vein, however, reflects an understanding of identity as constructed, in particular focusing on how social stigma—especially but not necessarily predicated on cultural perceptions of sexuality—shapes and impacts identities. HIV/AIDS is a primary example of a location where health and stigma intersect. This is because HIV/AIDS disproportionately affects already stigmatized groups: gay men and intravenous drug users. As a result, efforts to spread awareness of the virus effectively caused people to fear not only the virus but also those infected. Studies focus predominately on stigma as it extends to issues of disclosure (Allen et al., 2008; Caughlin et al., 2008, 2009; Maiorana et al., 2012), prevention/intervention (Berkley-Patton, Goggin, Liston, Bradley-Ewing, & Neville, 2009; Cohen et al., 2011; Jones, 2002), and support (Brashers et al., 1999; Muturi & An, 2010; Owen & Catalan, 2012; Peterson, 2009).

Poststructural scholars have productively discussed issues of HIV, stigma, and identity (Brouwer, 1998; Patton, 1996; Scott, 2003; Treichler, 1999). Tracing HIV/AIDS discourse through history, these scholars have identified the ways in which binaries shape

conceptualizations of the virus and those affected. Namely, findings demonstrate that by emphasizing the deviant nature of those “at risk” of transmission, conventional discourse purports that “ordinary sex” among “ordinary people” is “safe” and more healthful (Patton, 1996; Treichler, 1999). Subsequently this focus has constructed safer sex practices, like using a condom, as a deficient form of sex (Patton, 1996). The stigma surrounding HIV/AIDS has become central to the virus, largely due to how it has been taken up politically and socially (Treichler, 1999). The ways in which the discourse has embedded HIV in shame and stigma have caused some seropositive activists to attempt to subvert ideas around the virus by visually branding themselves with images that reflect their status (Brouwer, 1998). Consequently, issues of stigma are also painfully apparent in the counseling context (Scott, 2003).

While there have been significant advances in theoretical understandings of the relevance of identity to HIV, there has been little work to comprehend how this is mobilized within the prevention counseling context. With the present study, I aim to extend the work of these scholars to better understand the poststructural and performative nature of the cultural performance of getting tested and counseled for HIV. This dissertation could have both theoretical and practical benefits, as it will extend scholarly understandings and potentially improve counseling efforts. Namely, a more complex understanding of the counseling situation could allow for more nuanced and reflexive approaches on the behalf of the counselor.

Health Counseling

Historically, many health-counseling situations were and often still are conceptualized as counselor- or health care provider-centered, meaning that the counselor runs the session by asking leading questions and providing clear directives for the client. Scholars have critiqued this approach, arguing that it robs clients of agency and can subsequently affect clients' sense of self and by extension their sense of self-efficacy. Moreover, critics note this framework often positions the client as at fault for their condition and responsible for its resolution, which counselors promote by indicting "bad" practices and reciting "proper" precautions (Lupton, Mccarthy, & Chapman, 1995). Thus, this approach can exacerbate feelings of guilt and shame and cause clients to have a negative shift in personal identity and arguably result in even poorer health choices, such as feelings of fatalism (Peterson, 2009) and refusing to get tested again (Fox, 2007).

Rogers (2003) has suggested and designed a protocol for counseling that reorients the focus and allows clients to take more control of the session. Client-centered counseling is an in-depth and lengthy form of counseling that allows the client to steer the counseling conversation through open-ended questions and elicitation. Building from this foundation, further research has suggested that motivational interviewing practices also help counseling in health contexts (Miller & Rollnick, 2012). Motivational interviewing is a goal-oriented approach that is nonjudgmental, nonconfrontational, and nonadversarial. Adding to this, agency-promoting dialogue can also help directly combat issues of internalized stigma, demystify poor self-perceptions, and allow individuals to renegotiate self-expectations (Mattson, 2000). In sum, allowing and empowering a client to codirect and collaborate a counseling session helps him/her maintain a positive self-

image through the counseling process (Lambert & Barley, 2001).

Whether counselor-centered or client-centered, health-counseling situations largely fall under the rubric of risk reduction. Risk reduction essentially entails a process of identifying risky behaviors, discussing those risks, and then producing a plan to minimize or eliminate risks (Becker & Joseph, 1988). This plays directly into issues of identity, as what someone does, or even who s/he is, can position him/her as "at risk" (Patton, 1996; Treichler, 1999). Furthermore, there are critiques of the efficacy of risk-reduction counseling, demonstrating that it does little to get clients to alter behaviors (Weinhardt, Carey, Johnson, & Bickham, 1999). The way this risk is discussed and the level of empowerment offered to the client are therefore key in cultivating a strong and positive self-image for the client. Much of this continues to be underpinned by the transtheoretical model (Prochaska & DiClemente, 2005). The transtheoretical model is a five-step behavioral change model that has been widely applied in health contexts. The steps include: precontemplation, contemplation, preparation, action, and maintenance. The stages of this model are used explicitly in the training materials to become a HIV prevention counselor. In implementing this model, counselors gauge where clients are and facilitate them through this process to safer goal behaviors.

Conversely, harm reduction theory accepts the inevitability of unhealthy behaviors and aims to limit the harmful effects of those behaviors instead of attempting to eliminate the risky behavior altogether (Mattson, 2000; Monti et al., 1999). Following the goal-oriented tenets of motivational interviewing, harm-reduction approaches attempt to combat the possibility of judgmental counseling by focusing conversations on the adverse consequences of a behavior for the client and/or community and how to mitigate

these consequences instead of immediately and categorically trying to eliminate the behavior itself (MacCoun, 1998; Mattson, 2000). Harm reduction was originally conceived as a means to combat drug abuse but has since been applied to other issues like alcohol abuse (Marlatt & Witkiewitz, 2002), tobacco use (Stratton, Shetty, Wallace, & Bondurant, 2001), and unsafe sexual practices (Mattson, 2000). A common example of a harm-reduction measure is needle exchange programs, where injection drug users are urged to exchange old needles for clean ones. Such programs address the cause (sharing works) of the adverse consequence (HIV or Hep C transmission) without solely attempting to eliminate the injection drug use. Scholars have called for harm reduction to be directly applied to HIV prevention counseling (Mattson, 2000). Moreover, studies show that harm reduction has been effective in getting clients to take up safer practices to mitigate HIV transmission (Ameijden, Hoek, Haastrecht, & Coutinho, 1992; Parsons et al., 2005).

While research has linked harm reduction to HIV prevention counseling, there has yet to be an investigation as to how this is taken up in relation to identity. There have yet to be any studies that place enacted identities and health counseling in direct and explicit relation with each other; moreover, as noted, the conceptions of identity reflected in the majority of the extant literature do not reflect more recent poststructural theorizing of identity. The present study aims to fill this gap. Understanding the counseling process and the identities involved in a more holistic and nuanced manner can help counselors better act in productive, reflexive, and client-centered ways. I intend to gain an understanding as to how harm reduction is mobilized in the counseling process and to what extent identity is apprehended and negotiated in this process.

Method

In order to address the research questions, this project involved in-depth investigation of the counseling context. I personally became a HIV prevention counselor and gained intimate insight into the process. Additionally, data were collected and analyzed to better understand the complex interaction between counselors and clients within the counseling dynamic. The following section describes how I got involved in counseling and how I worked to maintain a reflexive position throughout the process.

In preparation for this dissertation, I decided to enter the field of HIV prevention counseling myself. In order to volunteer with the AIDS Foundation, one must attend the agency's orientation and training program. I attended the Foundation's volunteer training on February 13th, 2013. This evening training is for anyone who wishes to volunteer with the AIDS Foundation in any capacity. For those interested in volunteering with the test site, there is an additional training. I completed test site training on April 10th, 2013, in order to be part of the testing and counseling side of the AIDS Foundation. To be a HIV prevention counselor one must be certified through the State Health Department. This is an extensive three-day (8am-5pm) process that I accomplished May 8-10th of 2013. Since being certified, I have consistently volunteered for the AIDS Foundation on Mondays and Thursdays during test site hours (4:30-7:30pm) and have volunteered over 250 hours. Throughout the last two years, I have become committed to the vision and mission of the AIDS Foundation. I recently accepted a position with the AIDS Foundation, and I have developed strong relationships with the volunteers and community members involved with the agency.

Since I am close to the AIDS Foundation and the people involved with the agency,

a high level of reflexivity and transparency is paramount for this dissertation. Working with people and producing research about them is not something to take lightly. Some might critique that in my efforts to assimilate and become part of the foundation's culture, I could haphazardly end up producing work that Conquergood would call a result of an "Enthusiast's Infatuation" (1985, p. 6), meaning that I would potentially allow my identification with, and commitment to, the AIDS Foundation to cloud my assessment and produce superficial claims. My involvement with the AIDS Foundation has allowed me to move beyond the positionality of "naïve researcher" to "insider researcher." This has been extremely beneficial, as many of my preconceived notions about the AIDS Foundation, prevention counseling, and sexual health have been challenged. For instance, I had assumed that, because of the conservative nature of the state where the present study was conducted, the State Health Department training would promote conservative messages such as abstinence. I was pleasantly surprised to find that this was not the case. Some may critique insider research because it has implications for a researcher's objectivity, but as an interpretative qualitative scholar I would argue that true objectivity is a myth and through transparency and reflexivity I intend to provide more in-depth and rich analysis. Additionally, becoming an insider in this organization is something that I did for this research particularly, and something that speaks to the rigor of the study.

In order to more completely understand the complex enactments of identity occurring within the context of HIV prevention counseling, it is necessary to use methods that provide an opportunity for individuals to express an in-depth description and narrative of their experience(s). As such, qualitative methods were used to allow for flexibility and adaptability in this study. Doing so can help allow for fuller

understandings of the participants and their stories. Specifically, I use situational analysis (Clarke, 2005) to approach this study. To gather data, I conducted unstructured interviews with HIV prevention counselors, observed and annotated over 100 hours at the test site as a participant, analyzed the physical space of the AIDS Foundation, and reviewed the policy, protocol, and training material texts. This helped me gain an understanding of how HIV prevention counseling is constructed materially and experienced, enabling me to examine the enactment of identities within the counseling process and to recognize the complex interplay between them. Next I will discuss the methods chosen for data collection and analysis.

Data

For this dissertation I use texts, visual/physical space, interviews, and participant observation as data. I will briefly describe what constitutes each and how I collected the data for this study.

First, I analyze the various texts that constitute the policies, protocols, and training materials for HIV prevention counselors. These texts include the *Fundamentals of HIV Prevention Counseling Training Curriculum* (2009), the CDC mandated "HIV Test Form," "Test Site Client Encounter Form," and "HIV and STI Risk Factors Worksheet." I use a critical rhetorical orientation for this portion of the data analysis in order to identify fragments within the discourse and analyze those fragments in order to understand how the discourse functions to construct identities within the prevention counseling context (McGee, 1990). Critical rhetoric fits nicely with the present study because it recognizes situations as polysemic and performed (McKerrow, 1989).

Likewise, critical rhetoric commonly deploys poststructural perspectives (Cloud, 1994). For purposes of the present rhetorical analysis, I am familiar with the texts through my experiences as a prevention counselor. For this study, I revisited these texts in depth in order to more thoroughly identify the fragments of discourse that construct the foundational narrative of identity that undergirds the counseling context. To this end, I thematically coded each reference to counselors and clients, both explicit and implicit, found in the guiding texts. I initially coded sentence-by-sentence in order to divide counselor and client fragments. I subsequently derived themes from the two as they related to identity.

I also follow a critical rhetorical orientation for the spatial analysis of this study. Similar to the textual analysis, I analyzed visual fragments of discourse for this portion of research. Scholars recognize that place and space offer rhetorical planes upon which social realities are negotiated (Lefebvre, 1991; Massey, 1994; Cresswell, 1996). Plainly, the dynamics of space and place can construct subjects even before an interaction occurs. For instance, sitting at the head of the table has particular social connotations that are significant and should be recognized within the larger context of a communication situation. For the present study, visual elements of the physical space of the AIDS Foundation were extensively noted. I walked through the physical space of the AIDS Foundation as a client would several times. I also underwent testing myself in order to more accurately register the visual qualities of the space. Additionally, I observed the spaces often occupied by counselors. With these visual fragments of discourse, I assess ways in which the space of the AIDS Foundation positions the counselor and client and therefore potentially influences identity construction and negotiation.

The main source of data for this project is qualitative interviews. Qualitative interviews allow researchers and participants to co-construct understandings, explanations, and discoveries (Tracy, 2013). They allow for moments of reflection and interpretation of phenomena that might otherwise be invisible (Rubin & Rubin, 2005). Moreover, when conducting qualitative interviews, researchers should continually critically reflect on their role and positionality (Roulston et al., 2008). Unstructured interviews allow for more natural and flexible conversations with participants (Tracy, 2013). I use this design/arrangement in order to garner deep and organic insights about the research questions I have posed.

With the qualitative interviews, I implemented an unstructured interview protocol that probed participants on how they counsel, why they counsel, and how they understand identity as it relates to counseling. I began every interview with the same general question: "tell me about your experiences as a prevention counselor." Some participants took this question and provided a lengthy and detailed account while others needed more probes (see Appendix A).

In order to maintain an ethical and socially responsible stance throughout the interviewing process, I followed general interview standards (Lindlof & Taylor, 2010). To begin with, the interview participants were provided an informed-consent form to review and sign prior to the interview. Interviews were audio recorded and transcriptions were produced. To maintain confidentiality, each participant has been given a pseudonym. As part of my commitment to viewing participants as co-constructors and not mere subjects I gave them the option to provide their own pseudonym. All materials that contain actual names were securely locked, in a file or on a password-protected

computer, until transcriptions with pseudonyms were made and the original copies were disposed. Participants had the option to review transcripts in order to decide if they wished to continue participating in the study.

I initially used a convenience sample to recruit participants for this study. During test site at the AIDS Foundation I began to ask fellow counselors if they would participate. After I started interviewing I also implemented a snowball sample to recruit more counselors to participate. All individuals invited to participate were adults, 18 years and older. For the present study I interviewed 16 volunteers. Nine of the participants identify as gay white men. Three of the participants identify as straight white men. Three of the participants identify as straight white women, and one identified as a gay white women. This is largely representative of the demographic makeup of the AIDS Foundation. There are some Asian and Hispanic volunteers at this AIDS Foundation, but the counselors are mainly white men. At the point of the interviews, I was a fellow counselor. It is important to recognize that this may have affected the responses of the participant vis-à-vis the "Rosenthal Effect" (Rosenthal & Jacobsen, 1968). Plainly, participants may have said what they thought I wanted to hear since they had a preexisting relationship. Although, of course, I could not control for this, I attempted to account for this inclination by being conscious of it, first of all, and crafting and presenting questions in ways that did not clearly invite particular responses.

After interviews were transcribed they were analyzed and coded via a grounded, thematic close reading. The transcripts were initially coded event-by-event, using thematic, descriptive, and in-vivo codes. After the first-level coding, I revisited the data and conducted axial coding in order to elaborate and focus the findings and verify their

validity.

Once I completed all of my one-on-one interviews and began my analysis of these data, I also conducted an informal group theoretical interview session. Other scholars have used a mix of group and one-on-one interviewing techniques with great success (Rintamaki, Scott, Kosenko, & Jensen, 2007). This is advantageous because group interviews can help generate a certain synergy within collectives that can help reveal unarticulated norms and assumptions (Kamberelis & Dimitriadis, 2013). I held the theoretical group interview after test site on May 14th, 2015. Six participants were able to attend. I informally discussed the group interview with the other participants who could not make the interview, and documented their feedback in my participant observation notes. During the theoretical group interview, I presented the emerging themes and findings of my research and allowed the participants to contribute to and/or critique my working conclusions. Participants cohered with my findings and were able to offer more experiences to help bolster my evidence. Participants remembered different stories and found better ways to articulate their experiences as they engaged with one another. This was also helpful for me as researcher to fill holes in my previous data collection. The data from this group interview were further mapped along with the emergent themes from the interview data as well as the findings from the textual and spatial analysis.

Finally, as part of this dissertation I volunteered over 250 hours at the AIDS Foundation and created field notes for 100 of those hours as a participant observer. Ethnographic methods are not the primary approach to this study, but certainly help supplement and support the other forms of data. I got extensively involved with the

AIDS Foundation in order to fully participate in the organization. In my analysis and interaction I attempt to move beyond participant observation and become a co-performative-witness (Conquergood, 1991; Madison, 2012). "Performative-witnessing is to speak 'with' not 'to' or 'at' others and where ethnographic interlocutors are co-temporal in the report" (Madison, p. 25), meaning that I was part of these conversations and not simply reporting what the "subject" had to say. As such, I reflexively recognize my position within the conversations. Maintaining that performance is central to this study, I turn to impressionist recall of my observation (Van Maanen, 1988/2011). By impressionist recall I mean I merge realist and confessional approaches to reporting participant observations. Realist tales tend to focus solely on the "other" and reports on cultures without implicating the researcher. Confessional tales take the opposite approach and focus primarily on the researchers' experience within a given culture. Impressionist tales, on the other hand, focus on the dynamic interplay between self and other within the field observation. These ethnographic approaches ultimately serve as additional discursive formations that inform the situation. They supplement the interview data and are thus positioned within the great situational maps of the present dissertation.

Situational Analysis

Situational analysis is a postmodern/poststructural interpretation of grounded theory. Grounded theory is a methodological strategy that provides researchers with a rigorous framework for an inductive, emic approach to data analysis (Tracy, 2013). Simply put, grounded theory allows for theory to emerge from data, as opposed to forcing theoretical frameworks to fit particular situations. Sociologists Barney Glaser and

Anselm Strauss originally developed this research design in order to better understand localized and situational processes (Glaser & Strauss, 1978/2009). Since its inception, Glaser and Strauss moved in different directions as to how grounded theory should be conducted. Glaserian grounded theory has been described as being imbued in "dispassionate empiricism, rigorous codified methods, emphasis on emergent discoveries, and its somewhat ambiguous specialized language that echoes quantitative methods" (Charmaz, 2006, p. 7). Straussian grounded theory, on the other hand, recognizes humans as active agents of their lives, who, through language and actions, create processes which construct and maintain structures, as opposed to being passive products of structural issues (Charmaz, 2006). Thus, Struassian grounded theory follows the sociological concept of symbolic interactionism and considers the ways in which people construct, maintain, and transform meanings through symbols. Interestingly, Strauss and Corbin (1990) later extended the procedural demands of grounded theory research and were criticized by Glaser for being too prescribed and structured, which he contended was antithetical to the point of grounded theory.

Adele Clarke further extended the scope and aim of grounded theory to account for the postmodern/poststructural turn. Situational analysis supplements traditional grounded theory by expanding the focus from action to the greater implications of the situation that surround the actions studied. As such, situational analysis follows in "Foucault's footsteps" and considers how historical, narrative/textual, and visual discourses intersect the action(s) analyzed within the given context. Given that I intend to approach this study with a poststructural and performance lens, it is only logical to utilize this method. The present study focuses on identities as they are enacted in relation

to one another in the health-counseling context. This interaction involves multiple elements that constitute identity formation and negotiation, thus makes situational analysis the most appropriate for this study.

Situational analysis calls for a cartographic approach on behalf of the researcher, meaning the themes that develop from the data should be mapped together with other pertinent discursive elements in order to better understand the situation more holistically. Clarke proposes that this process begins with "messy maps" that inform more elegant maps that are constructed from discursive elements like social relations, narrative, and visual dynamics (see Appendix B). Accordingly, the present dissertation offers multiple levels of data and analysis that are mapped together. First, I offer a textual analysis of the narratives provided in the policy, protocol, and training texts. Following, I provide a visual analysis of the physical space wherein counseling and testing occurs. In order to analyze these discursive elements of the situation, I deploy a critical rhetorical orientation. Critical rhetoric provides a means to analyze the textual and visual components of the context that complement the situational analysis. The participant observation and interview data provide specific narratives of identity that are informed by the visual and textual elements. Furthermore, I plot these data in relation to each other and the greater social and historical landscapes that surround HIV/AIDS and health counseling. This provides a strong foundation for the performance perspective I provide. Informed by these discursive elements, the role of performance is ultimately the embodied enactment of these various parts.

Conclusion

Ultimately, attempting to apprehend the ways in which identities are negotiated and enacted in the HIV prevention-counseling context has potential to yield fascinating results, in both theory and praxis. The extant literature of health counseling and identity focuses on generic markers and linear models of behavior change. I hope to expand these understandings with this study. A poststructural and performance perspective of the health-counseling context can potentially offer greater insight to the interactions between client and counselor. This is significant because the greater the understanding of the situation, the better counselors can prepare for the situation and its complexity. Accordingly, situational analysis provides the perfect trajectory to move beyond the action process of counseling and analyze the greater context of the situation. The discursive formations surrounding HIV/AIDS position the virus in ways that deeply connect with one's sense of self. As such, qualitative methods, namely situational analysis of text, space, interview data, and participant observation, provide the flexibility and deep examination needed for this study. With the present study, I hope to examine and further our understanding of the role and relevance of identity in health counseling contexts in new and fruitful ways.

CHAPTER TWO

TEXTUAL ANALYSIS OF POLICY AND SPACE: CASING THE SCENE

Most studies on counseling communication thus far have focused primarily, and understandably, on interpersonal interactions during the counseling session, and this one ultimately will, as well. However, a number of other communicative artifacts constitute the context for this and thus inform that interaction, including counselor training texts and activities and the actual environmental setting in which counseling occurs. More specifically for my purposes, contextual considerations, like governing texts and setting, inevitably inform and contribute to the production of subjectivities and interactions. Following the tenets of situational analysis (Clarke, 2005), it is relevant to analyze various discourses that constitute the foundations of HIV prevention counseling. For this dissertation, I will analyze textual and visual elements that inform the counseling situation. Different texts used by counselors, such as training manuals, session checklists, and required paperwork, either constitute or prompt policies and protocols used to guide the counseling interaction. Furthermore, the physical environment where the counseling occurs also influences interactions and will be analyzed. While interactions inevitably vary from encounter to encounter, contextual considerations like standardized policies and protocols as well as the actual, material contexts in which

interactions occur plainly inform all encounters and accomplishment thereof, and thus bear analysis.

Policy and Protocol Texts

Scholars have established that policies and protocols constitute interpretative and symbolic events. Essentially, policies and protocols, like all texts, are embedded in social, cultural, and historic contexts that are important to uncover and consider (Patterson, 1997; Scheurich, 1994). In fact, policy knowledge is commonly constructed through social structure and situated interactions (Canary & McPhee, 2009). Any universalizing effect is thus not necessarily a product of well-written policy itself but the accomplishment of such policy through socially structured interactions and experiences.

As relevant to health, preexisting constructed beliefs about health issues have a clear influence on the creation of policy and protocol. For instance, the social construction of breast cancer versus cervical cancer has been shown to have material effect on the priority they receive in health policy, further subjugating the more sexualized nature of cervical cancer (Reichenbach, 2002). In fact, the difference in perceptions of breast and cervical cancer has an impact on prevention and treatment measures (Lantz et al., 2003).

HIV/AIDS is a particularly rich subject as relevant to the intersection of culture and policy. Initial conceptualizations of HIV/AIDS were embroiled in perceptions of those affected as deviant; the virus was considered a problem for injection drug users and promiscuous gay men and therefore did not garner much political action or direct policy (Treichler, 1999). However, the case of Ryan White, a young boy who contracted HIV

through a blood transfusion, introduced a more socially sympathetic face of HIV and subsequently brought more political momentum to the cause (Donovan, 1993). Furthermore, direct policy was created as a result, and the Ryan White Act was enacted. Critics argue that this act demonstrates the ways in which funds are disproportionately allocated to causes with more positive social constructions (Donovan, 1993). Senate voting on HIV/AIDS policy has confirmed this bias toward more positive, (i.e., "innocent" or "dependent") constructions versus more negative constructions (i.e., "deviant") (Schroedel and Jordan, 1998). Moreover, prison policy concerning inmates with HIV has directly correlated with social perceptions of the virus (Hogan, 1997). A virus like HIV, which is so deeply embedded in constructions of deviance, clearly illustrates the ways in which health policy and social construction inform, cohere, and redouble one another.

More importantly, there is also plenty of scholarship that demonstrates how policy and protocol can function to socially construct subjectivities, or identities and perceptions thereof, which inevitably influences how participants interact with each other. For instance, a classic example of a negative social construction of a health condition is leprosy, and research has found that this negative construction has been highly internalized as a result of a half century of public policy (Frantz, 2002). In the case of leprosy, fear informed public policy, which, in turn, cemented negative constructions of the infection. Policy cannot be held accountable for fully creating the social construction per se, but it plays a key role in perpetuating or combating, in some cases, social understandings of illnesses. Effectively, this creates a "stratification of 'goodness'" (Lupton, 1995, p. 91), which connects issues of health with other social factors that are

then further perpetuated through policy. Health care report cards, for instance, have been shown to reinforce biases against marginalized people who need help with health care the most (Davies et al., 2002). Clearly, there is a strong interwoven connection between health, policy, and social construction at work.

One common effect of policy is that it tends to construct the target population it is attempting to reach and/or address in particular ways (Ingram, Schneider & Deleon, 2007). It is clear that policy can have material effect on how people view themselves and others. Policy leads to a host of texts and practices that mediate and cultivate particular identities (Nichols & Griffith, 2009). Essentially, policy helps create role expectations within a given context, in this case HIV prevention counseling, and then the agents involved within the context will either comply with or contradict these expectations. Effectively, this discursive process functions to "render individuals knowable" (Wallace, 2003, p. 52). A major way that policy can render individuals knowable is through constructing individuals as *dependents* or *deviants* (Ingram, Schneider & Deleon, 2007). Both these constructions share a lack of overt power but differ in how people tend to view them. Dependents have a more positive construction and thus garner more sympathy and support. Deviants, on the other hand, are seen more negatively and suffer more blame. Often, these constructions are a direct result of policy.

