When counselors interview clients during the risk assessment session, clients often respond with statements of remorse, "confessions" about past risky behavior. This confessional dynamic can alter the relationship between counselor and client, potentially leading to ambiguity in communication and blurred boundaries in the counseling relationship.

Based on a study of audio transcripts from 30 anonymous test counseling sessions, this issue of the FOCUS Supplement explores confessional interactions and presents ways counselors can respond most effectively to confessional dynamics when they occur.

The Confessional Dynamic

According the Michel Foucault, the urge to confess transgressions to those authorized by society to grant a "clean slate" has been a defining feature of Western civilization. The best known form of this practice occurs in religious settings, for instance in the Catholic Church, when a person confesses sins to a priest who offers absolution. Like the reassurance people get from a seronegative test result, sacramental confession offers "sinners" a slate that may be wiped clean again and again. Both are private, one-on-one discussions that focus on, among other things, the sanctity of relationships and specific sexual practices. In a religious context, sexual behaviors are interpreted by the priest in terms of venial and mortal sins, while the HIV counselor views this information in terms of safer and risky behaviors.

A confessional dynamic can occur in test counseling sessions for several reasons. Test counseling can involve a discussion of behaviors that people consider "right" or "wrong" with respect to HIV-related risk. The process of recording a "moral inventory" on an "official" form can deepen the confessional dynamic and intensify feelings of vulnerability, anxiety, and guilt.

Because in U.S. society, public opinion functions as an arbiter, condemning or forgiving wrongdoers, individuals may expect judgment from their "confessors" in the test counseling venue. One client, interviewed after counseling and testing, described her experience of the counselor in these words: "I expected him to go on and on and ask me what risks I had taken and tell me at length how wrong those things are, and how I shouldn't be doing those things." Expectations of admonishment often evolve from projections of a client's own anxieties and self-judgment onto the counselor. Clients may unwittingly place counselors in the role of confessor.

The confessional dynamic, which involves a client's self-judgment, can make the counselor hesitant to explore the client's issues, resulting in a superficial test counseling session. By confessing, a client is saying in effect, "I know better, it won't happen again, so don't lecture me!" Counselors find themselves in the role of admonishing parent rather than empathic confidant. If the counselor asks additional questions about a risky incident, he or she risks being seen as overbearing.

As a result, counselors often preface questions about risks with phrases such as, "The state wants to know," or, "We ask this of every client," so as not to seem to be singling out clients. To avoid appearing judgmental, counselors often depersonalize advice by presenting it as standard information, for instance saying, "We recommend that clients..." While this strategy helps counselors provide information and advice, it does not serve as effective client-centered counseling, because
Seiten-denigrating statements can set up a confessional dynamic that requires the counselor to absolve the client of wrongdoing.

These sessions were recorded with the consent of clients. For detailed transcripts of these sessions, go to the "test sessions" index on the "counselor resources" page of the web site: www.managingdesire.org. The site also includes a useful list of open-ended questions for HIV test counseling.

too often, clients receive little new insight into their particular situations.

When counselors initially ask why clients are seeking HIV testing, it is not uncommon for clients to respond that "I've been a bad boy," "I was stupid," or "I've done some crazy things." These statements can set up a confessional dynamic that requires the counselor to absolve the client of wrongdoing. It may also make it difficult for the counselor to follow such statements with a productive discussion of risk behaviors.

The following two cases illustrate how risk assessment questions can create a confessional dynamic. Each case is structured around a client's confession of feeling "stupid" as a result of previous behaviors, and on counselor responds differently. In the first session, the counselor continues to probe without absolving the client, leaving the client feeling alienated. In the second session, the counselor absolves the client for his lapse but, in order to re-establish a cooperative dialogue, must forego any further exploration. While these examples are extreme ones, they illustrate a dynamic that is present to some degree in nearly all risk assessment sessions.

Session One: Absolution versus Denial

A 20-year-old, heterosexual woman is testing because she has heard a rumor that one of her previous partners has AIDS. The session has proceeded smoothly until midway when the counselor asks if the client engages in receptive anal sex. The client responds:

Client: Uh – – I've done that a couple times – – like three times and I don't think we ever used anything.

Counselor: Okay. In the last year?

Client: Yeah.