Considering that training materials commonly function to help create policy knowledge and proper protocol adherence, it is logical that these materials also contribute to identity perceptions and formations. Significant scholarship exists on how to train professionals to acknowledge or address different identities, but it tends to conceive of identity as a fixed or rigid state. Studies in this vein address how to avoid heterosexism

or homophobia in the workplace (Robinson & Ferfolja, 2002), how to conceptualize whiteness as a racial identity in order to avoid viewing race issues as “other” (Sabnani, Ponterotto & Borodovsky, 1991), or how to recognize identity as an individual enactment of various roles (Hull & Zacher, 2007). This work introduces significant components of identity to the literature regarding training materials, and I intend to extend this by analyzing how training materials and policy function to construct identities while being simultaneously informed by them.

Furthermore, especially in publicly regulated contexts like health, identity is negotiated at the intersection between policy-driven practices and actual encounters (Wallace, 2003). While each encounter is of course variable, contingent upon the experiences, perceptions, and performances of all parties; policy and attendant practices inevitably inform how identity is negotiated, and thus bear analysis. Policy can also offer an opportunity to understand how power functions behind the scenes by discursively ordering our understandings of particular interactions or processes between subjects (Buzzanell & Liu, 2007).

In sum, “texts create a textual reality that is sustained through the actions they coordinate and the concepts they legitimize” (Nichols & Griffith, 2009, p. 245). The present study aims to uncover how policy, constituted through the training curriculum, counseling worksheets, and the CDC report form, functions to construct identities within the HIV prevention counseling context. As I have stated, it is imperative to not read the text(s) in a vacuum but to recognize these materials exist within greater social, historical, and cultural contexts, and to appreciate the lived experiences of the prevention counselors who engage them. The dissertation extends this textual understanding in order to uncover

the ways in which identities are preconceived at the start of an HIV prevention counseling session.

Texts Analyzed

The texts I have chosen to analyze for this project are the *Fundamentals of HIV Prevention Counseling Training Curriculum* (2009), the “HIV Test Form” that all HIV testing and counseling sites have to submit to the CDC, and the “Test Site Client Encounter Form” and “HIV and STI Risk Factors Worksheet,” which are specific to the AIDS Foundation analyzed in this study. I choose these texts because they are the most prevalent and most significantly utilized in the AIDS Foundation.

The *Fundamentals of HIV Prevention Counseling Training Curriculum* is a standardized training program that anyone in the United States who wishes to become a prevention counselor must pass in order to be certified. Training comprises three full workdays (8am-5pm) in order for all the material to be taught and opportunities provided for future counselors to gain hands-on experience with different training activities and exercises. The curriculum begins with an overview that covers important definitions, explanations, and concepts, as well as a brief history of HIV prevention. The focus of the curriculum is to instill “Counseling Concepts,” develop “Basic Counseling Skills,” and teach the “Six-Step HIV Prevention Counseling Protocol.” In brief, the “Counseling Concepts” include: (1) focusing on feelings, (2) managing personal discomfort, and (3) setting boundaries. The “Basic Counseling Skills” in the training involve: (1) asking open-ended questions, (2) attending to the client, (3) offering options, not directives, and (4) giving information simply. The “Six-Step HIV Prevention Counseling Protocol,”

asks that counselors (1) introduce and orient the client to the session, (2) identify risk behaviors and circumstances, (3) identify safer goal behaviors, (4) develop a client action plan, (5) make referrals and provide support, and (6) summarize and close the counseling session. These are the major guidelines set forth within the training curriculum, and constitute a significant piece of HIV prevention counseling policy. In order to bring these concepts to life, the training material also provides a series of role-play activities and other exercises. The role-play exercises are the most significant in the training, in both their quantity and their overall impact on the training. Moreover, these role-play activities offer constructions of potential clients that can be evocative to the perceptions of client identity on the behalf of the counselor.

In addition to the training material that informs counselors of protocol and policy, it is also important to analyze the texts that counselors interact with during the counseling process. The CDC's "HIV Test Form" is a list of information that the CDC requires all counselors to fill out about clients in order to maintain funding. The form requires counselors to track information about the client and the test site. In filling out the form, counselors record information about the client's demographics, the type of test(s) the client is receiving, and a summary of a behavioral risk profile. The risk profile is broken down into a series of questions about sexual practices and drug usage with a "Yes," "No," or "Doesn't Know" allocation. The bottom of the form allows for the counselor to list additional risk factors and other session activities. Codes for these designations are listed on the back of the form.

The "Test Site Client Encounter Form" and "HIV and STI Risk Factors Worksheet" implemented at the AIDS Foundation address HIV education and ensure that

the necessary information required by the CDC is recorded. The "Test Site Client Encounter Form" is a form that the client initially fills out, providing basic information about him/herself. On the back of the form are "progress notes" where the counselor will initial next to the major points that were discussed in the counseling session and ultimately summarize the pre- and post-test session. The *Fundamentals of HIV Prevention Counseling Training Curriculum* does not focus primarily on education, so the "Test Site Client Encounter Form" enables counselors to discuss key features of HIV and its transmission with clients. The "HIV and STI Risk Factors Worksheet" is essentially a checklist of "risk behaviors" that directly correlates with the CDC Test Form. Both these forms are particular to the AIDS Foundation but adhere to, and are thus products of, national policy and reporting set forth by the CDC.

I first became acquainted with these texts over a year and a half ago when I decided to become a HIV prevention counselor in order to move past the position of naïve researcher and potentially gain richer and deeper understanding through insider research. I have revisited these texts extensively, thematically coding each reference to counselors and client. This included explicit and implicit references to the client and/or counselor in order to identify characterizations that might inform perceptions and, potentially, interactions in the counseling encounter.

Counselor Identity: Authoritative Positionality

The *Fundamentals of HIV Prevention Counseling Training Curriculum* (2009), defines HIV prevention counseling as "client-focused exchange designed to support individuals in making behavioral changes that will reduce their risk of acquiring or

transmitting HIV" (p. P 2-5). At the heart of counseling, the counselor is positioned as someone who is able to support and facilitate change in the client, and moreover knows what is best for the client. Throughout the training curriculum it is made clear that counselors are to "Assess… Provide… Interpret… Negotiate…" (p. P 5-5) and "Inform… Explain… Tell… Assess… Inform… Tell…" (p. P 5-10), and this clearly positions the counselor as someone with a certain skill set, expertise, and authority. There is a notion that as counselors "we need to help them [clients]" (p. P 3-5), and this places the counselor as an active agent in an authority position. When analyzing the texts that constitute HIV prevention counseling policy, it appears that the role of the counselor is most clearly characterized as an authority within the counseling dynamic. Within this authoritative positionality, there are also two distinct variants of authority that are offered through the text: *expert* and *mentor*.

Central to this sense of authority is that the counselor has the agency within this situation. Regardless of how much a counselor focuses on the feelings of the client, the counselor is expected to identify risk factors and develop an agreeable prevention plan for the client. Throughout the policy texts, there is an underlying notion that all clients who are tested need to undergo some sort of behavioral change that is directed or guided by the counselor. This implication is clear when considering steps 2 and 3 of the protocol, "identify risk behaviors and circumstances," and "identify safer goal behaviors." Clearly, this positions the counselor as an authoritative interlocutor with agency in the counseling session, no matter how much s/he attempts to combat this. This is also exemplified in the "HIV and STI Risk Factors Worksheet" and CDC "HIV Test Form." In accordance with these forms, the counselor assesses and fills out information about the client and his/her

risk(s). The designations reported in the form and worksheet are a result of a discussion, but the ultimate determination is still placed firmly in the hands of the counselor.

While the training curriculum in general stresses the importance of open-ended questions, the checklist format of the "HIV and STI Risk Factors Worksheet" and CDC "HIV Test Form" can potentially prompt a counselor to recite a string of closed questions. The impulse to use closed questions establishes clear parameters, wherein the client's agency is constrained while the counselor's agency is further established. While checklists should be used as a guiding tool for counselors, they can easily serve as scripts (Scott, 2003). If counselors are asking the standardized questions, they inevitably assume agency in the encounter. Closed questions demand a performative confession on the part of the client. "Confessional discourse works performatively to enact the subject. That is, confessional admissions help shape the very subject who utters them" (Scott, 2003, p. 133). Thus, closed questioning tends to place the determination of a client's identity in the hands of the counselor, which is then reinforced with the "HIV and STI Risk Factors Worksheet" and CDC "HIV Test Form." For instance, if a counselor defers to the "HIV and STI Risk Factors Worksheet" s/he might ask, "have you ever had sex in exchange for money or drugs?" Again, it is the agency of the counselor that will determine how this plays out, and that is continually perpetuated within the texts.

Expert. In addition to being constructed as the authority with agency, there are two significant positionalities within this authoritative umbrella. First, the counselor is continually positioned as an *expert* within the text. The counselor is present to serve and support the client, but the text makes it clear that the expertise, skills, and power are thus in the hands of the counselor. For instance, in a definition of counseling in general, it is

explained that the "counselor brings a set of skills to the interaction that can enable the client to reach a better understanding of the problem, deal with her or his related feelings and concerns, and assume responsibility for evaluating alternatives and making choices" (p. P 2-6). This description maintains a client-focused orientation but makes plain that the counselors bring a special set of skills to the interaction that direct clients to their better selves. The authority described in the texts is supportive and in the service of the client, but it is important to note the power differential inherent with the authoritative position. Furthermore, going through the training to become certified by a state health department creates a sense that the counselor has acquired an elevated knowledge, ability, and skill in the client-counselor dynamic.

The training curriculum does not heavily focus on the counselor providing information about HIV, but the "HIV and STI Risk Factors Worksheet" demands it. The "HIV and STI Risk Factors Worksheet" requires that counselors make sure that (1) the client is aware of the accuracy of the test they are taking and what the window period is for HIV antibody tests, (2) what four bodily fluids can carry HIV, and (3) how HIV is most commonly transmitted. Having to relay this information in a session can certainly position the counselor as an expert. The training curriculum mindfully points out, "counseling is different from education, although education can be a component of counseling. Good counseling does not equal good information giving" (p. P 2-6). With that in mind, the role of "expert" may not be the primary identity constructed for the counselor but it is clearly a substantial one, and one that is implicitly reinforced in a myriad of ways that cultivate an authoritative identity on the part of the counselor.

Mentor. While it is clear that the text constructs the counselor as an authority,

specifically an authority with agency and expertise, there is an attempt within the policy and protocol to temper this authoritative positionality by articulating it in ways consonant with and reflective of *mentoring*. While a mentor is still a position of authority, it is not associated with a strict power differential like that of a boss or an expert. As I have described, the authoritative construction is clearly embedded within the texts, so to combat this there is an impulse to provide protocol that aims to engender more egalitarian dialogue rather than top-down information giving, which effectively constructs the counselor as mentor subject position. One of the "Basic Counseling Skills" outlined in the training curriculum is "offering options, not directives" (p. P 2-10). Likewise, it is suggested that counselors should "give feedback, not suggestions" (p. P 3-8). Clearly, the protocol attempts to position the counselor on more of an equal level with the client in order to foster collaborative dialogue, as opposed to prescriptive advice. Ultimately, this functions to mitigate a monolithic or absolute notion of authority while not necessary limiting the authority of the counselor. In positioning the counselor as a mentor or a guide, the texts construct a kinder and gentler form of authority but do not eliminate the authoritative positionality.

It is significant to note that these two variants of authority, expert and mentor, while both present throughout the texts, are contraindicated in some cases, and the training curriculum implicitly acknowledges and attempts to negotiate each. For instance, the training curriculum does warn against going too far with an egalitarian or mentoring impulse and explains that "over-attachment occurs when the counselor hands over his or her ego, sense of self, and competence to the client" (p. P 2-7). Thus, counselors should not direct the client but also should avoid surrendering their competence or skill set to the

client. The training curriculum implicitly acknowledges both of these constructions when it declares that, "healthy detachment is not detachment from our clients but from our own assumption that our success is defined by our client's actions and behavioral changes" (p. P 2-7). Clearly there is a negotiation of a more sympathetic and connected mentoring position, and the more detached, matter-of-fact, expert position that is being exemplified here. Additionally, it is offered that counselors should "focus on things the counselor can change" (p. P 3-8). It is important to recognize how the agency of the client is taken into consideration. Implied here is an authoritative presumption that counselors can/should elicit behavioral change from clients, coupled with an understanding that counseling efforts can only be successful if the client chooses to enact them. Furthermore, this consideration sheds light on an important aspect of counseling. Investment on the behalf of the counselor is highly contingent on his/her identity position within the counseling situation. Following the text, the counselor would take on an authoritative investment in the client and therefore implement strategies to get the client to engage in safer goal behaviors. However, depending on the dynamics of the interaction, a counselor might become invested in other ways (i.e., friendly investment, paternal investment, caregiving investment). Focusing on things the counselor can change reaffirms the authoritative investment by potentially dodging these other investments. Thus, the policy attempts to maintain the counselor as a problem-solving authority within the counseling context. The authoritative position of the counselor is continually established throughout the policy texts for HIV prevention counseling. Branching from this positionality are two major variants: expert and mentor. While these variants may contradict one another at times or create conflict, they still maintain and underwrite the authoritative position. In the end,

the counselor is the one effectively directing the interaction.

Client Identity: Dependents and Deviants

Now that I have discussed the ways in which the HIV prevention counseling policy texts work to construct a counselor's positionality, I will shift the focus to how the texts construct potential clients. As previously mentioned, Ingram, Schneider and Deleon (2007) identified that policy can construct subject positions. There are four major categories that public policy tends to socially construct subjects within: advantaged (politically powerful and positively perceived), contenders (politically powerful but negatively perceived), dependents (politically weak but positively perceived), and deviants (politically weak and negatively perceived). Throughout the texts, the client is positioned as "politically weak" within the counseling process, meaning they are not likely able to control much within the counseling situation. As such, the client resonates with the dependent and deviant categorizations of the policy typology. The counselor, on the other hand, clearly resonates with the advantaged category. There is a clear history of this binary within HIV/AIDS discourse. When HIV was conceived as only affecting promiscuous gay men and injection drug users it was politically ignored (Patton, 1996; Treichler, 1999). The case of Ryan White brought more political momentum to the cause because of his dependent positionality (Donovan, 1993). These two broad characterizations are certainly represented in the HIV/AIDS counseling materials, and they play out in distinctive ways.

Deviance is most notably and most broadly apparent in the presumed heteronormativity that is embedded within the texts. Sexual orientation significantly

plays out in the role-play scenarios found in the training materials. Both the injection drug user scenarios are heterosexual men, and only one heterosexual male client is concerned with his sexual habits. Anal sex is not mentioned in the heterosexual male or female scenarios. This taps into a heteronormative impulse found within the policy texts. First, it appears that clients are assumed to be heterosexual unless the entire counseling situation is focused on homosexual activity. In the training material there is no scenario where a homosexual man is concerned about something other than his sexual habits. With this, the texts draw a clear and explicit line between homosexual sex and illness, inevitably associating it with deviance, whereas a healthy, and heterosexual, body is constructed as normal. It is important to recognize that anal sex, a practice relatively common in sexual encounters between men, is accurately associated with higher risk of contracting HIV. However, there is a virtual conflation of these things—homosexual anal sex and disease—creating an exclusive, and even fetishized focus on it, occluding myriad other risk factors to men who engage in homosexual activity, many of which have nothing to do with sexual practices. This is reinforced by the fact that heterosexual anal sex, which features levels of risk, is similarly omitted.

Heteronormativity is further perpetuated in another training activity in the curriculum. In an icebreaker activity, prospective counselors are asked to find someone who "considers anal intercourse to be normal" (p. HO 2-2), which plainly implies that it is *not* "normal," or at least that most people do not, or should not, consider it to be "normal." Insofar as anal sex is primarily associated with homosexual activity between men, at least in the public imaginary, this characterization secures a perception of homosexuality as deviant. Clearly, the word "normal" proves to be highly problematic in

this context and functions to reinforce heteronormativity that precludes anal sex. More to this point, the possibility of anal penetration among heterosexuals is erased in the role-play scenarios within the training curriculum. Ignoring heterosexual anal sex only further positions the act as homosexual and deviant, and reaffirms a sense of heteronormativity. These heteronormative moments effectively perpetuate a sense of deviance that is already linked with homosexuality and anal sex and thus functions to place clients who are homosexual, or have anal sex, in a deviant position.

Deviance is further underscored by the absence of certain identities in the texts. The CDC "Test Form," the "Test Site Client Encounter Form," and the "HIV and STI Risk Factors Worksheet" are rife with characterizations that designate a client's identity. The front section of the "Test Site Client Encounter Form" asks clients to fill out demographic information. Clients are asked to identify their age, language spoken, sex, ethnicity, and race by checking a box next to the corresponding answer. On the one hand, the form is fairly progressive and provides male-to-female and female-to-male transgender designations. On the other hand, these simple designations potentially establish a perception of identity as fixed and stable and do little to create a nuanced understanding of a client.

Beyond the aforementioned designations apparent in the forms and worksheets, the training curriculum also constructs client identity in specific ways. The training curriculum provides numerous examples and a series of role-play scenarios that connect particular identities to risk for HIV transmission. One important aspect of identity as constructed in these materials is absence: specifically, the identities that are excluded by or neglected in the materials are telling. For instance, there is no mention of lesbians and

their potential risk factors. There are also no scenarios or examples that feature bisexuality. Furthermore, despite the fact that transgender identities can be claimed on the intake form, there is no discussion of transgender individuals in the training curriculum. The CDC test form does ask that counselors report on whether or not a client is transgender or has had sex with a transgendered person, but it does not go into any detail or construct trans identity. This absence of lesbian, bisexual, and trans identities marks them as unimportant or irrelevant within the HIV prevention context. By leaving out these more complex identities, the test reinforces a simplistic and fixed understanding of identity in relation to gender and sexuality. Moreover, this reinforces the construction of a sexual binary. All of the examples and scenarios provided in the training curriculum feature heterosexual men, heterosexual women, or homosexual men.

The deviant/dependent binary is clearly mobilized throughout the texts. According to the counseling materials, clients should be questioned about their personal concerns and sexual experiences, habits, and/or proclivities, as opposed to their sexual identity or orientation. This effectively takes the client out of the cerebral dimension, in which the counselor resides, and places him/her in a physical, visceral, and arguably less refined role. The CDC "Test Form" and "Risk Worksheet" asks counselors to report on whether a client has had sex with males, females, men who have sex with men (MSM), and/or transgender individuals in the past twelve months. Additionally, counselors are required to ask and indicate whether any of these sexual experiences occurred without a condom, with a partner who is an injection drug user, and/or with a HIV-positive person. Furthermore, this confessional dynamic instantiates the deviant position by highlighting the visceral and impulsive nature of the client. How this information is discussed and

delivered is highly contingent on the interaction between the counselor and client, but there are certain topics that are necessitated through the worksheet and test form that frame the conversation, and they rely on the positionalities I have described.

In addition to the different designations of the client that the forms and worksheet provide, the role-play scenarios in the training curriculum collectively serve as a rich field for analyzing how counseling policy constructs client identity. The role-play scenarios create hypothetical situations and people for counselors in training to engage with. Within the training curriculum, there are eleven total role-play scenarios. Six of the clients are men, four are women, and one is not specified.

The deviant/dependent binary within the text reveals interesting gender implications. All of the female clients are constructed as exploited victims (read: dependent) and all of the male clients are constructed as primal and impulsive (read: deviant). Marie "has heard rumors that [her boyfriend] might be seeing someone else" (p. HO 3-2), Janet's boyfriend "has started using heroin and brags about his ex-girlfriends" (p. HO 3-4), Vickie is dating a guy who is injecting drugs and is abusive and she is concerned that he is "putting [her] at risk of HIV" (p. HO 6-2), and Maggie has "been hustling to make money for basic necessities" (p. HO 6-6) since she was kicked out of her home two years ago. All of these scenarios position the female client as a sympathetic victim, and thus a dependent role, but it also robs women of personal agency within the scenario. Sex and other risk behaviors are more or less done to them rather than something in which they actively or willingly partake. Marie "is afraid to bring up condoms for fear of losing [her boyfriend]" (p. HO 3-2). Janet feels helpless in her situation and her "main thought is, 'there's no way out'" (p. HO 3-4). Vickie feels

“defeated” and scared that her boyfriend might “snap again” (p. HO 6-2). Beyond being constructed as victims, who feel powerless and are essentially denied agency in their risk-related behaviors, the women in these scenarios are also positioned as sensitive, emotional, and reactive. This positionality further posits women as dependents in need of help and not able to help themselves: they lack agency. Maggie, of the homeless prostitute scenario, is the only character across these scenarios who potentially demonstrates some agency. In many ways she is a victim of circumstance because she was kicked out of her home, but she does try to carry protection and “almost always used condoms in these situations [with clients]” (p. HO 6-6). However, the scenario does not offer what factors contribute to not using protection. Do clients pay more to go without condoms? Is it a matter of just not having them available? Do clients make claims about allergies? Do they simply refuse? These are important questions that could reveal more about Maggie’s role in these encounters—including agency—as well as shape proffered practical strategies. As it stands, by not describing these things, Maggie’s agency is severely qualified, and she, too, is constructed as relatively passive.

Conversely, all of the male clients in the role-play scenarios are constructed as having agency, to the extent that they are characterized as visceral, impulsive, and animalistic in their risk behaviors. Mike “share[s] needles and works” (p. HO 3-1), “Charles is a 22-year-old gay male, who has multiple, non-steady partners that he meets online” (p. HO 3-3), Thomas is in a relationship but “once in a while, [he will] meet someone in a bar and have oral sex with him” (p. HO 3-5), Bill gets drunk at frat parties and has sex with girls while “rarely [using] protection” (p. HO 6-1), Jerry has “been injecting heroin for 15 years” (p. HO 6-3) but tries his best to use clean works, and

George is in a relationship but has “had one-night stands when [he is] on business trips or when [his partner] is out of town” (p. HO 6-5). Unlike the female scenarios, all of these examples demonstrate that the men are in control of their drug usage and sexual choices: deviant choices, to be sure, but self-directed. Likewise, this is significant for possible counselor perceptions.

In constructing men as active in the scenarios, the text positions the men in the scenarios as impulsive, primal, uncivil, and therefore deviant. Mike is not only an injection drug user but he was put out of his sister’s home “when some of her things came up missing” (p. HO 3-2). There are already deeply embedded negative social implications relating to injection drug use, and this is further compounded in this scenario with the implication that he may also steal from his family as a result of his addiction. Jerry is another injection drug use example, and he has lost relationships because he “refused to stop using heroin,” and is “resigned to being a junkie” (p. HO 6-3). This scenario positions him as a deviant drug user, who stubbornly and childishly refuses to change, which subsequently makes it easier to blame him for his addiction.

Charles defies implicit sexual norms by having a lot of casual anal sex with men. “He knows that what he is doing is pretty risky, but it’s also pretty exciting!” (p. HO 3-3). The deviant promiscuous gay male has historically been used as a scapegoat for ignoring HIV, marking the virus as something that people deserved based on their actions (Treichler, 1999). Charles’ scenario not only revives the promiscuous gay male stereotype, it also provides an arguably ignorant cavalier attitude along with that negative construction. This positions him as not cerebral or thoughtful but profane and primitive, not in control of his impulses. Thomas is in a committed relationship, but “sometimes

[he] want[s] to go out and have fun, let loose" (p. HO 3-5), which includes cheating on his partner. Likewise, George has also been cheating on his partner; even though they agreed that if one day they ever did engage in sex outside of the relationship they would use condoms, he has not "been as careful in [his] outside affairs as [he] imagined [he] would be" (p. HO 6-5). Furthermore, it is clear that George has not been honest with his partner about the outside relations. These examples of infidelity further position the male role-play scenarios in the unrefined and uncivilized "deviant" category. Furthermore, this is implicitly contrasted with the counselor, who is disembodied and cerebral per his/her knowledge and expertise, and also measured and systemic in his/her use of protocol.

Finally, in the case of Bill, he "tend[s] to get drunk on weekends and go home with *whatever* girl seems willing" (emphasis added), and "[he] figure[s] [he] can 'clean up [his] act' later" (p. HO 6-1). This scenario at least suggests that heterosexual men can also be promiscuous, but still manages to construct the male client as a deviant agent. Bill's admission that he plans to "'clean up his act' later" certifies this deviance, for dirt is matter out of place, something that needs to be removed or cleaned. In this situation Bill's sleeping around is the dirt, or dirty act, that needs to be eradicated. All of these scenarios can be construed as something that the client has brought upon himself. While they suggest that the client has agency in these situations, they position the client as primitive, visceral, unrefined, and essentially deviant.

Constructions of the client essentially bring to the surface an overarching binary of deviance and dependency. Heteronormativity is reaffirmed in a manner that further establishes a concrete sense of deviance. Gendered representations interestingly aligned

perfectly with the deviant/dependent designations. The females in the role-play scenarios are constructed as helpless victims, exploited by others, easily placing them in the more sympathetic dependent position. The men in the scenarios, on the other hand, are constructed as deviant. They are visceral, impulsive, and animalistic, actively participating in risky or harmful behaviors.

Space and Place

Moving beyond the policy texts, it is instructive to explore other factors that also serve as contextual considerations and potentially influence the counseling interaction. Clarke (2005) provides that visual discourses are also significant to consider when analyzing a situation. The actual physical context and setting of an encounter can impact the subjectivities of both counselor and client insofar as they constitute both physical and symbolic constructions that can be rhetorical, ideological, and function to contribute to identity formation, performance, and perception (Keith & Pile, 1993). Much as policy texts function to position subjects respectively and in relation, physical contexts, or spaces and places, likewise locate participants in the health encounter and inform the interaction. Space and place are definitely interrelated, but previous scholarship has distinguished the two in particular ways. For purposes of this study I will follow other communication scholars and define space as relating primarily to an abstract notion of spatial relations and social regulations, and place as referring to specific locations (Endres & Senda-Cook, 2011). Accordingly, I will analyze the rhetoric of a specific place, the AIDS Foundation, as well as the social relations spatially implied or invited. Most importantly, I will discuss how these spaces and places can constitute various

enactments and perceptions of identity.

Space and place are symbolically as well as physically constructed. As such, there are always pre-existing meanings to a given place (Endres & Senda-Cook, 2011). These meanings are not universal, and reconstructions can occur, but every individual will enter a place and interact with a space as informed by prior experiences, typically shaped by cultural conventions. Lefebvre explains that we engage in a tacit agreement of a spatial economy when engaging in public spaces based on notions of social propriety (1991). Moreover, this social process is constructed as natural, which can create a hegemonic order (Cresswell, 1996). Social relations are invariably interlinked within spatial relations, and both are ever-shifting, creating what Massey refers to as a "social geometry of power and signification" (1994, p. 3). Thus it is necessary to consider the physical, static qualities of a place in conjunction with the symbolic and rhetorical dynamics of that space and how individual subjects might engage it.

When discussing place/space and identity, scholars often focus on comparing and contrasting identifiable characteristics of people from one location to another (Massey, 1994). Many studies about place and identity will draw conclusions like "people from this town are more likely to identify as liberal than the people from a neighboring community." This trend is particularly prevalent within health research concerning space/place. A small but significant amount of scholarship has been growing within health disciplines focusing on the role of place and space. In fact, a subdiscipline, "geography of nursing," a scholarly discipline focusing on space/place in relation to nursing and health, has taken off with this sole focus (Andrews, 2002, 2003b; Andrews et al., 2003; Halford & Leonard, 2003; Liaschenko, 1994, 1996, 1997, 2001; Malone,

2003; McMahon, 1994; Peter, 2002; Purkis, 1996). Additionally, there is an entire academic journal, *Health and Place*, addressing the ways in which space, place and health interact. Most of this scholarship focuses on place rather than space, conceptualizing it in more static or fixed ways and attendant to correlations between particular places and health conditions. For instance, research might compare health issues in relation to physical locations, like smoking rates relative to urban and nonurban areas/places (Idris et al., 2007).

On the other hand, there are some researchers who have analyzed the ideological components of space within health contexts (Dyck & Dossa, 2007; Halford& Leonard, 2003; Stroller, 2003). Health care in women's prisons, for example, is characterized by severe barriers between health care provider and health care seeker, due to both the physical constraints of the place as well as the ideological constructions of the space, which often lead health care providers to treat imprisoned patients as objects instead of human beings (Stroller, 2003). Spatial relations are often left out when discussing identity formation, but it has been noted that place helps "constitute the sentient individual" (Keith & Pile, 1993, p. 8). Therefore, space and place are a significant area to analyze when considering the identities of HIV prevention counselors and their clients. Dickinson suggests that subjects are not only embodied, they are *emplaced*, meaning that an interaction is not only an embodied performance but is also reflective and reactive to the setting in which it takes place (2002). Thus, I maintain that recognizing the material effect of space/place in relation to identity formation and performance of self is crucial to garnering a nuanced understanding of how identities interact within the HIV prevention counseling session. Performances of self, perceptions of those performances, and how

these relate to counseling are exactly the issues with which I am concerned in this study, and this includes how space and place bear upon all three.

Impact of Space on Identity

The physical space of the AIDS Foundation functions in ways reflective of the counseling texts discussed above, at least regarding how it positions the counselor and the client. The counselor is positioned as an authority, or part of the advantaged category, who has control of the space, directs the client, and can survey the happenings of the Foundation. The client is again constructed in a dependent and passive position, and/or as a deviant in need of some sort of behavioral intervention.

To begin with, the spatial relations within the AIDS Foundation perpetuate the authoritative and advantaged positionality of the counselor. The counselor is situated as an authority within the physical space of the AIDS Foundation primarily as a result of the counselor's greater familiarity with the space and its resources. The counselor helps guide the client through the space, directing him/her to the room, and has access to various physical resources for the client. Counselors can establish their expert position within the space in a number of ways, such as providing demonstrations, handing out informational pamphlets, or offering referral cards; all of which reflect the counselor's knowledge of the space and place of the AIDS Foundation.

The counselor's authority is established at the very outset through the physical space, even before counselor and client meet. For instance, the vantage point of the counselor from the conference room, where s/he will wait in between counseling sessions, affirms the authoritative positionality of the counselor. The conference room has a one-

way window to the outside of the building facing the major street where the Foundation is located. Thus counselors can see when clients come in the front door, without the client realizing. There is also a door that provides some visibility to where clients wait to get their finger pricked for the rapid HIV test. Clients can also see the counselors in the room but do not necessarily know who they are or what they are doing. From this vantage, counselors can see how many clients are waiting, who they are, and how they are interacting with the space and one another. All of this information is obtained through the spatial dynamics of the AIDS Foundation, and provides the counselor with some knowledge before the session even begins.

The client, on the other hand, is spatially constructed in a more passive, or dependent, subject position. To begin with, the client is positioned as transient within the walls of the AIDS Foundation. The entrance of the AIDS Foundation often creates confusion for clients. What would appear to be the main entrance is not where clients are asked to enter. The entrance that faces the main street on which the Foundation is located actually leads to a secondary waiting room. The main lobby, where clients check in, is located in the back of the building. This can make sense to clients who park in the small parking lot behind the building, but many others park on the street and logically enter the main entrance. As a result, many clients, especially first-time clients, enter the building and are then directed to go down the southern stairwell into the lobby for intake. The way in which the client is immediately in need of direction upon entering can position the client as an outsider, transient within the space. Of course, positioning individuals as in place or out of place is a key rhetorical component of spatial relations (Cresswell, 1996). In being positioned as “out of place,” the client is further positioned presumptively as

dependent, in need of the assistance from others at the Foundation.

The client is continually directed through the space of the AIDS Foundation during the testing and counseling process, enhancing and reinforcing a transient positionality. After the client fills out the information with intake, a host will lead him/her to the second waiting room where s/he will sit until a lab tech is ready to collect a small blood sample for the rapid HIV test. The client is then instructed to wait in another waiting room more centrally located in the building until a counselor will call the client's number and direct him/her into a room for counseling. After the initial counseling session, the counselor will instruct the client to return to the waiting room s/he was last in. If the client is receiving a chlamydia/gonorrhea test, s/he will be called back to another station, where s/he will be given instructions about how to provide the sample needed and where s/he will be directed to the bathroom down the northern stairwell. If the client is getting a syphilis test, s/he will be called back into the personal office of a staff member, and the phlebotomist will take a larger blood sample. Finally, once the results from the HIV test are ready, a counselor will lead the client to his/her final destination in the AIDS Foundation and provide post-test counseling. At every point during the client's visit, then, s/he is directed, led, and guided to and through particular physical destinations and locations, placing her/him into a passive subject position.

Further establishing counselor authority, it is the counselor's choice where the session takes place. There are five rooms where counseling transpires at the AIDS Foundation. Each of the rooms used for counseling has its own unique idiosyncrasies for a counseling experience. Seating is one particular issue to consider. In one of the rooms, for instance, there are three chairs, two against a wall and one by the desk in the middle

of the room. A desk with a computer divides the space in two. This creates a little bit of a barrier between counselor and client, but the chairs can be reorganized to prevent this. Positioning the chairs in a manner that facilitates openness and limits barriers is at the discretion of the counselor, reinforcing counselor agency relative to control of space/place. While a client could take it upon his or herself to maneuver the chairs, in my own counseling experiences I have noticed that most clients observe conventions of the spatial economy and will not disturb the space with which they are unfamiliar and to which they have no claim. This observation has also been corroborated in informal conversations I have had with other counselors.

In another room there are three chairs facing each other before a large L-shaped desk. This keeps the counseling process enclosed in a smaller, more intimate area of the room and without barriers. Two of the chairs are identical, while the other is a slightly larger stuffed office chair. The larger chair provides an implication of executive status and creates a power differential within the space. In my experience, clients will commonly choose to sit in one of the matching chairs, allowing the counselor to take the perceivable power position in the space. This does not create a dramatic power differential, but it does further establish the counselor as the authority in the situation and the client as the more passive agent.

In nearly all of the counseling rooms, these dynamics will play out. Counselors have the opportunity to arrange the seats in a manner that seems appropriate and, if given a choice, clients will commonly sit in one of the smaller and perceivably less comfortable chairs, allowing the counselor to take the slightly larger and more comfortable seat. This supports Creswell's argument that social space configuration often appears to be natural

and is thereby internalized and maintained. Even though there is not always a major difference between the chairs, the fact that one is different constructs a social relation whereby the client assumes the passive position and offers the more authoritative seat to the counselor.

Ultimately, the counselor determines where the session takes place, how close the client and counselor sit to one another, and whether or not there is a barrier between the two. The counselor's access to and control of the space are key factors to consider because they materially position the counselor as the authority within the interaction. Subsequently, it places the client in a passive or lesser power position. As the client is directed into the room and commonly chooses the seat that implies a subordinate position.

Generally, the counselor functions within the space with more familiarity and therefore has a sense of control over the space that allows him/her to assume the role of director or guide for clients moving through the space. Additionally, counselors are placed in a more powerful position in the conference room, where they are able to get a glimpse of the clients coming and going.

The physical space of the AIDS Foundation also positions the client as deviant in various ways. First, the general decay of the building evokes a sense of seediness. Since so many people make their way through the AIDS Foundation for various purposes, it is no surprise that the building shows some wear and tear. The carpet of the AIDS Foundation is worn thin with foot traffic and stained with remnants of food and drink from various social events that have been held in the space. The walls have chipped paint in spots and are discolored in others. The ceiling is missing panels in areas and in the

main office space the ceiling is entirely exposed. Exposed ceilings might sound like a hip urban design choice, but upon first glance it is obvious that this is not the case at the AIDS Foundation. Considering the other rundown elements of the space, it is apparent that this lack of ceiling is the result of a lack of funding and priority. These worn-down qualities are arguably reflective of being a publically funded facility, but in the case of a space where one comes to get tested for HIV and other STIs, it is important to note how this can instill a connotation of "seediness" to the process that can further position those requiring the services of that space as similarly suspect. Having to go to a rundown building to get tested and discuss issues like sexual behavior and drug use further enhances this positionality. The multipurpose qualities and rundown nature of the general space of the AIDS Foundation can connote a sense of seediness for the interaction as a whole, but they also position the client in particular ways that complement and underscore the deviant characterizations described in the assessment of the texts.

Elements of the space also serve as a reminder that the client is in need of some sort of bodily intervention. Moreover, this effectively constructs the client as "a body," whereas the counselor is constructed as "a mind." These constructions function to animalize and primitivize the client, while elevating the counselor to a more cerebral plane. This animalizing of the client further positions the client as deviant within the counseling context.

As the client enters the intake lobby, s/he will see various pamphlets about sexual health and HIV, while some magazines, like *POZ* (which is a colloquial phrase referring to HIV seropositivity and a publication focusing on HIV and sexual health), and other

health-related publications are available on a stand in a corner. Condoms are also available on the coffee table in a wicker bowl, free for the taking. Prophylactics in themselves imply a sense of deviance, since safe sex has been historically constructed as deviant sex, because people in conventional, presumptively heterosexual, monogamous partnerships do not need to worry about condoms (Patton, 1996).

In the main waiting area, more HIV-related magazines and more condoms are offered. This again establishes the deviant positionality by positioning the client as a primal body within the testing and counseling situation. Specifically, these materials highlight that the client is a body in need of intervention, and, more to the point, that the client is primarily a body in this context. The walls of the room are red, which is a vibrant contrast from the dingy white walls of the rest of the building. Red is closely interconnected with HIV/AIDS. HIV is a blood virus, the AIDS ribbon is red; numerous HIV/AIDS campaigns have used red visually and verbally in their rhetoric. But more interestingly, red connotes a sense of danger. Again, the space provides reminders of bodily harm and further positions the client as the deviant in need of behavioral modification. It is significant that the client is identified in exclusively physical terms, i.e., his/her body, and moreover, that body is in need of intervention by a superior/authoritative entity.

Adding to this sense that the client is a deviant in need of fixing, one of the counseling rooms features safe sex posters, information about antiretroviral medications, and a box full of pill dispensers. The medically focused features of the room lend themselves to traditional connotations of clinical consultation but also function to position the client as a deviant body that requires intervention. Another counseling room

houses large boxes and bins of condoms, lube, receptive condoms, and demonstration dildos, further instantiating the deviant body in need of help position. These materials also provide counselors an opportunity to demonstrate their knowledge in the counseling session. This further positions the counselor as the cerebral element in the counseling situation, showing a client how to appropriately perform safer-sex practices (bodily). Likewise, this further positions the client as the body that should enact these safer-sex practices.

Another counseling room further establishes this positionality. On the wall of the "Memorial Room" is a large quilt that is captioned "In Memory of ________, 1968-1994." The quilt is mostly white with different brightly colored patches. Half of the patches are ironed-on photographs of the man it commemorates and the other half relate to his personality. On the wall facing the quilt is a portrait of a man in a hospital bed. The man is marked by the signs of HIV Wasting Syndrome: thin arms, sunken eyes, and his body swimming in a nursing gown. A corner shelf houses old photo albums, and an end table holds two antique lamps and a funeral program for another young man who has passed as a result of the virus. These all provide a clear message to the client. Death and decline are presented as the result of a body unchecked and an intervention unheeded.

Ultimately space, not unlike the policy texts, constructs the counselor as an authority with control of the space while placing the client in a more passive/dependent position in need of direction. Through surveillance, guidance, and control of the space, the counselor is further positioned as the authority. As a transient outsider in the space, the client depends on the counselors and others to help guide him/her through the space. Furthermore, the space functions to construct the client as a body in need of intervention

and the counselor as the cerebral entity that can provide that intervention. This firmly places the client in a more deviant or primal position within the counseling situation.

Conclusion

Overall, the policy texts and physical space of the AIDS Foundation manage collectively to position the client and counselor in distinctive ways before the counseling sessions begins. Per counseling goals and protocol, the counselor is situated as an authority within the interaction, and the counselor's control of the space further establishes this. The client, on the other hand, is constructed as the passive and dependent recipient of the counseling, who through various levels of deviance and/or dependency needs to seek instruction in safer behaviors. Additionally, the client is positioned as a body, itself establishing a particular positionality before particular actions are even characterized as deviant. Being positioned as a body essentially positions the client as animal or primitive and therefore allow for deviant characterizations to follow.

It is important to note that I am not making a valuation with this observation. While the power differential between an authoritative and passive positionality may have a negative connotation, this is also a productive and necessary dynamic. This chapter aims to set the scene and establish a foundation for the following analyses, which dig deeper into counselor and client interactions and how perceptions of identity unfold within this context. It is significant to recognize the largely authoritative position of the counselor and the largely passive and deviant position of the client that is established through the policy texts and physical environment in order to provide context for the

analysis of how identity is subsequently performed and perceived within the counseling session.

CHAPTER THREE

PERFORMING COUNSELOR

Now that I have established the ways in which the texts and space function to construct and position the counselor and client, I am going to turn the focus to the lived experiences of counselors at the AIDS Foundation. It is significant to look to lived experiences to understand how the subjectivities identified and described in the previous chapter are actually mobilized in practice. This chapter aims to answer the second research question for this dissertation:

RQ2: How are counselor identities and self-perceptions performatively operationalized within the counseling interaction?

In order to answer this question I conducted unstructured qualitative interviews with sixteen counselors from the AIDS Foundation. Qualitative interviews allow researchers and participants to co-construct understandings, explanations, and discoveries (Tracy, 2013). They allow for moments of reflection and interpretation of phenomena that might otherwise be invisible (Rubin & Rubin, 2005). Moreover, when conducting qualitative interviews researchers should continually critically reflect on their role and positionality (Roulston et al., 2008). Unstructured interviews allow for more natural and flexible conversations with participants (Tracy, 2013). In addition to the interviews I also logged over 100 hours of participant observation. I reached theoretical saturation

after the tenth interview was coded, and I then collated the interview data with the participant observation notes. Through the coding process two major positionalites emerged as the counselors discussed what they do: the *director* and the *peer*. Additionally, a third, hybrid positionality emerged: the *guru*. These positionalities are effectively the performative mobilization or operationalization of the "expert" and "mentor" positionalities that are ascribed from textual and contextual conventions. Rather than being straightforwardly implemented, the positionalities as operationally mobilized feature distinctive nuances and variations. Policy-as-written is commonly understood to be different from actual policy-as-practice (Kirby & Krone, 2002). Ultimately, the embodied enactments of written policy and procedures are bound to deviate from their textual constructions as they are mobilized through lived experience. I will begin this analysis by first addressing major motivations cited by the counselors. While all counselors had some level of altruistic motive to counsel, most had utilitarian provocations as well. The data support that the previously discussed ascribed identities, derived from the text and context, intersect with the counselor's motivations to produce distinctive operational positionalities. After the motivations are discussed I will detail the ways in which director, peer, and guru positionalities are performed respectively within the HIV prevention counseling context at the AIDS Foundation.

Counseling Motivations

It is important to remember that the population analyzed for this dissertation is counselors who volunteer their time to provide this service. Every counselor had his or her own idiosyncratic motivation to volunteer. Some had specific social and civic

inclinations that they satisfied through volunteering, some had medical interests, and some had been personally affected by the virus in some very direct ways. However, analysis revealed that motivations are broadly characterized as altruistic but have undercurrents of utilitarianism. Utilitarian motivations appeared to fluctuate between professional provocations and those of self-actualization. Professional motives versus motives of self-actualization appear to have a direct affect on a counselor's propensities within the situation.

Altruism

Considering that this is a voluntary role, it is not surprising that altruism to some degree is a common motivation cited by the counselors. For instance, Dan described having a proclivity to volunteer his time to a worthy cause:

> I have all this free time where I'm like "what do I do" and I knew I wanted to volunteer because that had always been something I wanted to do, whether it was with animals or people, I just always wanted to spend time volunteering.

Jeremy similarly provided:

> Well I started counseling just because I didn't have anything else better to do. I had a job that made me travel all the time, and the project I was on abruptly stopped. So I didn't have anything else to do until I got an email from [the] AIDS Foundation and I thought this would be a really good way to help people and figure out what to do with my free time. I went to the training and I started volunteering at the [AIDS Foundation].

Building on a general desire to volunteer, many counselors expressed an altruistic need to give back to their particular community. Many counselors described a desire to help the cause or volunteer their time for something positive and productive:

> I always like to volunteer places, different things and so I thought maybe I could volunteer there because it's right around the corner from my house, I like the

> cause and I certainly have used a lot of free testing over the course of my life. So I always feel like it would be a way to give back. I called right when we moved to town and I think they told me their first volunteer training was beginning in January of this last year, 2014.

Here, Gavin described his motivation for getting involved, which includes giving back to the community and working for what he sees as an admirable cause. Additionally, the majority of counselors at the AIDS Foundation identify as gay men, which proves to be a major motivator for many of the counselors. Nick described:

> I think being a gay male and that being one of the number one health concerns that faces our, I hate the word “community,” but I don't have a better one to use, faces the gay men's community, that's like the number one, right? Being able to provide a service to gay people, especially around something as serious as HIV, is beneficial to me because I think if it's coming from another gay person it might be better received than some nurse or some other person that isn't living the lifestyle or doesn't understand.

Dan explained, “I wanted to be more focused on something that I felt would really impact my community, the MSM community.”

While many counselors personally identify with the gay community, others noted that their altruism is specifically funded by a political sensibility that acknowledges the marginalized status of the people most at risk of the virus. Calvin shared that he likes to do HIV prevention counseling because he enjoys being around people who are generally marginalized within society:

> I guess I probably like that it's probably a little bit on the fringe of like what society accepts just purely for other reasons. I just think society's fucked… It might just be that along the fringe of what society accepts, you find people I mesh with better. Just people with more open minds. Like clearly not people that we don't all agree on the same things. People thinking for themselves. It's just not your ticky tacky, you do exactly what you were raised to do and you become exactly the person your father was, essentially. I know that's an oversimplification, but I like people that think for themselves, so I like the fringes.

For Calvin, the fringe aspects of HIV, the taboo of sexual deviance and drug use, make

counseling an interesting and worthwhile practice. Calvin's inclinations to altruism and social progressiveness motivate his counseling.

Even though the altruistic impetus may come from different places across counselors, it is nonetheless clearly apparent as a primary motivation across the majority of counselors interviewed and observed for this study.

Utilitarian Motivations

Some level of altruism is present in all the counselors who volunteer their time, but counselors also have clear utilitarian motives for what they do. Several counselors have professional aspirations that are assisted through counseling. Many are involved in social work, public health, or are planning on going to medical school. Other counselors are more motivated by a sense of self-worth or self-actualization that volunteering in this capacity provides.

Professional. A major factor for many of the counselors is some sort of professional aspiration. For instance, Chance is a social work student and counseling is helping him gain experience with clients:

> I'm going into social work and so this has been very helpful to me, meeting with clients one-on-one. My experience has been that it's been fun, it's been rewarding, it's a good mindset that it puts me in a good mindset of counseling in harm reduction as it does opposed to coming from just a teacher/student role where I think it's good for my future in social work to kind of find where they're at and go harm reduction as opposed to just dictating what should be done.

This is a clear example of a professional utilitarian motivation for volunteering, as Chance recognizes how counseling will help aid his future career goals. Sarah has other professional aspirations that are likewise nurtured through counseling:

> Two and a half years ago, I was done with my sophomore year of college and my friend actually volunteered at [the AIDS Foundation] for a while and I told him these are my career interests, I really want to become a therapist, I really want to work in sex research. He was like, "This is the place you get to do both." That's what kind of brought me there. It's learning those skills from [the AIDS Foundation] that I'll probably need later on in my career.

Clearly, there are a variety of skills and interests that can be cultivated through volunteering as a prevention counselor. Additionally, medical school applications, and general medical interest, are another major utilitarian motivator for many counselors. Jake explained:

> I am applying to medical school, so it's a good environment to get used to counseling and talking about sensitive topics. I've also been interested in autoimmune diseases and immunological disorders-type stuff. So it's kind of cool to learn more about the virus itself and just kind of get a better sense of and learn more information about it in general and the people it affects.

Aaron, and many other counselors, also started counseling during the medical school application process. Many of these volunteers reasonably stop volunteering once they begin med school, solidifying the utilitarian benefit to them.

Some counselors are in the public health field. Patrick described, "Since I was doing my Masters in Public Health, it was something I could focus on and get a lot of ideas for research in topics and things." Nick is also involved in public health:

> I first got involved because I was a health and safety instructor for the Red Cross. The Red Cross actually had a huge HIV prevention campaign that centered around what they call "Fast Facts," and we would go into schools. There is another one called Act Smart. Act Smart was mainly developed with the Boys and Girls Club and it would give the Red Cross the opportunity to go into Boys and Girls Clubs and talk with people about STDs, HIV and how to prevent it and all that stuff. Then the Red Cross kind of phased out, they lost their HIV funding I guess, and they phased out their HIV stuff. It's always been, I guess, a passion of mine and so I saw other opportunities and he Foundation was one of them.

Lindsey also works in public health. As a direct result of her involvement with the AIDS

Foundation she became the Ryan White Part B Coordinator with the State Health Department. As such, she helps people with HIV get assistance in order to get proper healthcare and treatment. Plainly, many of the counselors understand their role as complementary and/or advantageous to their professional pursuits.

Self-Actualization. Other counselors are compelled to volunteer because it gives them a sense of self-worth and provides potential for self-actualization. Some counselors feel strongly connected to the virus, and feel that they have something to share with clients as a result. Jon, for example, has an important story that motivates him to volunteer and help others. He disclosed:

> It would have been ten years ago next March, it was my fortieth birthday and I had just gone to Vegas with some friends to celebrate my birthday and ran into the Foundation to get tested because it was on my yearly list of things to do. I always get tested. I had the day off and thought I would run in there and get tested. I did, and without even thinking there was a chance it would come out positive, and I tested positive. In the blink of an eye, my life changed. The experience that I had there was pretty life changing. The counselor I had was very sympathetic, visibly concerned. Also I think he was as upset about having to give this information to me, as I was receiving it, he confided that he had gotten a false positive himself. He said he felt like he had some understanding of what I was feeling and what I was going through. I felt like that was important and that service they were providing. It wasn't until a couple years after that I actually started thinking about volunteering.
>
> That counselor that gave me my results has become a good friend. He still checks up on me, checks in. I think he will always have a special place in my life. He doesn't volunteer any more, but he said that's just because he's busy. I recognize what he did for me at that time of need for me. I just decided I'm going to see if I can do that for somebody else; I'm going to pay it forward. So that's kind of why I decided to do it. It's been very rewarding, and, at times, a little disappointing. But for the most part, I don't regret it at all. I think I'm very open about my status, even online. I've had people contact me because of that online and have asked me questions about AIDS and HIV and things like that. Some newly diagnosed people that didn't feel like they could talk to anybody else. I'm glad I can help somebody through that.