Noticing that the client has suddenly placed her hand over her stomach, an indication that the last question may have made her feel uncomfortable, the counselor asks, "Are you okay?"

Client: Mm hm.

Counselor: 'Cause you grabbed your stomach.

Client: I'm just thinking.

Counselor: What about?

Client: Well – – you go back over all the things that you've done – – and – – I don't really feel ashamed – – I just feel kind of stupid.

Counselor: Why stupid?

Client: Because – – to get something like that from somebody – – or to give it to someone – – is kind of heavy.

Counselor: What would that mean to you?

Client: I'm more concerned about whether or not I could have ever given it to anyone.

Counselor: Mm hm.

Client: And it's like murder.

Counselor: Why?

Client: You're not pulling a trigger, but it -- you've given what's going to kill them.

By emphasizing her possible guilt through exaggerated analogies, the client can reasonably expect sympathy from the counselor. Instead, the counselor continues to probe about her feelings. A fundamental rule of everyday conversation is that a person should never agree with another person's negative self-assessments. For example, when someone confesses, "I feel so stupid," the socially preferred response is to absolve them by saying, "No, you're not," or, "It's not your fault."

Because the counselor does not immediately disagree with the client's assessment that she is "stupid" and may be guilty of "murder," the client may interpret the counselor's silence as agreement. The counselor sticks to the role of interrogator so as not to enable the client's denial. But, the counselor's silence on the issue of the client's guilt leads her to continue emphasizing remorse in the apparent hope the counselor will grant her some absolution, which does not occur. As a result, the interaction becomes strained, and, for the remainder of the session, the client responds evasively and asks few questions.

Session Two: Exonerating the Client

The rule of everyday conversation that confessions should result in forgiveness—broken by the counselor in the Session One—is demonstrated in this case of a counselor who responds by exonerating the client. The client is a 24-year-old heterosexual man testing because of an incident of unprotected vaginal sex a month earlier. When the counselor asks about the role of alcohol in the client's lapse into unprotected sex, the client responds guardedly that he drinks "sometimes."

The client initially responds defensively, but, once the counselor justifies his question by stating that it is part of the "official" risk assessment, the client admits drinking had been a "big factor"
in his lapse. To explore risk factors other than alcohol, the counselor then proposes several possible face-saving accounts for the client's lapse—that there were no condoms around or that the client may have felt pressured by his partner to engage in unprotected sex. The client admits that there were no condoms present and that he felt uncomfortable raising the subject of condoms with his partner.

The client’s admission of feeling uncomfortable sheds doubt on his implied assertion that he would have used a condom had one been available, and offers the counselor an opening to explore the source of the client's discomfort in negotiating with sexual partners. The counselor's technique is similar to the “good cop” approach often used by police in interrogations. By minimizing a suspect's role in a crime, an interrogator makes it more acceptable for the suspect to admit to committing the crime.

Responding to this admission, the counselor abruptly switches from good cop to bad cop. He questions the client for not using a condom, and without any real evidence, generalizes the client's feelings of discomfort: he states, in a scolding manner, that the client now must deal with the uncomfortable prospect of waiting to test until after the window period of infection.

Put on the spot, the client responds by admitting, “That was real stupid of me to do. I usually don’t, but – –.” This confession of “stupidity” leads the counselor to shift abruptly back to being the good cop. He attempts to repair the dialogue by stressing, “No. It's not stupid. . . . It's human. Okay. It just – – it happens. I wouldn’t say it's stupid – – I mean I just know what I've done in my life. And I think counselors are among the bigger offenders in that sort of stuff.”

The client's confession has reversed the power dynamic and prompted the counselor to confess his own lapses in order to restore the dialogue. The client's self-deprecating statement places the counselor on the defensive and effectively blocks any further insight into the unprotected incident. This is also illustrated by the fact that, although the client stated earlier he felt “uncomfortable bringing up condoms,” the counselor merely absolves him, giving him a “penance” without confronting in a productive way the client's problem with using condoms. The counselor states, “Next time you do that, keep a couple condoms in your pocket. I mean obviously – – from what I'm hearing – – you're comfortable with condoms.” The client then agrees, “Oh yes.”