For Jon, his status is a fundamental motivating factor for his counseling. Counseling

allows him an opportunity to do something positive and productive with his status. He recognizes the help he received and uses that as motivation to "pay it forward." He notes that he makes it a point to be open with his status and provide advice for others, not just as a prevention counselor but also as a member of the community.

Diane, on the other hand, draws from her professional experience as a social worker to utilize volunteering as a self-actualizing experience:

> I used to do drug practice social work and I haven't done it in a long time. So one of the reasons I got back to it was a chance to be with clients. I think it makes you honest having to really look at people.

Diane makes a case that this kind of work helps better herself as a social worker and as a person. Even though this is connected to a professional inclination, it ultimately has more to do with realizing personal growth outside of an occupational goal.

Self-actualizing motivations are very similar to altruistic proclivities but distinct in that they spotlight personal gain through helping others. For instance, Patrick mentioned, "obviously, because I am a gay man, I felt like it was good for me to know and to stay on top of things." Likewise, counseling was even somewhat formative for Aaron's gay identity:

> It was, it's good to talk to people one-on-one to get to that level with people and learn more about the community and learn more about what is going on. This was also the same time that I was really, truly coming out, and so that was a whole different world as well. Yeah, it was a really good experience. I really like interacting with people, being able to feel like I could offer something to people even if that was just peace of mind or comfort or knowledge or information.

Offering something to others is key to the altruistic motivation many counselors share. However, Aaron's quote demonstrates that even selfless intentions can have self-actualizing consequences. It was not necessarily Aaron's intention to gain better insight

into himself through volunteering, but he plainly makes a case that that is what occurred.

These professional and self-actualizing motivations for counseling provide a foundation for a counselor's positionality. All counselors appear to have some sort of altruistic foundation coupled with a utilitarian motivation. Thus these qualities underlie a counselor's identities as s/he negotiates various subjectivities within the counseling session. Nuances of these motivations intersect with the major ascribed positionalities and are then mobilized within the counseling context. Specifically, particular utilitarian motives produce particular mobilizations of expert and mentor as prescribed in "official" texts and contexts: specifically, expert seems to manifest with professional motivations to produce *director*, and mentor with self-actualizing motives to produce *peer*.

Performing Director

Previously, I have discussed the ways in which the texts and contexts of HIV prevention counseling position counselors in the authoritative role of expert. After analyzing the interview and participant observation data, it is clear that the expert positionality plays out in certain contexts but is mobilized and enacted in distinct ways. Specifically, the expert subjectivity seems to be invoked alongside professional inclinations, producing the director positionality.

Conceptualizing the counselor as a director is the first prevailing positionality that came up in the data, and there are particular ways in which this subjectivity may manifest within the counseling context. Namely, when counselors enact the director subjectivity they tend to herald direct advice and information as the hallmark to good counseling. When counselors perform this positionality, they also tend to evaluate the client in a

manner that creates distance, elevating the counselor within the counseling context. This is consistent with the ascribed expert role but takes a less concrete and more human approach.

The first axis of the director positionality is defined by placing priority on direct education and information dissemination. This logically aligns with the professional inclinations of some counselors, especially given the emphasis of health and medical practices on patient outcomes. All the counselors interviewed acknowledge education as an important aspect of what they do, but in varying degrees. Obviously education is accomplished when discussing the virus and how it is transmitted. Every counselor interviewed described that they go over the “basics of HIV and transmission.” Plainly, education is apparent across all counselors, but some mobilize it in ways that sediment the distance implied by the ascribed expert role. To this end, a counselor may enact the director position by providing a demonstration. Jake described a particularly positive counseling experience, wherein he got to provide a demonstration:

> I also did a condom demonstration for her. So I actually grabbed one of the wooden dildos and demonstrated putting a condom on just so that to make sure that she understood exactly how to practice safe sex. A lot of it was more just kind of really explaining things, making sure she understood it, asking her "Does that make sense?" Just making sure she understood.

Plenty of other counselors share Jake’s approach to sediment distance from the client and follow in the expert position of providing information and directing behaviors. This, again, follows professional conventions within the health and medicine fields as the counselor attempts to draw hard lines between practitioner and patient. When asked about what he thought was the most important aspect of counseling, Aaron replied, “Education! Education, information. Yeah, good solid education and just being real with

people." Lindsey explains that she always provides the client with information, even if they seem reticent to receive it:

> They are here, obviously, for a reason, so you always give information even if they don't want to share anything with you, the only thing you can do is give them information, maybe they'll tell somebody else who will do something with it. But that is the main objective you can do.

Another counselor, Patrick, tells me, "I always try to find something they didn't know and to teach them," He goes on to describe why he likes counseling: "educating people that you think would know a lot, or know everything since they are sexually active. Trying to find something they didn't know." While education is obviously not a bad thing, it is important to recognize how the focus on education firmly places the counselor in an elevated position within the situation.

A focus on information and directives invites an implicit notion that the counselor knows what is best. "I guess overall I'd say my goal would be to get them the help they either are looking for or don't know they need yet." Brock adds, "my major goal is just really explaining common misconceptions to people." Education is not only a significant part of counseling when enacting the director subjectivity, it also places the counselor in an elevated position of knowledge to dispel misinformation.

Richard provides some prime examples of how this power differential is mobilized in a counseling context. First, he explains how he makes it a point to make sure the client has learned something after he has delivered results:

> I will ask what they learned, and if the say they "I haven't learned anything," well I'll say, "oh did you know you're supposed to change the condom every 20 minutes" and they be like "oh, why's that" and then I can start to teach them.

As demonstrated in this quote, Richard implements a tactic of quizzing clients when they

appear to be well informed. A strategy that clearly positions the counselor above the client, once the client is stumped s/he will reasonably have to heed the advice and knowledge of the counselor. Richard also shares, “I’ll ask, ‘where do you carry your condoms?’ If they have one in their wallet, I ask them to pull it out and I throw it away and get them a new one.” This is because condoms can deteriorate in hot spaces like a wallet in the back pocket, but Richard’s actions here communicate much more than that. He directly manages the client’s condom care by throwing away the prophylactic and providing the client with a new one. Essentially communicating, “you are doing it wrong, let me teach you.” Richard definitely offers the most blatant example of the managerial aspects of the director subjectivity.

Many counselors expressed great satisfaction from educating clients. Aaron explains, “I would say my favorite to counsel, for lack of a better terminology, would be either first-timers or just people who really need it. People who really appreciate the information, people who want the information and want to learn more.” Nick also describes the gratifying feeling of providing clients with information:

> It's always fun when they get it. When you're explaining something and then someone says, "Oh, that makes sense" like I should have know that all along. Those are good moments, I guess, to have with people. If you tell someone you shouldn't really brush your teeth immediately before or after oral sex right? If you tell someone that and they're like, "Oh, that makes sense. Why? Because you know, when you brush your teeth, your gums might bleed." They're like "Oh." Someone really gets why. It's real. I appreciate those moments too because sometimes I think we can sit and talk to people and not even as much as we're trying to converse, we're talking at people and then they leave and you wonder if they heard anything you said. Even though you tried your best to communicate and interact with them, you're like "I don't know if they learned anything," you know?

Providing information and demonstrating proper actions to a client are particularly

rewarding experiences for Jake when he previously described giving a demonstration. The satisfaction of information dissemination expressed by the counselors provides a personal dimension that exceeds the ascribed expert positionality. The director subjectivity maintains the distance sedimented by the expert positionality, but colors the subject with human motivation and response.

It is significant to note that this subjectivity is often rooted in notions of concrete "truths" and "realities," clear ideas of how to go about sexual health, which aligns well with medical and health-related mentalities. Within the director position the "real" is constructed as material fact. Following this, the data indicate that counselors are motivated by professional aspirations, especially those relating to health and medicine, and would more readily enact the director subjectivity. For instance, Nick, a health program manager; Patrick, a health educator; Aaron, a med student; Jake, a prospective med student; and Lindsey, a public health coordinator all primarily prioritize the director subjectivity.

Plainly the director subjectivity is embedded in the expert positionality described in the previous chapter, but is performed and mobilized in particular ways. Where the authoritative positionalities that emerged in the governing texts focused primarily on process and information dissemination, the director positionality takes this task further and provides clients with direct advice. This, of course, is part of the counseling process, but when a counselor enacts the director positionality s/he prioritizes this aspect of counseling above other aspects like validation and comfort. Subsequently this often leads to evaluating the client in ways that position the counselor in an elevated status. Essentially, the ascribed identity of expert meets the embodied subjectivity, as defined by

professional motives and experiences, resulting in a distinctive performance. Because the particular ascribed expert identity funds this performance, distance is maintained and sedimented, but it is operationalized in more personal and concrete ways. Namely, counselors express levels of satisfaction and personal connection when enacting the director positionality.

Performing Peer

The other major prevailing positionality that emerged from the interview data was the *peer*. Much how the ascribed expert positionality undergirds the director subjectivity, the mentor positionality, which is less prominent but also apparent in the counseling texts and contexts, funds the subjectivity of peer as it is performed on the ground. While the peer positionality has roots in the mentor position, it is enacted in distinct ways that, contrary to the director positionality, attempt to close the distance in the counselor-client relationship. When counselors perform the peer subjectivity, they deploy strategies to approach the client in an egalitarian manner, promote openness and honesty from the client, foster a nonjudgmental climate, and validate and affirm the feelings and behaviors of the client.

To begin with, when a counselor performs the peer positionality s/he attempts to connect with the client in a more egalitarian manner than the director positionality. For instance, Chance conceptualizes the interaction between counselor and client as a partnership:

> With the client, I want to partner with them to come up with a plan as opposed to just saying “abstain from having sex, wear a condom.” I want to come up with a plan where they're part of the decision-making process and it's not just me telling

them.

A significant way that this egalitarian sense of partnership, and the peer subjectivity, are accomplished is through creating a comfortable environment. Many counselors described at length the measures they take to make a client comfortable. First, in order to make clients feel comfortable, counselors must also be comfortable and genuine within the interaction. Jon explained that “being real and comfortable” is key to fostering a comfortable counseling session:

> Be yourself. If you're not comfortable with somebody, they're not going to be comfortable with you and they're going to pick up on that real fast. You're kind of doing both of you a disservice. Just be yourself and don't get so wrapped up in the rules and the lists, "I've got to do this and this and this." If you forget something, put a note on there and let the post counselor handle it. Because we all are human and human interaction is going to be fallible.

Here Jon privileges being “human,” or being comfortable, over being a director and providing information. This establishes an agenda to create a sense of equity with the client in the situation. Interestingly he also conjures the idea of being “real” within the session. Where the director position purports the “real” as something tangible, Jon seems to believe that being “real” is a matter of interpersonal sincerity. Being real, thus, is a key element to opening up and allowing a comfortable climate for the client. Jeremy provided, “I want to make whoever I'm talking to feel comfortable. I want them to feel like they're in a safe place, that they can talk about what they need to talk about.”

An egalitarian and comfortable environment also helps facilitate a sense of openness and honesty. Gavin further explained:

> I don’t want [clients] to walk away feeling like “God, that was so awkward, I never want to do that again, I never want to go back.” I really hope that's not the case. I want them to walk away feeling like, “I was surprised it was like an actual comfortable conversation.”

Clearly, making the client feel at ease and comfortable is a paramount concern for counselors who connect with the peer positionality. This is only sensible as creating an air of comfort is essential to make a friendly connection with someone. If a client feels awkward, nervous, or unsafe in some way, the collaborative relationship needed for the peer subjectivity to flourish will never occur. This focus on an egalitarian and comfortable space helps foster openness and honesty, which essentially helps bridge the distance between the counselor and client.

Another key axis to the peer positionality that aids in this goal is establishing a nonjudgmental environment. Once a client is put at ease in the scenario, many counselors express that it is important to make it clear that they are not here to judge, regardless of the client's actions or behaviors. Sarah operates with the belief that counseling needs to start with a foundation of nonjudgment: she explained, "Everyone has their own sex lives and subscribes to whatever makes them feel complete." Diane offered a story about a young woman who asked her a morality question:

> She was eighteen, and she said, "Do you think thirteen partners are too many?" I said, "All at once or sequential?" Then I thought, that really doesn't matter. I said, "Are you comfortable with this? If you feel as though you are about to get harmed, that's the only issue that I can see. Otherwise, it's nobody's business." But I thought, okay, that's a new one. Because she said, "Yeah, I'm eighteen." I'm thinking, I had been kissed by the time I was eighteen. But I certainly had not had thirteen partners, but I don't care. I did say to her, "You want to go check with your healthcare provider and start getting a pap smear because the more partners you have, the more risk of cervical cancer. So please go get your health checked." But in terms of morality, as long as you don't feel that you are in harm's way, as long as you aren't doing something you don't want to have done…

Even in a case where a client is asking for judgment, Diane remains nonjudgmental. A nonjudgmental stance is thought to help clients open up and maintain a healthy and even

friendly relationship within the counseling session. Jon described how his nonjudgmental stance helps clients open up:

> Personally, I like to get to know that person as quickly as I can and put them at ease so they feel comfortable with me and also that they don't feel threatened in any way or that I'm in any way judging them, so they do feel comfortable. Assure them that it's private, it's not going to go anywhere… Sometimes you can tell someone's holding back and it's always fun to get them to sort of let loose and reveal some things that maybe they thought was not going to be received well. Their kinks or whatever. Then once they do that and they realize that I'm not going to judge them, then it just takes a whole new turn. It's just kind of like okay, the floodgates open and they just kind of bare their soul to you. That's a pretty intimate thing. It's hard for some people to do. I don't take that lightly and I think that's really an important thing and I respect them and would never betray that trust. That's, I think, the purpose of why I'm there.

For Jon, he sees his purpose to put clients at ease and foster a nonjudgmental environment. He provided a specific example of how this has played out in one of his sessions with a lesbian couple:

> One of the women said, "Okay, we're just going to be honest with you. We're kinky." I just smiled and said, "Okay. What does that mean to you? To be honest, I've heard it all and done a lot, you can't shock me." They just opened right up and explained that they're into group sex, pansexual groups. Then we could really dig into what they were doing. They shared some stuff. They were very knowledgeable and they were right in coming in and getting tested for HIV because of some of the things they were doing. That was very truly fun. Just the interaction and the fact that they were kind of holding back and worried about - I think they didn't expect to find me and they find somebody they can really talk about all this stuff with. All they wanted was to get a quick test and then leave. So I explained to them that I had been involved with the [local leather scene] and I was very aware of pansexual community here in Salt Lake, some of the things that they were describing.

In demonstrating a nonjudgmental stance, and even relating to the clients, Jon managed to get the couple to open up and have a productive discussion about risk and prevention. Chance also has a passionate stance about the importance of being nonjudgmental:

> Coming from a very nonjudgmental place and valuing that's each person's experience, so I want to value and not try to dissuade people from doing first

> loving whomever they want to love or having sex with whomever they want to have sex with. That's not my role and it's also with counseling at the AIDS Foundation but also with counseling in general, I always want it to be from a nonjudgmental point of only stepping where it could be affecting their life. Somehow something they're doing is affecting their life and they've seen that as something they want to change in helping in that area. But if things are working for them, I don't need to, I can give them information, but I don't need to push them in any direction.

Michelle relates to clients through her own sexual history, which aids in creating a nonjudgmental environment. She explained, “No judgment here. I totally get the whole hook up, one nighters, oops, I don't have a condom.” Michelle operates with the understanding that “no one is perfect,” herself particularly included. She further shared a story about a recent client:

> I had a client the other day break down after I gave him his negative results. He was pretty risky, he was convinced he got it. I gave him his results and he cried, “I can’t believe I don’t have it” and I just said, “hey, I can’t believe I don’t have it either.”

In recognizing her own relationship with “taboo” sexuality Michelle tries to empathize with clients and establish a nonjudgmental climate. In establishing a sense that she is not that different from the client, Michelle attempts to demonstrate a nonjudgmental environment and facilitate openness and honesty from the client. This effectively helps close some of the perceived distance between the counselor and client, whereas the director position further sediments the distance, the peer subjectivity attempts to bridge the distance through tactics of self-disclosure and nonjudgment.

Following a nonjudgmental approach, counselors who favor the peer positionality also see a significant need to actively validate the client’s behaviors. For instance, Michelle shared how she actively validates the behaviors of her clients in a sex positive manner:

> Whenever I am with a client—and I don't care what they get into—fisting, orgies, PNP, whatever. I don't give a fuck. I tell them "Hey, I get it. We all have our kinks and shit but let's talk about how you can do this in the most fun, fulfilling, and safe way possible."

Validating behaviors further establish a nonjudgmental environment, but many counselors take this even further by validating and affirming a client's feelings. Jon explains, "I hope that I can make them feel better or arm them with tools so that they feel a little more confident the next time." Jon further states, "I don't try to tell someone how they feel or how they should feel because that's not my place. It's not what the purpose is." Sarah makes validation a paramount part of her counseling. "I always try to validate them as much as possible," she described. She also provided a specific instance of how validating a client's feelings and experience can play out in a session:

> A lot of his first comments in the beginning were, "I'm really ashamed because I'm looking outside of marriage" and "I think we're going to separate soon but I don't know what to do and I don't know if I should stay in this marriage of it I shouldn't or what I should be doing." I got to talk about that stuff. "This is completely normal. It's healthy. What you're doing is great and you're taking charge of your sex life. You're taking charge of what's going on and you're here". Talked a little bit about his marriage and how to invite that. I don't know, I felt good. I felt good because I knew I did something great that day. He got confirmation and validation that his sex life is fantastic, positive, and he's doing everything he can. It feels good. It feels good.

Sarah shared another experience wherein she felt a strong connection with a client and was able to validate his feelings:

> I felt like we were almost friends because I felt he told me a lot of details about his sex life and we didn't just talk about HIV and condoms or knowing your status. We talked about sex acts. How to make this more pleasurable. How to maybe invite your wife to this. Things like that I felt I don't get to go that next step with a lot of clients, I get excited. He was very welcoming and very accepting of me and vice versa.

Clearly, Sarah strives to affirm people's choices and make them feel positive about their

sexual lives. When asked about some of the role-play scenarios, Sarah always mentions that she would congratulate the client on what they are already doing in terms of prevention. Sarah also mentioned that "[she] recommend[s] to a lot of people [new counselors] to read up on what sex positivity really means." Plainly, validating a client's feelings and behaviors in a sex positive manner is a key aspect of the peer positionality. Michelle, the former Test Site Coordinator at the AIDS Foundation, added, "I want sex positivity and awareness." Being sex-positive and affirming of clients appears to be an ultimate goal of counseling when enacting the peer positionality.

The data also indicate that counselors with self-actualization motives are more inclined to readily enact the peer positionality. While it is important to note that no counselor is married to a single positionality, they all demonstrated a propensity to more readily enact one over another.

When privileging the peer positionality, counselors work to foster a comfortable and nonjudgmental environment to allow clients to open up. Part of this is accomplished through empathically relating to the client in some way. Furthermore, the counselor enacting the peer subjectivity will work extensively to affirm the client and validate her/his feelings and actions in a sex-positive manner. This subjectivity gives primacy to how the client feels rather than what s/he should be doing. The peer positionality thus works to close the distance between the counselor and client within the situation.

Performing Guru

Following a poststructural sensibility, it is important to recognize that counselors can continually flow between both director and peer positionalities. As I have

mentioned, the counselors demonstrated that they tend to have a preference of one over another but can seemingly enact either in a given situation. As such, I also discovered a third positionality that essentially merges the two; I refer to this hybrid subjectivity as the *guru.* The guru features some aspects of director, and some of peer, but is directed toward the self-actualization of the client. Essentially, the guru is a microperformance of the larger two positionalities. The guru emerged as a generic microperformance in the data when counselors discussed their general counseling approaches. Other microperformances were identified as a direct reaction to perceptions of the client, and will be addressed in the next chapter.

The guru positionality became apparent, and distinct from the other two major subjectivities, through another conceptualization of what it means to be "real." While the director position apprehends "real" as something concrete and tangible, and the peer position conceives the concept as being genuine and relationally sincere, the guru positionality approaches "the real" as a sort of existential authenticity. The concept of "real" when enacting the guru positionality appears to delineate how to act within the world. This goes beyond simply offering the information, the way the authority position established in the texts suggest. It furnishes actions and behaviors. For instance, Nick provided:

> I think it would be really easy, especially for some of the counselors who, this is my completely biased opinion by the way. I feel like especially with gay men, they come in and, like girls, or someone else, is counseling them, how much credit are they giving to them? Given that they don't, you know, they're talking about condom use and lube use, but if you don't, you know, like for me, I'm one hundred percent that way. If someone's trying to tell me something I don't think they know anything about, I'm not really going to take that advice, even though they may be right. I think having gay men there to know, I guess certain words… It's the credibility.

Nick makes plain that he believes his shared experience with gay men gives him credibility over other counselors and, in effect, allows him to better direct the safer goal behaviors of clients. In connecting with the client through a shared sexual orientation, and thus perceivably shared sexual experiences and proclivities, Nick aims to successfully direct the client and furnish particular safer-sex actions. When a counselor enacts the guru positionality, much like the director subjectivity, they often evaluate the client in a manner that provides the client with direct advice and subsequently distances the counselor from the client. For instance, Patrick believes that education can have true impact and function as an intervention of sorts:

> I like counseling younger, gay men, boys, I want to say that because they are young. In hopes that I'm stopping them from doing something that could hurt the rest of their life. I don't know if they don't follow up, but in my mind I'm picturing that I'm helping someone to stop a habit or stop a behavior and therefore they are not getting something later on or they are not creating that habit that they're coming in every three months.

This description clearly places the counselor as a guide of proper action and behavior, and the client as an infantilized subject, even referring to young men who are sexually active as “boys”. However, he focuses on empowering the client to a moment of self-actualization wherein his/her actions and way of being, are potentially altered. The guru positionality primarily functions to demonstrate how to be in the world, essentially shaping and directing identities, which creates a clear differential in terms of status during the encounter but fosters more of collaboration between the counselor and the client.

While the guru positionality may provide guidance for a client, it also shares qualities of affirmation, like the peer subjectivity. For example, Sarah offers that she

aims to affirm the feelings and choices of clients in a manner that facilitates continued positive action:

> I would say my ultimate goal, I guess, with HIV and STD testing, I want to make it more normalized. I like the idea that people have it as just a checkup. This is not something I should be ashamed of. It's very sex positive. This is my sex life and I'm going to own it. I'm going to be sexually responsible for myself and others and I'm just here to do my part. So my ultimate goal overall is to make them feel welcomed, to make them feel this is the place that you can come to and feel that you're not going to be judged. Whether you be a bareback, somebody in the poly community, or somebody in a monogamous relationship who has oral sex outside of marriage. Regardless, it's feeling safe to come here and know your status.

Through both guidance and affirmation Sarah attempts to normalize the counseling and testing process. Sarah clearly enacts the peer positionality most often according to her interview data, but here she supplies an example where she sought to guide a client's actions in a way that is indicative of the guru positionality.

Chance also demonstrates the guru positionality in his approach to validating clients. Recognizing various social structures and attempting to diffuse stigma is a major part of Chance's counseling strategy, and provides a good example of how the guru subjectivity can be enacted. He shared:

> So you know, especially on an individual level I can see what I guess barriers people have and things that are affecting them on the whole. But each counseling session and the groups I did at [the AIDS Foundation] are, were helpful to see how even systems of oppression are working and how not just those living with HIV, but those who identify as gay, how different institutions, whether it be religious institutions, different political aspects, how some of the messages that have pushed toward people in these populations, how they can affect these things. Also how this, it affects treatment, this stigma's a big one for me, where I've noticed how on the individual level, like discrimination and stigma has forced people to lower self-esteem, lower health consequences, even depression, even suicide attempts I've seen because of whether they've come out as first, when they first came out as gay, but then also another coming out process of coming out as HIV positive… So I think on a macro level I want interventions that could change mindsets of people on a whole so that way I think people would be, you

> would see less micro problems like depression, homelessness, substance abuse, all these different things that are really big issues in, especially the gay community, but in all communities. Because when young people are a vulnerable population and so coming out could, especially to a religious family, you know that you could be kicked out of your home, you could be not welcome, and even best case scenario, there are still many challenges that could present. Any ways to minimize those types of stigma, making people feel better about themselves.

Chance emphasizes a need to combat stigma and foster a nonjudgmental climate in counseling. In recognizing the "macro" and "micro" levels of power structures and social issues, Chance brings an insight to his counseling that aims for a connection with the client far beyond the facts of HIV/AIDS. He expresses hints of the director positionality as he discusses interventions but he operates with a prevailing peer positionality as he focuses on validating the client through combating stigma, which makes this a prime example of the hybrid guru positionality. Again, the data indicate the guru positionality functions to provide guidance and intervention but through means of validation and affirmation.

Ultimately, the guru positionality is a hybrid of the director and peer subjectivities and is thus funded by both the ascribed expert and mentor positionalities. Where the director is very information-driven, and the peer is very relationship-driven, the guru is driven by the self-actualization of the client. The guru positionality primarily functions to offer guidance, and in doing so creates distance between the counselor and client. However, the guidance aims to self-actualize the client. This is commonly achieved through the peer tactics of validation and affirmation. The data did not demonstrate a correlation between the guru positionality and a particular motivation. Instead the hybrid subjectivity appears to be a reaction to needs of the client. Essentially, the positionality is a microperformance of the two larger peer and director positionalities.

Microperformances appear to occur in response to particular perceptions of the clients, and the next chapter will come to grips with this more extensively.

Conclusion

In summation, the director and peer are the three major positionalities performed by counselors, and the guru positionality is a microperformance combining elements of the two. The director and peer are funded respectively by the expert and mentor positionalites that emerged in my analysis of the texts and contexts of counseling that inform the particular site, but are enacted in distinct ways. The director subjectivity, funded by the expert position and fueled by professional motivations, is enacted through education, managerial advice, and evaluation. This positionality sediments distances and maintains a traditional counselor-client dynamic. The peer subjectivity, funded by the mentor position and fueled by self-actualization motivations, is enacted through fostering a comfortable and nonjudgmental environment, and affirming the client's feelings and behaviors. This positionality attempts to bridge the distance between counselor and client for a more intimate counseling situation. The guru positionality is effectively a hybrid of the director and peer. The guru aims to bring the client to self-actualization through guidance and validation. All of these positionalities have strengths and serve different purposes in a counseling session. The director positionality is necessary because providing information and education is a key component of prevention counseling. The peer positionality helps create a comfortable situation for the client in order to facilitate open and honest discussion. The guru positionality helps guide the client to more positive ways of being and encourages the client to not fear getting tested

in the future. At the root of it, the director subjectivity places primacy on what the client should do, the peer positionality places primacy on how the client feels, and the guru places primacy on how the client should be. Much of what determines whether a counselor performs as director or peer is contingent on the counselor's perception of the client. In the next chapter I will focus on perceptions of client identity and how this affects counseling practices.

CHAPTER FOUR

COUNSELOR PERCEPTIONS OF THE CLIENT

How counselors perceive clients plays an important role in the prevention counseling context. The data collected from the qualitative interviews and participant observation for this dissertation support that there is an interconnection between a counselor's perception of a client and his or her enacted identity as counselor in that session. While I have already established that most counselors have a default positionality that they more readily enact, none of the counselors observed or interviewed are completely rigid in his/her approach. In fact, the data indicate that the positionality of the counselor shifts and reacts relative to interactions with and perception of a given client. A further analysis of this will help address RQ3 for this dissertation. As a reminder, this chapter will focus on the following research question:

RQ3: How do the prevention counselor's perceptions of the client and his/her identity play a role in constituting counseling enactments and approaches?

In the data, five primary perceived client positionalities emerged that have performative effects on the subjectivities enacted by the counselor in a given session. These perceptions of client include: client as *naïve;* client as *distressed;* client as *cavalier;* client as *routine;* and client as *informed risk taker*. The perceptions listed range from discernments of clients as least to most informed and appear to have a direct bearing

on whether, and how, counselor authority is navigated in the counseling session. First, I will address clients who are perceived as being naïve.

Client as Naïve

In a counseling session a primary task of the counselor is to gauge the level of knowledge a client has about HIV, transmission, and risk. This information is relatively easy to secure. Questions pertaining to these issues are pro forma, alerting the counselor to how much s/he needs to focus on providing information and education versus other aspects of counseling. The data indicate that often counselors strive to assert their authority, but this is always calibrated relative to the perceived knowledge of the client. This is not only supported by the policy texts, training materials, and protocols, but can also be observed in the general attitudes of the counselors. Many counselors expressed how they try to make sure each client leaves the session with something s/he did not know previously. Each interview provides insight into strategies for counselors to discover knowledge gaps and fill those informational voids. Plainly, much of counseling rides on the presumption that there is some level of naiveté on the part of the client. It is important to note that in some cases, naiveté is overridden by other positionalities, which I will discuss in coming sections. While naiveté is thus arguably the default projected client positionality, the data suggest that when naiveté is the overriding or sustained positionality attributed to the client, it is a bit more nuanced, with distinctive implications for how the counselor takes up the session, relative to the age of the client.

Specifically, the data indicate if a counselor presumes a client has a general naiveté, or has a particular perception about the client's knowledge based on his/her age,

the counselor will tend to perform a particular permutation that merges elements of both the director and peer subjectivities, much like, but distinct from, the guru. I identify this permutation as the *life coach* positionality. Unlike the guru positionality, the life coach is not about existential authenticity and self-actualization, it is more about practical behaviors and actions. Similar to how the director and peer positionalities are reflective of the expert and mentor subjectivities as they are mobilized on the ground, or in practice, the life coach positionality is a microperformance, informed by both the larger peer and director positionalities, that occurs when a counselor encounters a client that s/he perceives as naïve.

The data suggest that counselors are more likely to perceive younger clients as naïve than other populations and thus perceive them as requiring greater degrees of direction and education. With younger clients, there is a common and even reasonable assumption on the part of the counselors that they are relatively newer to sexual relations and activity. Logically, enacting the director positionality would seem to make the most sense when a counselor detects a level of naiveté from a client. Many counselors who demonstrate a clear preference to enact the peer positionality describe how they incorporate more aspects associated with the director subjectivity when dealing with naïve clients. However, the data do not support a simple jumping between the peer and director positionalities but rather a more nuanced performance that originates from these two positions and then transforms into the life coach positionality in reaction to the client. For instance, Chance touches on his tension between peer and director:

> Then when I'm with clients who typically don't know very much about the virus, I do kind of take on more of a student/teacher role because again, it's hard to not have that power differential there when you're teaching somebody basic things

> about the virus. It just depends on the style.

As previously mentioned, Chance is a counselor who more readily enacts the peer positionality in his sessions, but here he describes something distinct from both the peer and director positionalities. He has a desire to avoid the "power differential" but resigns himself to the necessity of it in certain counseling contexts. This conflict is where the permutation of the life coach subjectivity derives from. The life coach is distinct from the peer positionality insofar as it rooted in information giving and advice, but it also focuses on trying to create as much of an egalitarian environment as possible within the context.

Michelle shares a counseling experience that throws this dynamic into sharp relief:

> A while back I had a client, 19 years old, just clueless. He was meeting a lot of anonymous guys off craigslist and other hookup apps. He was bottoming. Just getting rawdogged by different dudes, left and right. When I asked him about condoms, he told me that he thought condoms were just to protect against pregnancy. Straight up, he told me that in his Sex Ed they just talked about condoms as a way to prevent pregnancy, so he didn't realize that he should even be thinking about using them since, obviously, he's not going to get pregnant. Finally a friend of his told him that he should get tested.

Michelle continues on to provide an example of how she enacted the life coach positionality when counseling this client:

> I asked if these guys he was hooking up with ever brought up using a condom, or even attempted to talk about status and he said they didn't. We talked about lube, of course. He wasn't using that either, at least not usually. It was a long session. Just breaking down transmission, and explaining how he needs to advocate for himself. I was really scared he was going to get a positive result. Thankfully, he didn't. And hopefully he knows a bit better moving forward now, hopefully he actually uses that knowledge.

Advocating for oneself appears to be a major concern or goal of a counselor when

enacting the life coach subjectivity. It is advice that functions to validate the client while also providing valuable knowledge.

Not all the young clients necessarily exhibit the same degree of "clueless"ness, but there is a clear theme of counselors apprehending younger clients as needing more education in the data. Chance also shares a story about a young client in need of a lot of education. He explained:

> I had a younger client the other day, who it came out during the counseling session that this client was doing some adult films. He was really young and from what it sounded like, from the information he was giving me, it didn't sound like a legit production company because he was talking about how they didn't test him beforehand, but they would ask him after doing a scene whether or not he had been tested. He and I went over some risk factors. In these films he was making he wasn't wearing any protection and his knowledge of HIV and how HIV transmission works was very limited.

Chance directly attributes the client's lack of proper knowledge to his youth. Chance further described his reaction in this session and exemplifies the life coach positionality:

> I was discussing the ways to advocate for himself when signing up to do a film. So if he met with a filmmaker then he could discuss beforehand, before doing a scene, whether or not they test. Also is he uncomfortable with the way that their testing is or if they don't test, then to advocate for himself to be able to use protection and that the actor use protection. There was also an aspect of substance use and we discussed that. A lot of time he was making the decision to do these films when he was high and so we talked about decision making and referred him to counseling. That was something he was interested in so we gave him a card of a place to go. It was mostly a decision making things and advocating for himself.

Focusing on advising clients to advocate for themselves appears to be central to the life coach position. As opposed to the more prescriptive advice associated with the director position, Chance engages in a conversation with the client in order to gauge his comfort and his desires. By focusing on decision making, the life coach position allows the client to determine what s/he is comfortable with advocating for him/herself based off the

information provided by the counselor.

Sarah also supports this, noting, “I've gotten a few younger clients I would say are more like, ‘What's the big deal of not using condoms?’ Or ‘What's the big deal of like having sex with people I don't know?’” She goes on to describe, “in cases like that it is important to try to empower the client with knowledge. It is more than just teaching them something, it’s about getting them to own that knowledge.” It appears that when a counselor enacts the life coach positionality s/he will not only direct/advise the client but attempt to couple that advice with a level of affirmation in order to empower the client.

Clearly, younger clients appear to prompt a presumption of naiveté, which in turn encourages counselors to react with the life coach positionality. Specifically, counselors emphasize the importance of teaching these younger clients to advocate for themselves. Interestingly, similar presumptions and reactions seem to occur when counselors meet with older clients, but with a slightly different emphasis in counseling.

Where counselors appear to carry a presumption that younger clients would reasonably have less experience and therefore less understanding, many counselors expressed how surprised they were when they encountered older clients who were not very well informed about safe sex. For instance, Patrick shared:

> This guy was older than my dad and I remember thinking that was weird, that was like talking to my dad about his sex life and understanding that not everybody knows everything that you do and you just take it for granted that everybody knows to use a condom and everyone knows the rules and all that stuff. But talking to an older gentleman, or older person, that you think was seasoned or knew what was going on, didn't know. Didn't know the risk factors, didn't know what was the riskiest behavior he was participating in.

Here Patrick has a perception that a man “older than his dad” would know more about sexual health, and this situation challenged his assumptions. To this end, Calvin points

out an important consideration when counseling older clients:

> I think it is particularly important to not come off as patronizing with older clients. Like it's important to not be patronizing all the time but especially with the older ones. If a client is much older than I am and I start talking to him like he's dumb or something, he's probably going to be like "who the hell is this punk kid?"

Plainly, when counseling older clients who demonstrate a level of naiveté, it is "particularly important" to provide information in a way that does not distance the counselor from the client. This exemplifies the nuance of the life coach positionality. Patrick tries to pull from both director and peer subjectivities in order to provide advice that does not come off as condescending or patronizing. Whereas counselors enacting the life coach positionality with a perceivably younger and naïve client will focus on how the client can use knowledge to better advocate for him/herself, a counselor enacting the life coach positionality with older clients will primarily strive more for an egalitarian, or nonpatronizing, environment.

Jon also shared how you cannot take a client's level of knowledge for granted based on age:

> I know there was a fifty-some-odd-year-old man who came in who was recently divorced, had a new girlfriend and after the counseling session said, "By the way, my girlfriend wants me to learn how to use a condom." I was kind of taken aback that somebody in their fifties had never used a condom before. That was, putting on a poker face, you know? That was kind of interesting too. It just goes to show that you just can't take anything for granted.

Much as counselors react to younger clients by enacting the life coach positionality, Jon demonstrates the life coach subjectivity within this example. Jon described how he puts on his "poker face" in order to provide education in a manner that maintained a level relationship. He added, "I made sure to not talk down to the guy, even though I was

taken aback I tried to make sure I didn't come off as patronizing or something like that." The life coach positionality truly merges the education-driven nature of the director and the egalitarian impulse of the peer positionality.

This quickly starts to look like a pattern. Many counselors, including myself, have experienced this sort of client, as well as the surprise that accompanies encountering one. Some counselors draw on their experiences to make clear theories as to why this is the case. For example, Lindsey provided:

> A lot of them are actually coming out of marriages. They have been in a heterosexual relationship for however long and that marriage either ended and they're beginning to experiment with this new sexuality and it's like being a teenager again. They didn't know the rules, they're starting to play the field with people who did know the rules and I think it was a little shocking to them what they didn't know. You can speak to that bringing in sexually transmitted disease. Usually like the older generations like forty-five, fifty, will sometimes see a spike because they have been in a monogamous relationship for so long and they forget safe sex techniques or they never had to worry about it and all of a sudden they're experimenting with different sexual partners and different things and they learn very quickly that safe sex techniques are really important.

Lindsey positions the older client as being a "teenager again," as a way to make sense of the way that a major change in life (coming out, leaving a marriage, etc.) can affect a client and also as a way to imply a knowledge gap that a counselor should address. Logically, if an older client is perceived as being like a "teenager," the counseling session will proceed in a similar way to the younger clients.

This turning point in the older "naïve" clients is a common observation from the counselors. Gavin shared a specific story about counseling an older client going through a turning point in his life:

> I remember an older guy that was probably around sixty maybe, he was married, had a family, but had realized later in life that he was gay or maybe always knew but had never really admitted it to himself. I felt really kind of, it was touching to

> hear his story. He was also, he had come to terms with it and was I think his wife, what was her deal? I think she lived in Idaho or something and he would go up and visit her on the weekends or every other weekend or something like that. Now, he was just starting to dabble in having these extramarital relations with guys and was just kind of feeling it out. That was a memorable thing for me because I was like yes, I know this happens, but to listen to a story and to hear a struggle that he must be going through internally, was really touching and also kind of scary because like oh man, he's putting himself and other people at risk big time. I really think because he had lived his whole life in this monogamous, heterosexual relationship where I don't think typical people use condoms when they're a married heterosexual couple.

Here is a clear example of an older male client, coming out or experimenting later in life, and not fully understanding the importance of safe sex practices and the risk factors he is engaging. In this situation, Gavin goes on to demonstrate a shift from his preferred peer positionality to life coach:

> Now he's kind of like bridging on this new era of his life and he was being a little risky. I think he knew it, but at the same time he didn't really know the seriousness of it. Hopefully he walked out a little mindful...

Gavin later explained:

> It can be difficult to teach someone older, and plus I like to try to avoid thinking about counseling as teaching. I like to think of it as a conversation or something like that, but when there is a clear lack of information you have to help fill that.

Gavin emphasized his life coach positionality in the encounter as he mentioned the tensions between the director and peer positionalities directly and then seemingly reconciles them with the life coach subjectivity. Again, the life coach positionality brings together the empathic and egalitarian elements of the peer subjectivity and the educational components of the director position.

Clearly, there is a perception of older clients being naïve, especially when they are associated with a turning-point narrative. This turning-point narrative appears to have direct implications for the counseling. It breaks the assumption that older clients might

be more knowledgeable and calls for a counseling session that is informative while being particularly mindful of not creating too much of a power differential.

When a counselor encounters a client s/he perceives to be naïve, s/he will commonly enact the life coach positionality. The life coach subjectivity works with the client to inform him/her about safer choices, with certain attention to fostering an egalitarian relationship within the session. The life coach subjectivity has roots in both the peer and director positionalities, essentially merging the two. The life coach positionality strives for an egalitarian relationship, but is also predicated on the direction and presumably superior knowledge of the counselor. Moreover, I found that specific enactments of the life coach positionality are contingent on the factor of age. Counselors seem to attempt to empower younger clients to advocate for themselves, whereas counselors appear to focus on providing information to older clients in an egalitarian manner. Next, I will address clients who may or may not be naïve, but exhibit some sort of emotional block that takes hold of the counseling situation.

Client as Distressed

Clients commonly enter the counseling situation with a significant level of distress. Some feel guilt or shame for a decision they made, others are scarred from abuses that were perpetrated upon them, and some are simply terrified of the stigma associated with HIV. "Distress" might originate from many quarters—including physical assault, emotional upset, or identity crisis—but it is uniformly seen as a hindrance to the counseling process by counselors and prompts the *facilitator* positionality. The facilitator positionality is seemingly enacted in three slightly varying ways: (1) unblocking through

reflexivity and resourcefulness, (2) unblocking through acting as a confidante, (3) and unblocking through rationalization.

Facilitator as Reflexive and Resourceful

When a counselor enacts the facilitator position s/he will commonly implement strategies to get a client to open up or get more comfortable when there is a clear block in communication. For instance, in some cases counselors forego counseling until the results are provided. Nick explained:

> Sometimes you can tell they are not following you at all. Especially if they are really nervous—like they know they had an exposure, or they are just paranoid for whatever reason. Sometimes if that's clearly the case I'll just write a note so whoever gives them their results will know to discuss transmission, and come up with a plan and all that. It's just more effective because I know there's nothing that person is hearing until they know that result.

Nick perceives a client's nerves as a hurdle to overcome in this situation. He asserts that foregoing counseling until the result is delivered helps unblock the client's distress and allow for more productive counseling. This is contrary to protocol but serves as a resourceful response to a despondent client.

Sarah also offered an example of a challenging client that she had to forego pretest counseling with:

> He was extremely distressed. He talked about how he's been going to a lot of parties with HIV positive men knowingly and having unprotected sex. He was in his late forties, so he's been around for a while and knows a lot about HIV, but has been completely distressed, feeling like he was in a really, really dark hole. That kind of counseling session threw me off. But this person was bawling and I'm not trained to kind of handle that. He seemed in complete distress. He got his result and we did a pre and post together. I told him the result five minutes into the session and he was just broke down. He was like, "I can't believe…" his results were negative and he was "I can't believe I'm negative. I can't believe that I've gone to this, this is where I'm at." Just in complete distress, talking about suicide,

> depression and things like that. It was a lot.

Clearly, clients who have had an exposure due to some bad judgment provide a particularly difficult obstacle for counselors and are perceived as being some of the most challenging. Sarah clearly enacts the facilitator positionality as she provides the client with his results as soon as possible. Again, this manages to unblock the client and allows for the counseling session to continue unhindered. Even though this reaction disregards protocol, it is seen as necessary for these counselors to facilitate a productive dialogue.

This “do whatever it takes” mentality is key to the facilitator positionality. Further exemplifying the facilitator position and this mentality, Dan provided an example where a client’s trauma caused him to find a counselor better suited for the session:

> Another session I remember pretty vividly was when I had a woman come in. I came in, I told her what my name was, I told her what we were going to be talking about that night and I said, "So you're here for HIV testing?" And she said, "Well, I was raped." That was a test for me to make sure I wasn't in like shock mode of “oh my God, I've never dealt with this before.” We kind of started into the discussion. Even though she started out pretty bold, I could tell immediately she started retreating from the conversation, she was uncomfortable with me because she was raped by a man.

In this situation the client experienced a powerful trauma. Dan characterizes her enactment of this distressed positionality as being initially bold but then withdrawing. When a counselor enacts the facilitator positionality, s/he will try to foster openness even if that means recognizing that another counselor may be better suited to counsel the client. In this case, Dan continued on to explain how he felt the client was just not going to get comfortable with him:

> I feel like she was uncomfortable with me discussing this with her. So I immediately, the CDC training kicked in and I was like "You know, I feel like you may be more comfortable discussing this with a woman. Am I getting that right?" She said, "Yeah. You're one hundred percent right on that. Sorry, it's just

> uncomfortable for me." I said, "I completely understand. Let me go see if I can get someone who is going to make you more comfortable, so you can open up and talk about what happened and they can provide you with the best information available. I've got a great resource here, her name's Lana. Let me go see if Lana is available." I went and talked with Lana about it, she agreed to take over the counseling session. I just remember that because again, it was the shock factor. Like something I completely never dealt with. For a minute, I felt completely inadequate to even start discussing with a person. Because I almost wanted to jump into the whole, "Oh, I'm so sorry" kind of mode when it's like that is not what we're there for as a counselor. That's why I felt like my counseling skills were tested and I'm glad I was able to pick up, get Lana in the room, and have her take over the counseling session where the client felt more comfortable at that point.

Dan demonstrates self-reflexivity as a counselor and recognizes that another counselor might be better equipped for this client. In this case the "whatever it takes" mentality of the facilitator subjectivity prompts Dan to excuse himself from the session, in other situations a counselor might turn to professional referrals for the client's needs. For instance, Aaron shared an experience he had with a client who was going through a lot of issues outside of the scope of his expertise:

> There was a girl who was like "I was kicked out of my house" she was a pretty young girl and had put up a lot of walls and was, like, doing a voice and had, like, a fake character. She had been kicked out of her house, and she was using intravenous drugs and she was living with these two guys and both of them were having sex with her and she just, like, didn't know what to do and she didn't have a job. There was just no way out of it. She needed someone to talk to primarily and I think she was hoping for her problems to be solved by coming here and taking this first step.

Here, Aaron characterizes the client as "putting up a lot of walls," even potentially modulating her voice, and producing a "fake character." Again, distress from this kind of trauma seems to construct a perceivable barrier between the counselor and the client, as it, is seen as something that inhibits the appropriate openness needed for proper counseling. Aaron further described how he worked with this client:

> You can refer them to counseling… and these different things, but ultimately it's up to them to follow up, it's up to them for all that. I just remember her and it was like this, I mean I was happy to provide what I could, but I fully did not have solutions and it was just going on and on and one and setting goals and talking about the same things. It was rough. That's one that sticks out in particular.

Referrals are a common way that counselors enact the facilitator positionality. When clients have substance abuse or mental health issues that are out of the scope of the counselor's expertise, all the counselor can do is refer them to services that can potentially help. Here, we see a counselor who describes his primary goal as "Education!" take a backseat and perform the facilitator positionality in favor of the client's needs. The facilitator positionality focuses on getting the counseling session on track no matter where that puts the counselor in the situation. Aaron and Dan's examples demonstrate the "do whatever it takes to help" mentality of the facilitator positionality. In both cases the counselors self-reflexively release their own ego and recognize that someone else (a specialist, or another counselor) could better serve the client's needs.

Jon shared an example of a counseling moment wherein he enacted the facilitator positionality by going outside of his counseling duties:

> This person was already overwrought just coming in. He had been drugged and, in my mind, raped by somebody he trusted and had low self-esteem already. I tried to diffuse it by saying, "What are your concerns? People don't die of HIV anymore." He had explained to me through counseling that he was from a large Mormon family and that when he came out to his family, he was ostracized and pretty much had little or no contact with his family and that was very hard for him. He was early twenties. So it was trauma. It was traumatic. It also played a role in his self-esteem so he had no self-esteem. This person was somebody he trusted and he found out that this person he had sex with was positive. There were a lot of things playing into that. I tried to reassure him that he wasn't going to die from this traumatic thing. I finally said, "So what is it that you're so afraid of? If you're not going to die, you have a good job, you have insurance." He said, "It's just one more thing for someone to reject me for." It was heartbreaking. When I went and found out that he was positive, of all the people, of all the people to have to give that news to, why did it have to be him?

Jon speculates that the client's trauma of being ostracized from his family, and then sexually abused by someone he trusted, piled on to his already low self-esteem. Thus, Jon perceived that this young man had a very emotional fear of rejection, which interfered with his ability to truly accept information about HIV. While the client might have been open he was still hesitant to receive certain messages.

Following the "do whatever it takes" mentality associated with the facilitator positionality, Jon described how he "broke the rules" with the client. Out of a personal concern for the client's well-being and desire to help him transition into, and come to terms with, his HIV positive status, Jon enacts the facilitator positionality. He further shared:

> I broke the rules. I'm not supposed to give anybody my phone number or contact information, but he told me in the precounseling session that he was going to kill himself if it came back positive. Some of that is sometimes melodrama and so I didn't, but once he found out it was going to fruition, that was difficult. I gave his roommate my number and said, "Would you please call me and just let me know that he's okay. Just for myself." We spent hours, it was a late night. He thanked me and said, "I think I'll be all right." He did, well I didn't expect him to share my number with the client, so I got some texts and that was okay. He just needed some answers. That was a case where I broke some rules. He still texts me once in a while and asks me things, because he knows, I totally revealed to him that I was also HIV positive. I think he felt comfortable with me and also didn't have support from family and a lot of friends and was afraid of rejection.

Jon goes to great lengths to provide support for the client. He admittedly breaks the rules and protocol in order to demonstrate that he is there for the client. It is interesting to note that with these all examples, the facilitator positionality seems most common when a client is not only perceived as distressed, but also seen as not having much support. The facilitator positionality attempts to provide a support system for clients in a manner that surpasses protocol and the peer subjectivity. Moreover, this positionality seems to invoke

a critical reflection of self, counseling, and protocol.

Facilitator as Confidante

Counselors enacting the facilitator positionality may also work to help unblock a client by simply listening. Nick shared an example about a client who was cheated on and had difficulty moving from that in the session:

> Sometimes you get the clients who were cheated on and that's like all they can think about. Like I had a guy the other week who found out his boyfriend was cheating on him with a bunch of dudes. I was trying to go through my risk assessment and explain transmission and all he could say is "that fucking asshole cheated," "fucking cheating piece of shit." Obviously he wasn't really listening to anything I had to say, so it's just like, cool, dude, you're ex is an asshole, let's move on.

In this example distress is, once again, interpreted as creating psychological noise for the client and effectively creates a barrier during counseling. Granted, Nick explains his reaction in a rather flippant way, but it is clear that he attempts to placate the client in a manner to further facilitate the counseling session, again prompting the facilitator positionality.