What can the counselor do in such situations to respond and re-engage in a constructive dialogue? The first thing is to understand that the counselor is not responsible for the confessional dynamic. Confessions are not an indication of bad counseling. The confessional dynamic arises more from the unequal power relationship inherent in the risk assessment process than from the personalities of the client or the counselor.

One approach is to gently confront a client's statements of guilt or remorse by pointing out the confessional roles that these engender. For example, when a client says, “I was stupid,” or, “I should really know better,” a counselor might respond:

Counselor: Let's stop for a second. Why do you think it's stupid?
Client: Because I knew better.
Counselor: Well that's not stupidity. Stupidity is about ignorance. You're totally informed. You've demonstrated that by coming here today. If it's not stupidity, what might be going on?

Counselors should be alert that clients may make confessional statements as a way to preempt further discussion. A client may do this, for instance, by making a statement such as: “I'm never going to have sex again!” The counselor can ask the client how realistic he or she thinks this is and under what circumstances he or she might someday decide differently.

Confessional dynamics can influence a client's reasons for seeking a test and keep him or her in denial about underlying issues. For this reason, it is especially

References

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important to help clients explore the meaning of the test in the context of their lives and relationships. Return at various times in the counseling session to the subject of why a client is seeking a test. Often, counselors ask this question only at the beginning of the session, before rapport develops. As a result, clients tend to give non-committal answers, such as, "I just want to know," or, "I'm testing because it's been a while since my last test."

Because questions on risk assessment forms focus primarily on risks of exposure, clients sometimes answer that risk is their primary reason for testing, assuming that this is the "right" answer. Risk of exposure, however, may play only a minor role in motivating some clients to test. Issues of intimacy or new developments in a relationship, for instance, often play larger roles in the decision to test, but these elements are far more difficult to articulatate in the session. To help clients articulate unconscious motivations for testing, validate the fact that there are many reasons people might seek testing and counseling services and that risk may represent only one element.

### Responding to Repeat Testing

Clients often use the existence of the six-month infection window period as a justification for routine testing. A client’s doubts about his or her infection status often stem more from the passage of time since a previous test than a concern over a specific incident. Such patterns of routine testing are usually symptomatic of unresolved issues for which testing can offer only temporary reassurance.

Like recidivist sinners compelled to attend regular confession, some clients test with consistent frequency but continue taking risks. Unable or unwilling to change risk behaviors, clients may unconsciously view regular testing itself as a form of prevention. Determine whether this is the situation for the client by asking if he or she plans to test again. When a client says he or she plans to test every six months, respond by saying, "Okay, but remember, it's what you do between tests that protects you from getting infected, not the test itself." Ask why the client needs a clean slate every six months. Point out that "the test might help to reassure you, but unless you try to look at where your anxiety comes from, for instance, a particular relationship, you'll probably test again with the same doubts about your status."

When clients feel little control over their risk behaviors, they may use routine testing as a way to avoid the challenge of consistently practicing safer sex. Clients often feel particularly vulnerable during the risk assessment because they can no longer undo the lapses that they have disclosed. To build a sense of self-efficacy among clients, validate the steps, such as getting tested, that a client has already taken to protect him or herself. Focus on future steps the client can take to protect him or herself. In this discussion, explore the meaning of testing in each client's relationships.

For some clients, repeat testing can serve as a ritual of purification to deal with self-blame for “giving in” to unprotected sex, punishment for not maintaining boundaries with an abusive partner, or unresolved guilt over sex outside a primarily relationship. To help clients recognize the influence of these other issues, counselors can point out the confessional tone of the narrative. Respond, for example, by saying, “From what you just said it sounds like you're really beating yourself up about this. Do you think punishing yourself is really going to help?”

### Conclusion

A client’s motivations for seeking HIV testing can be complex and difficult to articulate. The strategies presented here can help clients explore in greater depth their motives for testing and how these motives affect decisions about risk, and help counselors recognize and confront the confessional dynamic before it pre-empts meaningful discussion within the counseling session.

### Call for Submissions

The **FOCUS Supplement on HIV Antibody Test Counseling** encourages HIV test counselors to submit proposals for articles. Among the topics that would be appropriate for Supplement articles are: counseling methods, current issues in HIV test counseling, and day-to-day counseling challenges.

Proposals should include a summary of the idea and an outline of the article. Please send to:

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