In certain situations distress and lack of support can prompt clients to confide in the counselor because they have no one else with whom to discuss these issues. Jeremy shared an experience where a client was conflicted with his sexuality, his church, and his family:

> One case in particular that I remember, was someone that had come to be tested that was from a very conservative part of [the state]… He was my age [in his forties] and was being tested. He had told his wife he had come to [the city] for a baseball game to do that. But he was someone who had tried to do the right thing. When he was younger, he believed in his church and they told him that if he got married those feelings would go away and so he did. Then he is all of a sudden in his mid-30s or 40s, and it comes back with a vengeance. He was someone that I

> believe had a high position in the church and was well known in his community and had absolutely no one to talk to. At that time, we had the freedom to just sit there and if they wanted to talk, we could just talk. We tell them we're not licensed, we're not professional counselors, but if you need someone to talk to or vent to we're here. And we did. I gained myself so much insight with that. This guy was just crying because he wanted to talk to somebody, but he had no one to talk to. Up until that point I had been very judgmental with respect to people, especially who were LDS, that were looking for a little action on the side. That was one of the experiences that helped me realize that even though I still don't necessarily agree with the choice to do that, because I don't believe dissension is a good thing, I understand it more. It's allowed me to have compassion toward people that are living in the situation.

Jeremy enacted the facilitator positionality because he recognized that the client did not have an outside support system to discuss these issues. Clearly, the focus of a counseling session like this is not to direct or educate the client. It is much more about entering a nonjudgmental environment in order to allow a client to vent. Major counseling protocols and tenets are put aside in order to be a confidante for the client.

Diane also shared an experience wherein she enacted the facilitator positionality by effectively acting as a confidante for the client:

> I said, "So how's your Monday going?" He just said, "My partner of twelve years just died two weeks ago." Well, that stopped everything. I just handed him a box of Kleenex and the person shadowing said, "I'm so glad you were there, because I wouldn't have known how to handle it." Well, through my social work experience this is the way we focus on the client. This is his presented problem, this is what we do, and we hear them out for however long it takes and then we get to the issue at hand. It turns out his partner died of AIDS, so it all led to it. The background experience really does help in terms of being able to focus on clients, listen to what they're saying and understand their presented problem. Some of the times, to the things they don't say. Well if you haven't had a sexual encounter for the past year, why are you coming in? "Oh, I just wanted to." There's only so far you can press them. If I were in a true social work experience, I'd be pressing this more. This doesn't make sense to me. But I know enough to just let go. It's helpful listening to people.

In this situation, the client is facing the painful identity crisis of losing a partner of twelve years. Like the scenario Jeremy described, this client really needed someone to talk to

and Diane enacted the facilitator positionality, effectively making herself available for that. She mentions, "it's helpful just listening to people." This is more passive than other enactments of the facilitator subjectivity but follows the "whatever it takes" mentality nonetheless.

Counselors may enact more reflective or attending means to unblock a client's distress in a counseling situation. Counselors will cue in on a client's needs and do whatever it takes to get that client to an appropriate space for productive counseling. Often this requires counselors to reflect upon themselves, the counseling process, protocol, and the client. Conversely a counselor might simply recognize that the client needs a sounding board and just listen to the client vent before getting into the counseling portion. Rationalization is a more active way counselors will facilitate a session when a client is blocked.

Facilitator as Rationalizer

Less common, but still significant, counselors will at times enact the facilitator positionality through rationalizing with the client in order to overcome the obstacle of distress, getting them to perceive their situation differently, specifically less emotionally. This happens when a counselor tries to calm or comfort the client with the "clear facts." This sort of "soothing with science" approach was exemplified when Brock described a session with a particularly despondent client:

> You can talk a bit about how living with HIV is no longer a death sentence, and focus on how treatable the virus is now, but you also don't want to jump the gun too much. All of that stuff will be covered if they do end up with a positive result. It's just hard to comfort someone who knows, or at least convinced themselves, they made a big mistake.

Brock may not have clear advice about how to put a client at ease but his priority is clear. He is concerned with providing comfort and does so by supplying the client with concrete scientific information about the virus and the state of modern day antiretroviral medications. This is clearly different from focusing on a client's emotions but can effectively help provide a level of comfort. Calvin explained a situation wherein he tried to put a client at "ease" by using the "truth" of his "risk factors":

> I could not guarantee that he was negative but I answered his questions about transmission and I assured him that if he was telling the truth there was no real chance of him having it. In situations like these the priority is not to direct the client, because they are not engaging in risk factors, it is about trying to put the client at ease and get them their result.

This still very much functions as part of the facilitator positionality as he ultimately seeks to work through the distress in order to provide productive counseling.

Counselors seem to most commonly enact this variant performance of the facilitator positionality when the client is perceivably convinced that s/he has contacted the virus. For instance, Jake shared an experience:

> A woman came in concerned because she was HIV positive because she had gotten a notification from a plasma donation site and they just did batch testing with all the plasma and someone in the batch was positive, and she was just extremely concerned that it was her and was very hard to talk with because the whole time she was very nervous about it being a positive result. Trying to keep her, talking with her and getting her to relax a little bit, just kind of giving her more information. Just talking with her, you could tell she really hadn't learned a lot about HIV or safe sex or just sex in general. Everything I would say, she was like "Oh, I didn't know that."

Here Jake provides information in order to calm a client who is distressed from the news of her batch test. In this scenario Jake sees the "facts" as the best way to soothe the client and get her ready for the counseling objectives. This is indicative of the facilitator positionality, as it recognizes the particular type of distress a client is experiencing and

works around that. Jake shared another story wherein he enacted the facilitator subjectivity by rationalizing with a client:

> Probably the most challenging one was a guy who came in who—I mean a lot of the clients who come in are nervous about their results. But this guy was especially nervous. I think he had known that he had slept with a partner who was HIV positive. He was very concerned about his status. Just again, trying to calm him down and talk through everything. Just like talking with him about some of the safe sex practices and some of the practices to stay safe.

Jake describes how the client's known exposure caused him to be "especially nervous" to the point that Jake categorizes him as the most challenging. Again, Jake implemented a rationalizing facilitator positionality in order to attempt to work past these anxieties and get through the counseling session.

Michelle had a client who was given two tests at another testing site and was told he was positive both times. She explains, "he was in a monogamous relationship for over two years, he didn't do drugs, poor guy thought he might have had it because his dad was positive which we both know doesn't make any sense," when his test come up negative Michelle had to show him the test and the two of them discovered that the practitioner at the previous site was not reading it accurately. In this case the client was so hopeless that he needed to be walked through how the test is read in order to calm down. This perfectly exemplifies how a counselor can enact the facilitator positionality through logical rationalization with a client.

The facilitator positionality has roots in both the peer and director subjectivities, which stem from the expert and mentor positionalities respectively. Facilitating works to unblock the client's distress through being reflexive, acting as confidante, and rationalizing the situation. While a counselor will likely function as a facilitator to some

degree in all counseling situations, it is particularly prevalent when a client is perceivably distressed. Now that I have discussed two perceivable client positionalities that can be rendered as naïve, I will address the more knowledgeable client positions. Next, I will specifically discuss cavalier clients.

Client as Cavalier

I have already discussed how many counselors carry a presumption that younger clients might be more naïve than other clients, but there is another positionality commonly associated with the younger population. Counselors noted that many of the younger clients seem to "care less" or be "not as concerned" about HIV/AIDS. As a result counselors appear to take on what I call a *disciplinarian* subjectivity when working with the more cavalier clients. The disciplinarian positionality derives from the director subjectivity and manages to create even more of a power differential within the counseling situation.

For instance, Jeremy, one of the more senior counselors at the AIDS Foundation, provided insight from his twelve years of experience about how younger clients seem to care less and less about HIV and thus care less to learn about it:

> I've noticed that the younger ones don't seem as worried about it. When I first started in 2003, it wasn't that terribly that much, not a lot of time had passed since people were dropping left and right. I think that kind of tapered off around '98, '99 if I remember right. Yeah. So a lot of time hadn't really passed since then and I think that people dying of HIV or dying of AIDS, at that time, was still something that was fresh in everyone's mind.

He continued:

> I think that a lot of younger people didn't grow up in a time, or know a time, where everyone was dying. The feeling that I get from a lot of them is that they

> feel like it's no big deal. If they get it, whatever, they'll just take a pill and they'll be fine.

Jeremy explains how he believes he has personally witnessed a shift in attitude from one generation to next. Jeremy also seems to implicitly create a contentious dynamic between counselor and client in this situation, as he essentially positions the client as foolish. Jeremy continues to theorize about why younger people might be more cavalier and engages in some of the common traits of the disciplinarian positionality:

> When I first started volunteering, it was that if you test positive for HIV, then “it's not the end of the world.” There's no reason why you can't live a normal healthy life. Part of me wonders if that message might have been somewhat of a contributor to it. Because even thought we said if you test positive for HIV and you take your medications, you live a healthy life, there's no reason why you wouldn't believe that you wouldn't live and have a normal lifespan. One of the things we didn't talk about was the side effects of being on the medication and how that impacts your body, how the virus can mutate and how you're not religious in how you're taking your medication. It's not really as simple as taking Tylenol. It's much more complicated than that. Our message, back then, not a UAF thing, that wasn't a part of the health thing. If you test positive for HIV, it's not the end of the world. You can manage your viral wellbeing. A part of me wonders if maybe in trying to reassure people that maybe we were somewhat sugar coating the reality of what that really means, that you are living with HIV.

Here, Jeremy provides a theory as to why clients might be more cavalier in their attitudes and risk behaviors, but more importantly he expresses a concern about how these clients should understand the bigger picture. Again, there is a “kids these days” tone to his assessment that adds to his disciplinarian positionality.

Focusing on the cost and side effects of the medications for HIV is a common tactic for counselors when enacting the disciplinarian positionality. For instance, Jon offered:

> When they act like it’s not a big deal, it is important to acknowledge that “sure you can live a full and healthy life” but there is still a lot expense and maintenance involved that is not always pleasant. Also it is highly preventable;

so let's talk about transmission so you can avoid that.

Here Jon provides a crafty maneuver wherein he recognizes the root of the client's cavalier attitude and then supplies the client with other concerns s/he should be considering. The disciplinarian is not necessarily beating the client over the head or pushing the client to a particular action, but there is a clear notion that the client is being foolish and immature, and needs to be made aware of the larger picture. This is not necessarily bad and can be rather reasonable, but enacting this positionality creates a clear power differential.

Richard, who notes that, "16-to-26-year-olds don't seem to have any understanding," shared a specific scenario where he enacted the disciplinarian positionality:

> I told him, "What is it going to take for you to start using condoms every time so you don't get HIV? Because you realize that will cost you up to 3000 bucks a month, what will it take for you to do something?" And he said "I don't know" and I let him stew in that, and I was probably in there for a good 5 minutes while he did that. He finally kind of decided you know I really need to start doing something differently. And I said, "well you do, or you are going to get something you don't want." I didn't push him, I just let him try to figure it out because he didn't realize it was a big deal.

Both examples are essentially scare tactics that are often associated with patronizing attitudes. Richard's enactment of the disciplinarian seems particularly steeped in a notion that clients sometimes need to be knocked out of their own stupidity. He mentions that he didn't "push" the client, but offering that someone has to use condoms or s/he *will* "get something [s/he doesn't] want" seems like more than gentle guidance.

To this end, Gavin also provided an example of his experiences with younger clients who appear more cavalier:

> I had a client not too long ago. He was doing some pretty high-risk stuff, and kind of seemed to understand that, but not really. I think the attitude is sort of, like, cavalier. I don't know if it's - he didn't even seem to have an attitude that was like it's not going to happen to me but it was more like "Eh, if it happens, it happens, I'll just deal with it." I feel like he was 20, 21. Maybe young kids don't really have that because less people are dying now. Anyway. So that was not surprising but maybe having firsthand experience with talking with people who have that attitude is like, oh.
>
> As we discussed, it seems like it's younger, totally not trying to generalize, but a lot of the younger people—eighteen, nineteen, twenty, twenty-one-year-olds—that come in that do sort of have this, some of this have this sort of cavalier attitude about sex. I think there are several reasons for it, but a lot of it is not having grown up when AIDS was a crisis—the way it was. A lot of people are living with HIV now that you would never know. I think that's the attitude they have. Like "If I get it, I get it and still live a happy, long life." It's not that simple.

These perceptions of younger cavalier clients clearly position the client as someone who needs a level of parental guidance. Gavin concludes his observation with "it's not that simple," harkening back to what the other counselors have voiced. The disciplinarian subjectivity drives counselors to provide clients with the bigger picture, often through paternalistic scare tactics.

The perceived willful ignorance of the cavalier client prompts counselors to enact a much more direct and paternalistic positionality. Unlike the life coach and facilitator positionalities, the disciplinarian subjectivity does not seek an egalitarian relationship between the counselor and client but instead creates a large power differential in order to push the client toward a realization about his or her attitudes, behaviors, and actions. The disciplinarian derives from the expert/director, "counselor knows best" mentality, and is then performed in an explicit-paternalistic manner. I will now discuss routine clients and how counselors performatively react to them.

Client as Routine

Most often, clients who come to the AIDS Foundation are seen as routine. Counselors describe the routine client as someone who is coming in for a checkup. These clients are largely characterized as knowledgeable. Because they are knowledgeable and have been tested before they are also characterized as a bit impatient and reasonably resistant to redundant counseling. When interacting with a client who is resistant to counseling and has demonstrated a high level of knowledge, most counselors appear to enact what I call the *administrator* positionality. When a counselor enacts the administrator positionality, s/he acts very pro forma and impersonally goes through the motions in order to get the client on his/her way. This positionality is straightforward and is therefore funded by the director position.

Routine clients are largely described as white men who have sex with men [MSM], in their mid-twenties to mid-thirties, who get tested on a regular basis. Sarah summed the routine client up nicely with this excerpt:

> I would say most clients that come in, they call it a "checkup". Most people, I feel, know a lot about HIV, a lot of them are MSM or identify as gay. Those sessions kind of um, they're a little bit quicker. They're like, "All right, have you been here before?" and we just talk a little about HIV, they mostly know all the answers. You try to make it as open-ended as possible and they're just here "hey, I already got my test six months ago, just here for another checkup". That's typically what I come across.

Here, the client appears to take control of the session by explaining that he has recently been tested and does not necessarily need a lengthy counseling session. Sarah perceives this kind of client to be knowledgeable, "know[ing] a lot about HIV." As a result, Sarah enacts the administrator positionality and moves through the counseling process quickly without belaboring much of the educational or supportive elements of counseling. She

explains, “with those clients, it’s pretty much in and out. You get the info you need and make sure they know the basics.”

Lindsey went into some more depth when asked about the average client and typical counseling session:

> Most of them are intelligent, they're educated, they're on top of things. I think that's actually changed since when I started volunteering. I feel like with giving information, people were like "Oh, that's interesting. I didn't know that" has now changed to a generation or group of clients that they're actually very on top of it. They're very well versed in HIV. It's something they've grown up with and it's kind of like almost the responsibility of their culture. Like I need to know this stuff and I was being challenged and asked questions that I wasn't really familiar with. But most of them, they're just doing what they think they need to do and it's not necessarily me providing information. They have the internet, they can find that information, it's more of individuals coming in to get the testing and ask questions and generally open up to someone and get support.

Again, the checkup client is generally seen as intelligent and not in need of education in this context. Lindsey also touches on how these clients get tested as a cultural practice of sexual precaution. Following this, Aaron explained, “You have a certain kind of demographic of people that are coming in to stay safe and keep themselves safe, so it's a lot of really easy, ‘I'm just here for my six month’ or ‘I'm here for my yearly’ or whatever.” Chance further supported this perception:

> I would say even close to half of the clients that come in to get tested know quite a bit about HIV and actually are clients that come in regularly. So with those type of clients there's kind of a knowledge and there's less of an education part than to sort of appealing to them to try different, lower-risk factors and things like that.

Dan provided that the average client includes “ones who come back often enough that they can recite to you the window period and all of that, obviously they've got that foundation.” Diane explained that clients can be rather blunt in how they demonstrate their knowledge, “They know the routine, and I say ‘You've been here before, any

questions? Why are you in here?' They'll say, 'I know about the window period.' I mean, they're pretty matter of fact, they're not necessarily brusque about it."

Ultimately, many of the counselors characterize these sessions as "quick," or "easy." Jeremy explained how routine clients tend to make for "cut and dry" sessions:

> Some counseling sessions, most of them, in fact, are just cut and dry. Someone, especially a lot of LGBT people, gay men in particular, being tested is just a routine part of their lives. It's just something that we do. They've all been a million times, they all know everything there is to say and so there really isn't, you can't really educate somebody who already knows everything. So most of the counseling sessions are like that. You just kind of go in and have a conversation, get the information you need for your paperwork and that's it.

Clearly, when faced with a client who "knows the drill," it is reasonable for a counselor to enact the administrator positionality in order to satisfy the client and move on to other clients who might have more needs.

In addition to being perceived as knowledgeable, checkup clients often display a level of impatience and resistance to counseling. For example, Gavin shared that, "there have been a couple of instances where they're just ready to get out of there. They are only there to get their test, which is good. Just being tested is a step in the right direction." Here Gavin is discussing the typical checkup client as occasionally just wanting the result and nothing more. Michelle shared similar experiences:

> There are people that will come in and they know everything and they don't want to talk to you about anything. Just tell me the result. They'll say "I know all this" and they don't want a prevention plan, they know they're just here to get tested and very resistant to any sort of counseling.

Diane also provided that, "Every once in a while, not very often, you get people who are like, 'I don't need to know this.' Sort of like,'buzz off, lady'."

Considering this perceived impatience, when meeting with a routine client, it

appears that the education component of a counseling session logically gets bypassed or significantly truncated. Even counselors who highly prioritize the educational aspects of counseling minimize or even skip over some of the expected information in the session. For instance, Aaron shared:

> I think that it's probably similar for everyone, but for me it's all centered around education and so it depends on their knowledge base. If they come in every six months, it's a pretty quick, like you don't have to go over the education portion necessarily, like modes of transmission. They knew it six months ago and the probably knew it before that. So it goes pretty quick. They're familiar with the style of prevention plan and so they've probably made one before, they're probably ready to make one again, or they don't buy into that whole part of it and it's just an exercise to roll through. I'd say it's just faster, it's faster, they're easy to do. Which can create a false sense of security. You figure ah, they're in every six months, I can skip this, this and this and it may be that was the part they needed. Most likely not, but maybe. That would differ from somebody who's first time just because you are much more conscious of covering every base and hitting every single portion because they've never heard this before.

Central to the administrator positionality is quickly moving through the session only touching on what is necessary for the client. Diane echoes what a regular counseling session looks like:

> There are also a number of cases in which it's the same. It's fairly straightforward. People have been before, they know how AIDS is acquired, they come every six months regularly, and those go pretty fast. They're pretty routine. I won't say they're boring, but they're routine.

When performing the administrator subjectivity, counselors will recognize a client's prior knowledge and move through the session in a "straightforward" manner. Chance provided another example of how this positionality is enacted:

> Usually if it's somebody who seems to have more knowledge of HIV, then I'm going to appeal toward reducing their risk, trying to get to know them and make it more of a partnership so it's not like telling them stuff they already know. I feel like people kind of shut down when you're telling them stuff they already know.

He further details how he tailors the conversation in order to avoid overloading the client

with information s/he might already know:

> If they've been there before and they've created a prevention plan, I think it's critical to start with that prevention plan. What's worked, what hasn't worked, because for people that come back often enough, they remember their prevention plan. It seems really, what's the word I'm looking for…it's doing no one a service when you start from like "Okay, do you know what a condom is?" right? If they have a prevention plan, they've been using condoms.

When a counselor enacts the administrator positionality, s/he focuses on tailoring the content in order to streamline the counseling process. Tailoring the counseling appears to be significant when a client demonstrates a level of resistance. Calvin discussed how important he important he finds this step:

> I think personalizing it is important. Making the person that's there, if they understand how HIV works and they've been in there seventeen times, I don't spend the first five or ten minutes talking about HIV so that by the end they're like, "Yeah, I know, we've talked." I mean, just personalizing it and maybe talking to them like it's a conversation, because it is.

Routine clients are the most prevalent according to the counselors interviewed. Routine clients often enter the counseling scenario with a high level of knowledge about HIV and other STIs and will actively demonstrate this to the counselor in order to move the counseling sessions along. Working with these clients in an expedient and tailored manner then is paramount to effectively interacting with a client who might be impatient and allowing for more time for clients who require more education or emotional support. Given that the administrator positionality calls for less focus on information and more of a tailored discussion of prevention, it logically stems from the director, or even the more basic expert positionality, as it essentially assesses information in order to give the client a pass. Since the administrator is a relatively passive position, going through the motions, it is a bit thinner than the other subjectivities, but significant nonetheless. I will

now address the final and most challenging perceived positionality, the informed risk taker.

Client as Informed Risk Taker

Far less common than the other client characterizations, but possibly one of the most significant, is the informed risk taker. Even though this perceived client positionality is less common, its implications on the counseling situation are important to analyze. As the title implies, the informed risk taker is someone who is knowledgeable about HIV but engages in high-risk activities regardless. This is distinct from the cavalier clients, who may also be engaging in high-risk activities but are perceived as more foolish and immature, or not entirely grasping the gravity of their actions. In reaction to a client who is perceived as an informed risk taker, there are two positionalities that counselors appear to enact: *pragmatist* and *pedant*. The pragmatist and pedant positionalities both follow tenets of harm-reduction theory, meaning they accept "the inevitability of unhealthy behavior positing an emphasis on reducing the harms associated with risky behavior rather than eliminating risky behavior" (Mattson, 2000, p. 335). While both subjectivities follow tenets of harm-reduction theory, they mobilize harm reduction in distinct ways. The pragmatist positionality is funded by the peer subjectivity. The pragmatist tries to discuss harm-reducing alternatives to the current behavior with the client, even if those alternatives fall far short from the tried-and-true methods like condom use and limiting partners. On the other hand, the pedant positionality is funded by the director positionality. When enacting the pedant positionality a counselor will rely on information dissemination as a last ditch effort for

these clients, allowing clients to do with it what they will. This seemingly functions as an implicit, perhaps even unconscious attempt to reassert counselor authority.

Pragmatist Positionality

Dan provided a detailed example of a client who fits the informed risk taker characterization:

> So I guess one of the most extreme examples of that was a client I had who came in and I was newer as a counselor, so it really, again, was testing my counseling skills. But he was like "I know what the risks are." We started talking about what was your prevention plan in the past. He was like "To come get tested, use condoms if I can." I was like "Okay, let's talk about that." He knew the window period, he knew the four fluids, he could just ramble it off like he was super educated on the topic. But the only thing that turned him on was basically being tied up and having completely anonymous sex in hotel rooms with no protection, and he has no idea who these people are. That's it. So at the end of the day, he was, whoever had told him to use condoms, I think it was like a last ditch, let's throw this in here kind of a thing. So at the end of the day, even though I didn't personally love it, and I didn't feel like I left the session feeling like I had succeeded, at least immediately. The conclusion we basically came to was, come back and get tested every three months. Just know your status because at the end of the day, he wasn't willing to use condoms, he wasn't willing to force the person to use lube. He thought, "Well, I guess I can bring some and put it next to him. If they use it, great, if not, it's up to them." So we at least talked about that option.

This is a prime example of a client who is perceived as an informed risk taker. The client quickly asserts his knowledge and demonstrates a resistance to change. Similar to the checkup client, clients characterized as knowing risk takers are perceived as being knowledgeable and resistant to redundant counseling. The major difference is that checkup clients are seen as precautious in getting tested and knowing risk takers are perceived as reckless.

By exploring alternative options with the client Dan already demonstrates qualities of the pragmatist positionality. He further explained how in situations like this

his CDC training is ineffective:

> Sex and go. He doesn't know what they look like. He's blindfolded, it's completely anonymous. That's where the session was just, like, this whole risk-reduction thing is, like, how do you even, that whole CDC training almost goes completely out the window and all I was left with was, take a bottle of lube, put it on the bedside next to you. If they use it, hope they use it, because that'll help reduce the risk. Other than that, come back every three months. That's what we ended with and he was totally fine with his level of risk at that point.

Sometimes getting testing is the only line of defense a client is willing to incorporate into their life. This does not reduce the risks that the client is engaging in, but it does potentially reduce the harm that the client may cause if s/he contracts the virus. The sooner the client knows his/her status, the sooner treatment can begin, which will help prevent further infections. The pragmatist positionality seems to be a permutation of the peer positionality and clearly links to harm-reduction theory.

Sarah sums up the perceived attitude of the knowing risk taker with this excerpt:

> Sometimes I have clients that are like "whatever, I don't like condoms. I'm going to have unprotected sex." “It's whatever.” "I'm going to have sex with whomever I want." I don't know, it's kind of difficult, but you kind of recognize that's not my role to kind of change them, it's just to have that first conversation.

Resistance in this case is recognized and Sarah acknowledges that it is not her duty as a counselor to necessarily combat that, invoking elements of the peer positionality with her pragmatist approach. By enacting the pragmatist positionality, Sarah is grateful to have a conversation as a first step with the client and tries to gauge where the client is.

Some clients engage in high-risk behaviors because that is what they enjoy, while others do it for survival. Diane shared a story about a young man who turned to sex work because he could not find a job:

> Well one that comes to mind was a male prostitute, young man couldn't find a job so that was his. So it was the way in which he earned money. I talked to him

> about it. He would go online and hook up with people. I talked to him about the risk factors, and he knew about the risk factors, and he understood. I just said, "Okay, as long as you understand. Here are these choices. Are you sure you can't find some other kind of job? Because, I said, besides sexually transmitted diseases, you don't know what these people are going to do to you, what kind of physical harm they may do to you. You're putting yourself at risk in a multitude of ways." I wished him well and said, "Stay safe out there."

Diane continues on and demonstrates how she enacted the pragmatist positionality in this situation:

> Basic philosophy for me is to listen to the person. It's not me to, like the prostitute, if he were a buddy of mine, I'd be saying "What are you doing?" I sort of said that, but I also let it go, it's his choice. It's really listening to the person and the choices the person wants to make. Sometimes helping that person realize there are more choices than something like "Well, maybe I'll just give up sex." We don't want you to give up sex, we just want you to be safe while you're having fun. "What are some other things you can try doing that will make it work?" that's one, to listen to the person. Two is to have outcomes that this person can really implement and feel comfortable with. We know this through our training, but we also notice through our experience, telling somebody who has clearly said, "I'm not going to use condoms." It makes no sense to say "Well try using condoms. Carry them with you." It's not going to happen. What are some other choices to reduce the risk? Help people understand there are ways for you to reduce the risk while still having enjoyable sex.

Central to the pragmatist positionality is discussing options and meeting the client where s/he is, providing advice that can work for the client. Counselors explain that attending to the client's proclivities, desires, and abilities, is crucial in order to give them guidance that is applicable.

During my interviews I asked all counselors about a training scenario wherein a female client was a prostitute who sometimes did not use condoms with clients, and many expressed a pragmatist approach to apprehend why she sometimes did not used them. Instead of insisting that she should always use condoms, the questions were about why she chose to sometimes not use them. "Do clients offer more money to go bare?"

“Does she not have access to condoms?” “Does she just not insist?” Keeping the “why” as the focus is indicative of the pragmatist positionality when counseling a client who is perceived as an informed risk taker.

When clients are being particularly resistant, Calvin explained that he tries to level with them, much like he would when enacting the peer subjectivity, in order to perform the pragmatist positionality:

> I usually point out that they're there for a reason. They're already in the office being counseled because they're worried about their status. So clearly their status isn't irrelevant to them because they're there being tested. So I just usually explain that and then I usually explain that I'm not judging them. What they do is not relevant to my wellbeing or what I'm doing with them at all. I explain that obviously if I was advising them to be safe, the real advice would be to be abstinent. I would say, "You and I both know that neither one of us is going to do that. So how safe are you willing to be? Are there things you're willing to change? I'm not telling you to wear condoms, or I'm not telling you to do anything specific. Here's a whole bunch of lesser things. Like even if you would just commit to get tested every year, just that is more than you're doing. You're here getting tested now, so it's something you're willing to do. Are you willing to come back every year and get tested? I mean, we can usually work something out.” But I feel like they leave, they may not do it, but I feel like by the time they leave, they're telling me the truth about what their plan is.

Once he connects with the client he is then able to begin discussing various alternatives that could potentially work for the client’s personal situation.

Jeremy provided another example of a prostitute who is characterized as an informed risk taker:

> I remember one person in particular, when I first started volunteering, he was a male prostitute and also in a different county, but he would come in and get tested, sometimes weekly, sometimes once a month. He had no sense of self-worth at all. He felt like whatever someone did to him or no matter how much he didn't want to do it, he felt like he deserved it or he felt like he didn't have the right to say "no" or to stand up for himself or protect himself or anything. I don’t know what ever happened to him. I'm assuming that he stopped being tested because he got the answer he was waiting for after a while. But I don't believe I've seen him since.

These examples bring forth another key characterization of the informed risk taker. Jeremy mentions that his client had “no sense of self-worth.” This notion seems to undergird many perceptions counselors have for the informed risk taker. This perceived lack of self-worth prompts counselors to enact some of the emotional labor associated with a distressed client but is distinct because the distress of the client is not seen as the hindrance to the counseling—the refusal to change is.

Further exemplifying the pragmatist positionality, Brock provided:

> You know, I'm actually okay with them being like "I don't want to change" because that's their lifestyle choice. I think we have clients who are not ready to be like "Use condoms or lube or always practice safe sex." I don't think that's realistic to be, like, tomorrow, this behavior modification. I think everyone knows when they're really ready and my goal is not to change their behavior and they're like "I really hate condoms, it makes me flaccid." I'm like "Okay, that's fine. That's fine." It's really more about what other options are there at that point for me. If you don't want to do this, here's this. If they don't want option B, hopefully I have an option C and if they don't want option C, usually I'm just really frank with them again and be like "Okay, I know you don't want to wear condoms or you don't want to do this. These are your risk factors, so you know you're at risk. You can do these things to reduce that risk factor." Really it's up to them at that point. I don't usually let it deter me. I've had clients come in who are drug users and be like "I’m still going to do drugs." I've had clients tell me "No, I'm still going to do this." I always say, "Okay, that's fine. That's your choice." I try not to let it throw me because my job is not to judge their lifestyle and their choices in that lifestyle. I feel like I've met a lot of high-functioning people who do things that are deemed by society not appropriate, but they seem to be okay for whatever that thirty minutes I see them. I feel like, yeah, that's their choice if they're not ready for it. You can't make someone get help or accept behaviors unless they really want it. That might not be the time. Maybe their third counseling session, at that point where they're like "Okay, I'm ready to kind of try this." So wherever I am in that timeline is irrelevant as long as they get there eventually, I feel like.

Clearly, Brock emphasizes the importance of laying out multiple options for the client. These options focus less on what will most effectively reduce risk, and instead, focus on what the client is most likely to actually incorporate in his/her life. This also

demonstrates how the pragmatist positionality is funded by the peer subjectivity, as it is nonjudgmental and respectful of individual choices and practices.

Chance discussed the tenets of harm-reduction therapy directly when he explained why he prefers it:

> My first year of social work, doing my MSW (Masters in Social Work), there's a lot of different modes of therapy where in most of them it kind of leans toward the therapist being in some sort of more of a power position. There's always going to be somewhat of that power position in a therapist/client role. But in harm reduction, I feel you sort of even the playing field a little bit where it's asking them what are things that will help you in a prevention plan, so I'm not just saying what - I have some expertise in training where I know some safer sex tools or different prevention ways. But it's about what works for them and so that is helpful to me where I'm going to be able to, whether it's people dealing with addiction or people, various situations that all meet in my future social work. Instead of saying it's about what works for them and kind of hearing a tailored plan for them.

Chance outlines several key qualities of the pragmatist positionality. He notes that it is about what works for the client. As opposed to offering prescriptive advice, he tailors and personalizes the conversation. Jon also discussed how he attempts to implement harm reduction within his counseling sessions:

> Yeah, that happens. It happens a fair amount whether they want to admit it or not. Sometimes people will not admit to risky activity. If I think they're maybe not being honest with me, I'll just say, "How do you feel about condoms? Do you really think you can use them? Because if you're not, then we're going to go down a different path into a harm-reduction path versus talking about condom use and things like that." If I still don't get any reaction out of them, I'll say, "Some people I counsel just simply refuse to use them. That's your choice. Let's talk about things you can do to mitigate or reduce that risk." Then I go down that path of harm reduction.

As Jon describes here, when a counselor enacts the pragmatist positionality s/he will work to personalize the session in particular ways. Jon follows the basic nonjudgmental tenets of the funding peer positionality and recognizes that some clients will refuse the

primary recommendations for safe sex. He further enacts the pragmatist positionality when he begins the conversation about alternatives.

Other counselors are attempting to enact this pragmatist positionality in more tangible ways. Needle exchange programs are a common example of harm reduction theory and, while they are illegal in the state, one counselor is trying to see what she can do to this end. Michelle shared:

> I know needle exchange is illegal here, but I am trying to see the legalities of me taking some of those funds, going downtown, buying a shitload of syringes at a pharmacy and leaving them there so that people can come in and say, "Can I get a syringe under [the AIDS Foundation]?" and they can take them. I'm trying to figure out ways I can get around it.

She concludes:

> Meth isn't going away, heroin isn't going to go away, sex isn't going to go away. Because of our lack of wanting to help or get involved, HIV will never go away. It could.

Michelle offers here that a pragmatist approach could be the answer to limiting, or even eliminating, the health concerns surrounding HIV. She believes that the actions are not going anywhere, so counselors should look to alternate ways of performing those actions. This is at the heart of harm reduction and the pragmatist positionality.

Pedant Positionality

The pedant positionality is the other major subjectivity counselors appear to enact in reaction to an informed risk taker. Also following tenets of harm reduction, a counselor enacting the pedant positionality will recognize that they may not be able to alter the risk behaviors. However, this is more accomplished through offering information instead of having a dialogue. Funded more so by the director positionality,

when counselors enact this subjectivity they tend to jockey for their authority, while recognizing that they may not be able to limit or reduce the client's risk. When clients are particularly resistant to counseling, Lindsey explained that she simply provides them with the information:

> But for the most part, I came to a point where I really would just let them own it and repeat back to them "Okay, what I'm hearing is you really don't want to change. You're okay with the decisions you are making and accept those consequences" and then just give them information. "Okay, here's the information I'm going to give you and then you can do whatever you want with it. If you decide you do want to change we're always here, if you need information or support, let me know." It was kind of like, I'll do what I can. But most of those clients when you told them that, to their face, like, I understand, this is what I'm hearing you say, and then just not push it. They almost came more forward. It was like a push and pull. If I would stop pushing and stop pulling they would—"Well wait a minute. I do actually want to do something." For the most part I just got to the point of "you know what? I have a handful of clients that will actually want to change their behavior and I get that you're not ready for that right now. Maybe one day that will change. In the meantime, here's the information, do with it what you will and come back if you change your mind."

Inundating the client with information is one reaction a counselor may have with a resistant client. Lindsey expresses a bit more of a patronizing tone but ultimately realizes that it would not be productive to necessarily "push" the client. Subsequently she finds that just providing information and allowing the client to consider it is the best course of action. Respectively, this pedantic reaction is a clear permutation of the director positionality, where the pragmatist has roots in the peer positionality. Nick also discussed how he will enact the pedant subjectivity when interacting with a knowing risk taker:

> That's always a tough one. I would, I don't know. I struggle with this because I never want to come off confrontational. Again, some of these clients are doing these higher-risk activities and don't seem to be open to any change. Sometimes it's also tough because you don't want to write it off and say because they're not going to hear you out, you're not going to give the information. I still try to give

> the information. I will try to find any area where, maybe, any crack in their armor where I can find a place to give them either a new type of prevention strategy, even if it's just a start or if the client ever refuses to work on them. They have lots of partners, they have higher risk activities, then what I'll try is small things like using extra lube or different strategies that might not seem like, “wear condoms one hundred percent of the time,” or “limit your partners.” I'll try to do strategies that are not as major for that client.

Gavin also appeared to enact the pedant positionality when he described his experiences with knowing risk takers:

> My experience is this is really a necessary part of the whole process of trying to educate people and help them make better decisions, or at least inform them and give them more ammunition for when they do make decisions. At least they know the potential risks that they're getting involved in. Whether or not they choose to minimize those is totally up to them.

When counselors enact the pedant positionality, they appear to offer a last-ditch effort in throwing information at the client in hopes for the best. This positionality follows harm reduction, insofar that the counselor recognizes and surrenders to the fact that some clients refuse to reduce their risks, but the counselor does not work collaboratively with the client to seek out alternatives. In actuality, it appears to reassert the authority of the counselor within the situation.

Informed risk takers provide a difficult scenario for counselors. They are aware of the risks and, for whatever reason, are not inclined to eliminate or lower that risk. Some counselors enact the pragmatist positionality and attempt to find something the client is willing to do, even if that is just coming to get tested on a regular basis. This positionality more loosely aligns with harm reduction theory, as harm reduction has roots in motivational interviewing and calls for a dialogue between the client and counselor in order to identify potential means to lower the harm associated with risk behaviors. The pragmatist positionality clearly stems from the peer positionality, as it is more focused on

an egalitarian exchange to discover alternatives. When counselors enact the pedant positionality, on the other hand, they follow harm reduction theory insofar as they acknowledge the inevitability of certain risk behaviors but resign themselves to providing information, allowing the client to do what they will with the knowledge. The pedant positionality has obvious roots in the director positionality, as it is much more focused on information. However, the positionality is quite distinct in the way that it recognizes the counselor's inability to effectively direct the actions of the client.

Conclusions

In summation, the perceived positionality of the client triggers a more nuanced performance on behalf of the counselor. These nuanced performances appear to reflect and refract the perception of the client as well as the preferred positionality of the counselor. When counseling perceivably naïve clients, counselors tend to enact a life coach positionality, which effectively merges both the director and peer subjectivities. When working with distressed clients, counselors facilitate the session through means of being reflexive, acting as a confidante, and rationalizing. These different facilitative tactics are reflective of the source of distress as well as the counselor's personal proclivities to the peer and director positionalities. When clients are seen as cavalier a much more paternalistic enactment of the director positionality is performed as disciplinarian. Counselors essentially act as administrators, a particularly depersonalized form of director or expert, when counseling more routine or check-up clients. Counselors turn to the tenets of harm-reduction theory when faced with a client who is an informed risk taker. Counselors enact the more peer-oriented pragmatist positionality, or the more

director-oriented pedant positionality in order to provide uncooperative but informed clients with whatever they can. All of these are important subjectivities that help illustrate the complex ways in which the counselor positionality can significantly alter from session to session. In the next chapter I will discuss the theoretical and practical implications of these findings.

CHAPTER FIVE

CONCLUSIONS AND DISCUSSION

Each analysis chapter has added a layer of nuance and complexity to the HIV prevention counseling interaction. Starting from the constructions of the client and counselor cultivated from the policy texts and physical space of the AIDS Foundation, to the more intricate counselor reactions to perceptions of clients, this situational analysis has served to complicate understandings of the counseling process and extend existing research on health counseling. Following a poststructural understanding, it is important to note that the positionalities identified are continually in flux and often intersect with one another. However, for the present study, I aimed to uncover various fractures of the counseling situation and how they are performativity mobilized. In this section I will first review the findings from the previous analysis chapters. I will then focus on the theoretical and practical implications of this dissertation. Finally I will discuss the limitations of this study and consider directions for future research.

Review of Findings

The first research question addressed in this dissertation was: "How do conventionally employed counseling protocols and policy in nonmedical HIV testing and

counseling sites position counselor and client identities?" After analyzing the relevant texts (training materials, protocols, counseling forms), I concluded that the counselor and client were constructed in clear ways. The counselor is positioned as an authority with agency within the counseling situation. Delineating from this basis there were two distinct positionalities that emerged. First, the counselor was commonly constructed as an *expert* in the counseling context. As such, the counselor is positioned as an authority with certain specialized knowledge and skill. For better or worse, this creates a clear power differential within the counseling situation and supports a "counselor knows best" mentality. On the other hand, the text also constructs a *mentor* positionality. While the mentor subjectivity is still rooted in an authoritative position, it seeks to diminish the power differential through more of an egalitarian collaboration with the client.

Conversely, clients are constructed as passive recipients of the counseling. Regardless of how active or passive a client may be in his/her risk behaviors, the client is broadly positioned as passive in the counseling context. Like other health policy texts, the policy and protocols analyzed tend to divide clients into deviant and dependent categorizations. Following historic understandings of HIV/AIDS, clients are constructed as deviants or more sympathetic dependents. Much of this is linked to a client's knowledge and agency with their risk behaviors. For instance, clients who knowingly put themselves at risk by participating in promiscuous and risky sexual activity, or injection drug use, or often both, are positioned as deviant. The deviant positionality is also seen as something that is animal, untamed, and in need of discipline. Clients who have been put at risk for reasons outside of their knowledge and control are positioned in the dependent category. Clients who were cheated on, sexually abused, unknowingly

sleeping with an injection drug user, or potentially exposed during a nonsexual or drug-related interaction are placed in this more sympathetic position. These clients are constructed as passive in both their risk behavior and within the counseling situation—depending on the counselor to come provide support and information.

Following the discussion of texts, Chapter Two also addressed how space functions to construct the counselor and client. Spatially, I set out to answer the following question: "How does the physical space of a counseling encounter construct counselor and client identities?" The physical space of the AIDS Foundation reaffirmed the constructions that emerged from the policy texts. The authoritative and active qualities of the counselor are further demonstrated as the counselor directs and guides the client throughout the space. Likewise, a client's passive position is also further established with this spatial interaction. Furthermore, the counselor has discretion in how s/he would like to perform counselor within the space. Whether that be through demonstrating an expert positionality, utilizing resources in the counseling rooms, or managing more of a mentor subjectivity by creating a sense of equity in the seating arrangement of the room. Clients are spatially constructed as tacitly deviant within the space. The general decay and seediness of the building that houses the AIDS Foundation provides the client with a setting suitable for a deviant. Moreover, the client is continually positioned as a problematic body within the space: a body to be poked and prodded, a body from which suspect specimens are extracted, a body in need of intervention. In juxtaposition with the counselor who is constructed as a cerebral and knowing authority, the focus on the client as a body further places the client in a primal, animalistic, and deviant position. Thus, the physical space of the AIDS Foundation

ultimately correlates with the findings from the textual analysis and adds further dimension to the subjectivities constructed by nonhuman elements in this situational analysis.

Chapter Three further analyzes these subjectivities by taking into account how counselors report their personal enactments of counseling in practice. The research question posed for this chapter was: “How are counselor identities/self-perceptions performatively operationalized within the counseling interaction?” Interestingly, I found that counselors take up the ascribed identities, or positionalities, that emerged in the analysis of the text and space, but enact them in ways that are distinct and related to personal motivations. There is a common disparity with policy-as-written versus policy-as-practiced (Kirby & Krone, 2002), and the findings of this chapter support this. Namely, this analysis demonstrates that ascribed identities are always taken up in ways that change them. The data for this dissertation demonstrate that counselors commonly take up an expert positionality with a professional inclination that brings forth what I call the *director* subjectivity. The director positionality maintains a similar distance between counselor and client, like the expert, but performs duties in more personal and concrete ways. Where the expert construction remains abstract, the director positionality introduces a human element to the counselor. Counselors not only "focus on the facts," but also pull on personal experiences as well as the experiences of the client to provide directive advice. Further, I found that the mentor positionality is performativity mobilized as what I call the *peer* subjectivity. The ascribed subjectivity of mentor intersects with a motivation for self-actualization in a manner that sets in motion the more affirming peer positionality. The peer positionality shares the egalitarian impulse of the

mentor construction but is taken up by counselors in ways that further prioritize validating the client. This chapter also features the first microperformance, with the hybrid *guru* positionality. The guru positionality shares qualities of both the director and peer as it focuses on guiding the client to self-actualization through validation and affirmation. Ultimately, the ways in which identities are performatively mobilized will differ from the textual constructions of those positionalities.

Chapter Four adds the dimension of how counselors perceive, and subsequently react to, clients. For this chapter, I set out to answer the following research question: “How do the prevention counselor’s perceptions of the client and his/her identity influence counseling?” Counselor perceptions of clients ranged from less to more knowledgeable and positivity correlated with a sense of deviance. Each perception was accompanied by particular reactions, or microperformances, from the counselor. These reactions were ultimately transmutations of the director and peer positionalities. Clients who were perceived as naïve were commonly met with the *life coach* positionality from the counselor. The life coach subjectivity effectively merges elements of both the director and peer positionalities in order to provide gentle and friendly, albeit directive, advice for the client. Clients who are perceived as distressed are commonly met with a *facilitator* positionality from the counselor. When a counselor enacts the facilitator positionality s/he works to unblock the client from some sort of emotional barrier to help the efficacy of the counseling process. This is rooted in the peer subjectivity and focuses much more on emotion than concrete information. Clients who are seen as routine, regular, or in for a check-up are commonly met with the *administrator* positionality from the counselor. The administrator subjectivity is rooted in the director and expert

positionality, as it remains almost solely information focused. When a counselor enacts the administrator positionality, s/he will expedite the counseling session in order to avoid redundant counseling. Clients who are perceived as cavalier are commonly met with a *disciplinarian* positionality from the counselor. When a counselor enacts the disciplinarian positionality, counselors will use scare tactics and other patronizing messages in order to get clients to change their behavior or attitude. This is also rooted in the director positionality and creates the most dramatic distance between the client and counselor. Finally, when a client is perceived as an informed risk taker, counselors will often react with various harm-reduction strategies. Following the director positionality, some counselors will take on a *pedant* positionality when interacting with an informed risk taker. When enacting the pedant positionality a counselor will inundate a client with information and allow the client to "do what they will" with the information. This is a harm-reduction tactic insofar that it does not demand a specific action that might be unreasonable for a client and allows the client to make the choice for him/herself. Following the peer subjectivity, some counselors enact the *pragmatist* positionality. When enacting the pragmatist positionality the counselor will attempt to collaborate with the client in order to uncover all potential possibilities for increased prevention or reduced harm.

From the naïve client to the informed risk taker, the client perceptions gradually shift from least to most knowledgeable about risk. Correlating with this knowledge is a perceived level of deviance. Clients who are seen as more knowledgeable and still participate in risky behaviors are, not surprisingly, seen as more deviant. This also seems to correspond to positionalities enacted by the counselor. The naïve and distressed

clients, which correlate with the dependent ascribed subjectivity, are met with the friendlier positionalities that have roots in the peer subjectivity. The more knowledgeable and perceivably deviant clients appear to elicit counselors to enact subjectivities embedded in the director positionality. Interestingly, this relationship appears to be inverted in the case of the informed risk taker. While some counselors may enact the pedant positionality, which is funded by the director, the pragmatist positionality is more in line with harm reduction theory. I will elaborate on this more in the next section, where I will discuss the theoretical contributions of this dissertation.

Theoretical Contributions

This section highlights the theoretical implications relevant to scholars. The contributions represent progress in research in communication, specifically as it relates to health and identity, and health counseling. First, the findings of this study provide greater depth and dimension to the health-counseling experience by bringing a poststructural lens to the event. Poststructuralism broadly functions to dismantle the impulse to see the world as comprised of concrete and essential parts. Instead, the poststructural view attempts to complicate our understandings by seeing the world as something that is in an ever-shifting state of negotiation. As such, I performed a situational analysis that accounted for multiple discursive elements of the prevention counseling context. This is particularly pertinent when conceptualizing identity, or the enactment thereof. Stemming from the poststructural perspective, a performance lens offered a productive means to this end. As mentioned in Chapter One, performance scholars do not view identity as something that someone *is*, but rather something

someone *does*. It is the doing and the desired material effects of that doing that this study aimed to apprehend. It is useful to examine the inevitable dynamism of the counselor and client interaction from a poststructural perspective—specifically as performance—because it sheds light on the interactive aspects of the counseling experience. Counselors provide a performance in flux for the client in order to provide what they believe to be effective counseling. Every subjectivity discussed in this study is not a concrete, or fixed, identity, they are all enactments that counselors can play with within the counseling context. Identity is an object of belief (Butler, 1990), and this study demonstrates that counselors use this object of belief within the counseling context.

The data analyzed in this study help illuminate the ways in which identities are ever-changing in reaction to our perceptions of another person. The ways that counselors discussed their general positionality was far different than the more nuanced and reactive reports they gave in reference to interacting with particular clients and situations. When speaking generally about their role, counselors invoked the director and peer subjectivities. While these are not mutually exclusive categories, each counselor expressed an affinity to one over the other and it was clearly linked to a sense of self-perception. "I am here to educate people and help them make better decisions," or "I like spreading sex-positivity, I want people to feel good about coming in and getting tested," are the kind of remarks that many counselors shared that illustrate how these subject positions get linked to personal identities.

Poststructural theorists conceptualize identity as constituted through multiple discourses (Foucault, 1969/2013). Obviously, there are a number of discursive formations at play in a HIV prevention counseling session. While I do not claim to have

comprehensively addressed all the formations involved within the counseling context, I followed the tenets of situational analysis to map out some of the major discursive fields at play. This is an important opportunity to extend and complicate the current health-counseling literature. Much of the research funding the health-counseling literature focuses on linear behavioral change models and often positions the counselor as depositing information to the client. The transtheoretical approach (Prochaska & DiClemente, 2005) remains a pillar of health counseling. The five-step process (precontemplation, contemplation, preparation, action, maintenance) offers a good foundation, and a sound persuasive strategy, but falls short of recognizing the complexity of the interaction that a poststructural perspective offers. The poststructural perspective is important to this end because it disrupts the self/other dichotomy and frames counseling as a relationship; this helps counselors with their self-awareness as they react and respond to clients. Additionally, the transtheoretical approach, when applied to health counseling, can easily fall into the trap of conceptualizing the counseling session as a linear form of information dissemination. The counselor essentially deposits information to the client in order to elicit some change in behavior. Motivational interviewing techniques (Miller & Rollnick, 2012) and client-centered counseling have shifted this paradigm by suggesting a more collaborative approach to counseling, but they do not take into account the poststructural relations within the discursive formations of the counseling context. A client-centered approach combats the positivist notion that good counseling results in safer behavior change on the part of the client. If the counselor is client-centered, he or she may deem the session successful based on whether or not the client’s needs or desires were met. However, a complex understanding of the

situation, one that a poststructural perspective can provide, allows counselors to better recognize their role in the session and serve the client in a reflexive and productive manner.

In this dissertation, I offer three levels of analysis, each adding a new discursive element to the prevention counseling interaction. Through a textual analysis of the training materials, protocols, and policy as well as a spatial analysis of the testing and counseling site I provide an understanding of how counselor and client identities are constructed even before the interaction occurs. Extending this, I accounted for the discourse of self-perception on behalf of the counselor. Finally, I analyzed perceptions of the client and the shifting identities of counselors in reaction to those perceptions. Each chapter provides another discursive layer to the HIV prevention-counseling context. Subsequently, each chapter provides insight as to how these discursive elements shift, mutate, or transform the positionality of the counselor. This is an important observation because it breaks binaries by highlighting the increased complexity of the situation, the deeper one looks. Subsequently, counselors and scholars can better apprehend the counseling situation. In expanding understandings of how positionalities are enacted and negotiated in the health counseling contexts, this research invites counselors to be more fluid and accommodating in their approach. As demonstrated in the data of this study, many counselors already act in fluid and flexible ways with their counseling. The present dissertation illustrates that this should be more encouraged, even within the rigid and confining structures of the current protocols and policies. More specifically, the research supports a more tailored and personalized approach to counseling. Additionally, as this study identifies various positionalities that are commonly enacted, further lines of

investigation could apprehend what positionalities are most productive and expand the best practices offered in the training materials for new counselors.

In addition to approaching counseling with flexibility, this study also provides a tool for counselors to be more self-aware and reflexive. Recognizing the performative qualities of the health counseling situation allows for counselors to gain a heightened understanding of the experience as a whole. Different performative acts, whether they are through text, space or interaction, manage to position subjects and elicit reaction. The role of performativity is plainly exemplified through the analysis chapters of this dissertation, but Chapter Four explicitly addresses the role of performative agency. The ways in which counselors shift their enactment of counselor is a performative response to the performance offered by the client. Various performative cues clue counselors into a particular perception that, in turn, elicits particular performances from the counselor. These performances are enacted in order to elicit certain performative responses from the client, whether that response is to move past an emotional barrier or scare a client into safer behaviors. This can be achieved through the performative act of confession, like when Michelle admits to clients that she is no stranger to casual sex or Jon shares with clients that he is HIV positive. These confessions leave the counselor vulnerable, and potentially shift the dynamic of the counseling session. Likewise, direct advice and education can also produce performative effects. For the counselor providing the education the desired outcome would be that the client takes up safer behaviors, but the client is ultimately an individual agent that will respond to that performance as s/he chooses, based on a lifetime of experiences. Ultimately, it is clear that the counseling process is a much more intricate interaction than top-down information dissemination.

Starting from the binary construction of expert and mentor, it is easy to see how various discursive frameworks pile on top of one another, creating a more complex and nuanced mobilization of performance of identity. This is crucial because it highlights the relationship involved in the counseling process. Performances of identity inform how people engage their health, because health cannot be separated from identity, which is a dynamic interaction, especially in a counseling context. As opposed to viewing the client and counselor in the health counseling process as two distinct, siloed entities, the present study offers a conceptualization of the complexity of the interaction involved. Behavioral change models and motivational interviewing techniques have their uses, but this poststructural perspective offers insight into the ways in which positionalites are performed in action. This insight makes a clear case for the interplay between client and counselor positionalities, which is significant to consider when entering a counseling session. Being self-aware and flexible can help a counselor truly provide a client-centered session. Furthermore, the positionalities identified go far beyond the constructions presented in the current health-counseling literature, such as the policy texts and training materials analyzed for this dissertation. This exemplifies the fact that the present policy texts and training materials for HIV prevention counseling fall short of what actually occurs in lived experiences.

This study also provides important insights about perceived performances of health and identity. Counselors described clients as presenting their health concerns in myriad ways. Some were described as naïve of their risks, some as distressed, some as nonchalant, some as cavalier, and some as well informed but reckless. There was a clear correlation that counselors tend to treat the less informed, and thus less deviant, clients in

more friendly ways, funded by the peer positionality, whereas the clients who demonstrate more knowledge, and therefore more deviance, appear to often be met with combative efforts on the part of the counselor in order to further educate or direct the client into action. As I established in the second chapter of this dissertation, the “deviant client” is conceived as being of the body, while the counselor is constructed as being of the mind. There appears to be an interesting impulse at play when a client displays that s/he is also of the mind in order to place him/her back into the body category. Cavalier clients and informed risk takers appear to provide the most frustration for counselors because they disrupt the conventional counseling dynamic and demonstrate a level of agency that is clearly outside of the counselor’s control. Of course, every client has agency out of the counselor’s control, but these clients make that explicit throughout the counseling. The disciplinarian and pedant positionalities function to reestablish the counselor as more knowledgeable, and thus reestablish the client as a deviant body in need of intervention.

It is also important to note that the existing literature on health counseling largely focuses on the client, while there is little to no research that theorizes on the counselor’s subjectivity. The transtheoretical approach, motivational interviewing, and risk and harm reduction theories, all of which inform much of prevention counseling, focus on client behaviors. The present study provides a novel contribution in addressing the role of counselor subjectivity within the health-counseling context. This is significant because counselors are much more likely to be reading this kind of research than the average client. Research that focuses on the counselors can allow for more awareness and reflexivity in practices.

Finally, this study provides a look at harm-reduction theory on the ground. Mattson (2000) conceptualized what a harm-reduction approach *could* look like in the HIV prevention counseling context; this study reveals what it *does*, or at least *can*, look like. Obviously, given the fluid and dynamic nature of identities per a poststructural perspective, there is no universal way that harm reduction plays out in health counseling, but the present study offers several glimpses into lived experiences of providing harm-reduction counseling. Harm reduction is something that is commonly discussed amongst counselors, but the data suggest that harm reduction is more nuanced than previously thought, and is accomplished through various positionalities, contingent upon equally varied perceptions of clients. Most notably the pedant and pragmatist positionalities utilize harm reduction theory. The pedant positionality gleans from harm reduction theory insofar as not all clients are willing or able to change their risk behaviors, and accordingly offers the client as much information as possible. This also preserves the counselor as the purveyor of this information and seemingly functions more to further establish the counselor's elevated or specialized role in the situation. The pragmatist positionality, on the other hand, better illustrates how counselors utilize harm-reduction strategies. Interestingly, this positionality requires the counselor to relinquish the impulse to discipline the client and reaffirm his/her own status in the session, and in many ways appeared to be one of the more difficult subjectivities to pull off. Collaborating with a client to ascertain where s/he is and what s/he is willing/able to do disrupts the counseling context, and can call for counselors to place themselves in vulnerable positions, it can also be time-consuming trying to understand where a client is coming from. Additionally, this research demonstrates that prevention counseling has

come a long way in the last fifteen years as topics around harm reduction are common and the general counseling process appears to be much more involved than what Mattson (2000) observed. This is important not only because it provides insight to the current state of prevention counseling, but it also offers additional levels of understanding. The present study exemplifies that there has been significant progress in the field of health-counseling practices, but also demonstrates that continued progression is possible and necessary. Next, I will address the practical takeaways of this study.

Practical Implications

For this dissertation I worked within the community, and as such it is important to me to provide more than just theoretical contributions but also offer practical applications. For this study there are three major practical contributions. First, the research expands the dualities of expert/mentor and deviant/dependent constructions offered in the policy texts and training materials. This situational analysis can potentially help complicate and improve the current training processes. For instance, the five common client characterizations that emerged from the data far exceed the constructions of the client provided in the current training materials and policy texts. As such, the role-play scenarios in the training manual should include at least one of each of the perceivable client positionalities identified. It is important to note that the various positionalities identified in this study are by no means a comprehensive list of identities but rather a perpetually expanding understanding of client and counselor enactments. This study does not aim to provide a comprehensive view of the counseling experience, but rather to make a blueprint of a complex and intricate interaction. These lists of

subjectivities attempt to make the growing complexity of identity sensible, and should not be seen as limiting or constraining.

Second, the present study promotes flexibility and rejects rigidity in counseling. This data can help counselors who may be in a rut or apprehensive about changing their counseling style. Plainly, shifting counselor positionalities appears to be common and prudent; awareness of this among counselors can help facilitate more adaptability. A significant contribution of a poststructural perspective is that it complicates, extends, and provides nuance to what it analyzes. In this case the more complex understanding of prevention counseling sheds light on the fact that counselors not only do, but should, exercise adaptability within the counseling context. Until the present study, there had yet to be any research focusing on the subjectivity of the counselor in health counseling, and this has some clear practical utility as it can broaden a counselor's perspective and approach.

Third, the present study provides a resource for counselors to be more aware and self-reflexive. The findings of this dissertation could be implemented in trainings in order to encourage counselors to be aware of their own motivations to counsel, as well as their own perceptions and assumptions of clients and the ways in which these potentially inform their approach to counseling. As counselors are more aware of the various components that affect the counseling scenario, including themselves, they can potentially be more accountable for their role in the interaction. This can lead to more mindful and ultimately more client-centered interactions. This is significant since much of the literature positions the counselor as simply the one to assess and help the client, which disregards how the counselor's subjectivity can play into the context.

Limitations

Every study has limitations. For this dissertation I have identified four potential constraints to the present research. First, I only researched one site for this study. Sites are a limitation in any case, because every site is located in a particular cultural, political, and economic context. In this particular case, for instance, this AIDS Foundation is located in a metro city in the Intermountain West that, while liberal, features a powerful, conservative religious influence. This could arguably impact the ways in which testing and counseling are practiced for this particular site. However, I did not aim to provide universal findings for this study. Instead I offer a rich investigation of this particular site and the identities at play between counselors and clients.

Second, and also related to the fact that this study only utilized one site, there was little diversity among the participants of this study. The counselors who volunteer at the AIDS Foundation largely identify as gay white men. This is partially reflective of the fact that the city where the data was collected has a largely white population. Also, as HIV/AIDS disproportionally affects the gay community, it is not surprising that many gay men would be apt to volunteer in this capacity. For the present study I interviewed 16 volunteers. Nine of the participants identify as gay white males. Three of the participants identify as straight white men. Three of the participants identify as straight white women, and one identified as a gay white female. There are some Hispanic and Asian counselors at the AIDS Foundation and their experiences are reflected in the field notes and participant observation components of my data. Because I did not seek specifically to examine race/ethnicity—or any other specific identity marker, for that matter—for this study I did not want to risk tokenizing any participants or data by

recruiting counselors of color more heavily than the others, and reached out to all counselors for interviews equally.

Third, since I functioned as an inside researcher for this project, I developed a closeness to my participants that can have potential advantages and detriments. It is possible that some participants may have omitted certain details during my interviews so as not to disrupt our personal relationship. Likewise, some participants may have been reluctant to completely share their counseling experiences because they recognize that I am also a counselor. This could be because they assume that I, as a counselor, have a certain level of understanding of the counseling process and therefore leave out important details. This could also be due to a self-policing impulse where a counselor might not want to admit some of his/her practices that might be outside of, or contrary to, the protocols and standard operating practices. On the other hand, it is also possible that my "insider status" helped facilitate more open and honest interviews between the participants and myself. Either way, the personal nature of my relationship with several of the counselors inevitably defined and potentially delimited the study in particular ways

Fourth, it is important to recognize the potential of my own personal bias in this research. Much as participants may have potentially treated me differently as an interviewer, there is also potential that I may have treated the participants differently due to my relationships with them. As discussed in the methodology section in Chapter One, I took several precautions to assuage this potential issue. I adhered to rigorous coding processes in order to analyze the data in the most unattached manner possible. Additionally, I conducted a group theoretical interview to allow participants to provide opinions about the research and voice any concerns about their representation. Beyond

my relationship with the participants, it is also significant to note my personal connection with the cause and the organization. HIV/AIDS is a health concern that disproportionately affects my community and therefore resonates with me. Thus, it could be inferred that I am too close to my subject to be objective. As I mentioned in Chapter One, I reject the idea that any research is truly objective, and I attempt to account and correct for my own personal bias throughout my work by being continually self-reflexive.

When I started this project I became a state-certified prevention counselor. As such, I have certain ideas about counseling and what practices work best. However, I argue the focus of this study probably corrects for any of that potential bias since this research is not assessing the efficacy of counseling processes but, instead, looks at the ways in which counselors perceive and respond to clients. After volunteering for over two years, I recently accepted a paid position with the AIDS Foundation as their HIV Prevention Coordinator. This could be seen as a conflict of interest, but again, the aim of this dissertation is not to assess the effectiveness of the AIDS Foundation. The present study takes an in-depth look at the experiences of counselors in order to make sense of the ways in which enactments of self develop and interact within the counseling context. This is regardless of whether I think someone is an effective counselor or if I think the AIDS Foundation is an exceptional organization.

In terms of bias it is important to recognize that I do carry my own assumptions and opinions as a counselor. First, I started this research with the assumption that how we understand and do health counseling, in general, could be better. I also navigated my preferences and style of counseling through this research. I did not have a specific agenda about particular practices or positionalities with this research, but I certainly

related to, and rejected, particular approaches. I have tried to allow my work with this dissertation to improve my counseling as opposed to remaining stagnant or indignant in my approach. Ultimately, it is impossible to ensure total objectivity, but I have tried to be as self-reflexive and thoughtful about my own commitments and investments as possible.

Future Lines of Research

As is the case with most research, concluding this study left me considering further lines of inquiry and alternative directions. I identify four major future lines of research that will progress the theoretical and practical work produced in this dissertation. First, this work needs to be extended among multiple sites. Interviewing other counselors at other nonmedical testing facilities across the country could help validate the findings of this study and potentially uncover more nuance to the subjectivities of the counselors and clients. As I previously mentioned, the sample for this study was entirely white. More diversity in regards to race and ethnicity could yield some different results. African American and Hispanic communities in the United States are disproportionately affected by HIV (CDC, 2015), and this should be given particular attention. Expanding this research to multiple sites could help fulfill this lack of racial diversity in the present study. Race and ethnicity of both counselors and clients are relevant in all contexts, and especially meaningful in relation to/for communities of color, given the disproportionate impact if HIV/AIDS for those communities. Additionally, other identity markers, such as gender and class, could be fruitful for future directions as well. Such studies could help provide even more tailored and effective counseling as it will continue to add to a

nuanced understanding of the situation.

Second, interviewing clients and accounting for their perspectives could further complicate this research. While there have been plenty of studies that account for client experiences with the testing and counseling process (Rintamaki et al., 2007; Weinhardt et al., 1999), none have focused on the interaction between client and counselor in regards to enacted identities. Adding the client perspective could provide another dimension that will likely further complicate the models developed in this study. Again, the more research can expand understandings of the situation and the discursive formation therein, the better equipped counselors could be to engage in this work.

Third, adding multiple researchers to a larger study could help account for some of the potential issues with personal bias and closeness with participants. Additional researchers could fulfill both insider and outsider roles in order to glean different levels of information. By having a larger research team with varying levels of commitment, multiple researchers are more likely to balance out and account for potential biases on the part of individuals. Also, a larger research team could have divided foci; some researchers could focus on issues like identity markers and others could focus on something like linguistic cues. This could significantly expand knowledge on this topic.

Fourth, this study did not attempt to gauge the effectiveness of the counselor positionalities identified. Future research could measure the effectiveness of the different approaches in order to comprehend best practices for counselors. This could be achieved through surveying clients or creating a rubric of efficacy that counseling could be measured against. With a poststructural perspective, effectiveness is not always clear cut or easy to define, but further research could work toward this end. With that, multiple

rubrics could be used to identify various aspects of effectiveness, and these could be synthesized with particular client enactments. For instance, efficaciousness in addressing emotional needs would likely be more effective when counseling a distressed client, whereas efficaciousness in providing information would likely be more effective with naïve clients. As such, various rubrics of effectiveness could be mapped along the various and multiplying client positionalities that counselors encounter.

Summary

Research on health counseling has largely focused on behavioral change in the client. While this is clearly an important factor to the counseling process, this study provides a significant contribution in focusing on the role of the counselor's personal subjectivity in a counseling context. A poststructural perspective illuminates a number of discursive formations at play in constructing perspectives of the client and performing an appropriate positionality in response. This is significant because it allows for more awareness on the part of the counselor, both of him/herself and of the situation in general. This research can potentially encourage counselors to be more flexible and reflexive in their approach, which could make for more effective and client-centered sessions. Ultimately, the HIV prevention counseling context is a complex interaction and warrants commensurately complex theoretical and practical assessment.

APPENDIX A

EXAMPLES OF INTERVIEW PROBES

- *Why do you volunteer as a counselor?*
- *How did you start counseling?*
- *Tell me about some memorable counseling experiences.*
- *Good/Positive/Rewarding*
- *Bad/Negative/Stressful/Challenging*
- *Tell me about your training experience?*
- *Who generally comes in for testing?*
- *Do you have preferences about what kind of clients you like to counsel and why?*
- *How do your counseling sessions differ from client to client?*
- *How do you personally judge how to speak to/with a client?*
- *How do you handle clients who do not seem willing to change certain behaviors?*
- *What are your thoughts about the protocols and standard operating procedures provided by the CDC?*
- *What is your counseling philosophy? What is your main objective when you enter a counseling situation?*
- *What tips do you like to give new counselors?*

APPENDIX B

EXAMPLES OF SITUATIONAL ANALYSIS MAPS

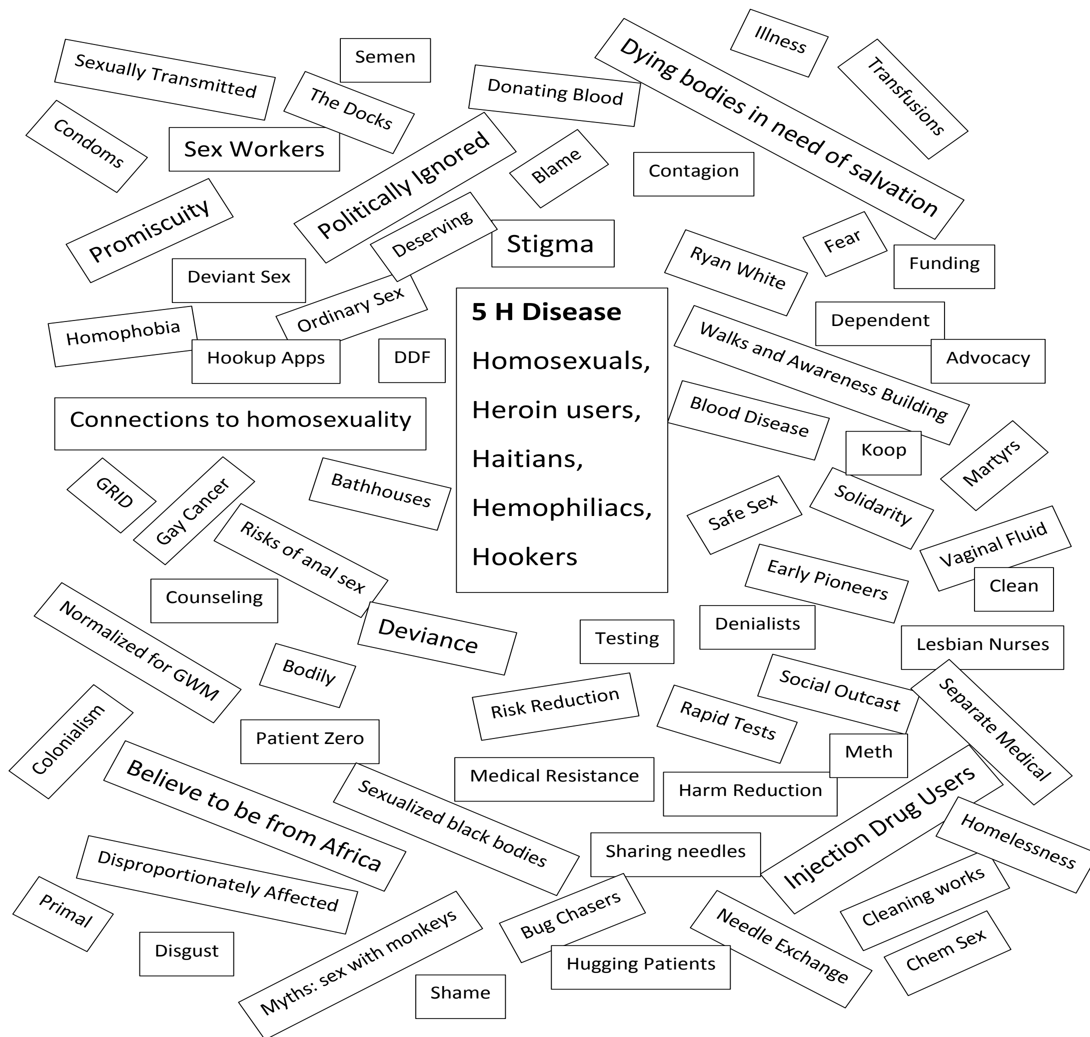

Figure 1: Messy Map: Historical Implications of HIV Prevention Counseling

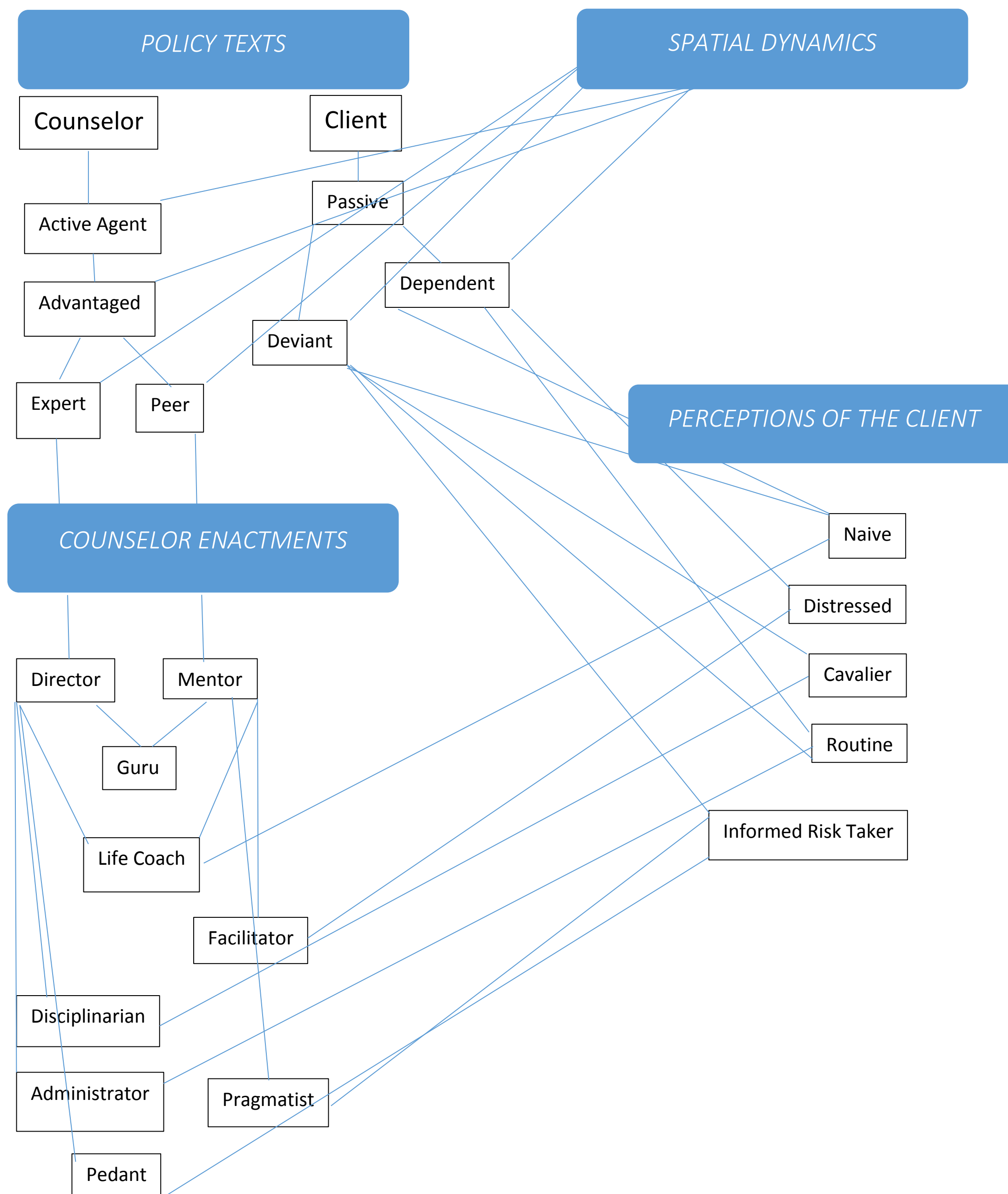

Figure 2: Narrative Map: Constructions, Perceptions, and Enactments of Counseling

APPENDIX C

EMERGENT COUNSELOR SUBJECTIVITIES

	Enacted Counselor Subjectivity		
	Director	**Guru**	**Peer**
Aim	Prevention Counseling Providing information and education	Self-Actualization of Client Guidance and validation	Open and Honest Communication Establishing a comfortable environment
Primacy	What the client ***should do***	How the client ***should be***	How the client ***feels***
Funding Positionality	Expert Professional Motivations	Hybrid of Director and Peer	Mentor Self-Actualization Motivations
Enacted	Education, evaluative, prescriptive advice	Encourages client to move forward with positive lifestyle choices and habits	Fosters nonjudgmental environment, affirms clients feelings
Dynamic	Traditional counselor oriented dynamic	Bridges the distance of the relationship while remaining directive	Bridges the distance to a more intimate relationship

APPENDIX D

DYNAMIC INTERACTION BETWEEN PERCEPTION AND APPROACH

Perception of Client	**Counseling Approach**	**Counselor Positionality**
Naïve	Informative but not patronizing Funded by Director and Peer	Life Coach
Distressed	Reflexive Confidante Rationalizing Funded by Peer and/or Director	Facilitator
Cavalier	Paternalistic messages Scare tactics and threats Funded by Director	Disciplinarian
Routine	Depersonalized information gathering Funded by Director, even reverts to Expert	Administrator
Informed Risk Taker	Centered on client motivation Search for alternatives Funded by Peer	Pragmatist
	Inundate with information Re-assert expertise Funded by Director	Pedant

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