Advice can be highly problematic interactionally, especially in pretest counseling sessions for HIV and AIDS where the advice concerns the already highly charged topic of sexual behavior. However, there is surprisingly little research examining the delivery and receipt of advice. Using detailed transcripts obtained during twenty-five pretest counseling sessions in a clinic that tests for HIV, this study examines the various ways that counselors deliver advice to clients and the ways that clients respond to that advice. Analysis concerns structures of advice giving that are collaboratively produced to maintain an ambiguity between the giving of advice and the giving of information. Implications of these findings both for counseling and for ethnography and conversation analysis are discussed.

THE DELIVERY AND RECEIPT
OF SAFER SEX ADVICE IN PRETEST
COUNSELING SESSIONS FOR HIV AND AIDS

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THE DELIVERY AND RECEIPTION of advice is integral to a wide range of settings—from the visits of home health visitors to new mothers (Heritage and Sefi 1992), to doctor-patient interaction (Costello 1990), to clinics that test for the human immunodeficiency virus (HIV) (Perakyla and Silverman 1991; Silverman 1994; Silverman et al. 1992; Silverman and Perakyla 1990; Silverman, Perakyla, and Bor 1992). Previous research indicates that advice giving in service encounters can be highly problematic; advice givers and recipients can become bound in inextricable asynchronies and paradoxes (Jefferson and Lee 1981; Heritage and Sefi 1992). Given such difficulties, it is surprising how little research there is on the interactional delivery and reception of advice, especially in a historical context

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where counseling individuals to prevent HIV disease and AIDS is of paramount concern.

Our purpose is to investigate how counselors in a clinic for HIV antibody testing give advice to clients. Our primary analytic framework is conversation analysis, supplemented by ethnography. Recent discussions of ethnography and the analysis of discourse in institutional settings have suggested different ways in which these enterprises can be balanced. In an introduction to a special issue of *Journal of Contemporary Ethnography* on this topic, Spencer (1994) proposes that ethnography and investigations of discourse are mutually relevant in field research. Accordingly, Miller (1994) argues for a complementarity between ethnomethodology, conversation analysis, and Foucauldian discourse analysis; and Nelson (1994) reviews issues surrounding the use of “transcription extrinsic information” in doing conversation analysis. All of these discussions reflect what Silverman (1993, 115) has suggested to be an increased recognition of the “linguistic character of field data,” the raw material of interaction in many social settings being participants’ spoken and/or written words. While our intent is not to address methodological issues raised in these and other such dialogues concerning the study of language use in field settings, we want to observe that our research follows Maynard’s (1984, 1989) approach to ethnography and conversation analysis. The first-order emphasis is not on how participants “see” or experience their world but on the question, “How do participants do things with their words?” While we believe that how members see and experience the world is an important topic, we assume that it is most effectively addressed through exploring recorded, real-time conduct, whereas interviewing or observational note-taking tends toward rendering or accounting for behavior instead of presenting that behavior itself (Maynard 1989). Hence, in our research, ethnographic information is used to help characterize the setting where conversational data was recorded and to explicate patterns of language use and social interaction that we analyze in this data.

The setting for this study was a clinic located in a large, midwestern city that provides anonymous tests for HIV and other sexually transmitted diseases. The second author recorded pretest counseling sessions as part of a larger field and conversation analytic study on posttest informing interviews. At this clinic, counselors took a “carrot and stick” approach (as one counselor characterized it) to the clients who availed themselves of the clinic’s services. The carrot that induced people into the clinic was the test and the results that would tell clients whether they were or were not infection free, as best the test could indicate. Counselors regarded the stick as being their own elicitation of discussion—before drawing blood to be sent for laboratory examination—about the client’s sexual practices and possibly risky behaviors. During this discussion, counselors would explain the blood tests, the means of the virus’ transmission, and issues in regard to “safer” sex. They also assessed the client’s ability to deal with a positive result emotionally and psychologically. Our analysis deals with the topic of safer sex; as we collected recordings of the pretest sessions, and transcribed them, it became very apparent that counselors spent a great deal of time giving advice and making safer sex recommendations during the interaction. In Jefferson and Lee’s (1981) terms, the counselors constructed the situation as a “service encounter” in which they seemed to assume the relevance of giving advice. From early in our investigation, it also was evident that clients were largely unenthusiastic about receiving advice and recommendations. Hence we decided to investigate the sequences of advice giving in depth to ascertain just what was going on. This article reports what we found.

**PREVIOUS LITERATURE AND RESEARCH**

Literature on pretest counseling (Wisconsin Department of Health 1986; Matuszak et al. 1987; Morgen 1987; McCreanor 1989; *The AIDS Antibody Blood Test* 1988; World Health Organization 1990; Nokes 1991) agrees as to what content constitutes good pretest counseling. The session should include information on what a positive or negative result means, what the test actually does, the accuracy of the test, and the time
period for seroconversion or development of antibodies to the virus; techniques for reducing the risk of exposure to HIV; a discussion of a patient's support networks; and the means for clients who are HIV positive to notify and refer their sexual or needle-sharing partners.

Writers treat the issue of "how" to give advice more loosely than issues of content. This is especially true for the discussion of safer sex techniques, which is a "delicate area" that requires "sensitive handling to overcome embarrassment" (McCreaner 1989, 27). Generally, according to the World Health Organization (1990), prevention messages should be made personally relevant in order to promote a feeling of trust and understanding. "Explicit words and descriptions should be used, but not to the point that the client is too embarrassed to identify with that behavior" (Nokes 1971, 74). Being explicit will establish a level of trust between counselor and client (McKusick 1990). Also, the counselor must project a sensitivity toward the patient's sociocultural group and be frank and nonjudgmental (Morgen 1987; McKusick 1990). Finally, the counselor should use language that is appropriate to the patient or client's group (Kelley 1990). In these ways, counselors can encourage clients to modify their behavior in order to reduce their risk of exposure (Kelley 1990), and they can confront individuals with the responsibility of not infecting others (Kaplan, Sager, and Schiavi 1985; McKusick 1990). However, the literature is vague and nonspecific regarding exactly how counselors are to accomplish sensitivity, frankness, nonjudgment, and appropriate language use.

In addition to being vague about exact advising techniques, the literature does not address the issue of response. Even if advice is given properly, it may be rejected for a variety of reasons, such as embarrassment or, as Bauman and Siegel (1987) observed, a tendency to underestimate one's risk of contracting HIV. How can counselors give advice that has a greater likelihood of being accepted by the client rather than rejected? Previous literature, with its normative approach about content and its generalizing character, does not provide an answer to this question.

A handful of conversation-based studies have dealt with the actual structure of giving and receiving advice and how it is accomplished as a collaborative production of the participants. This research, by analyzing devices for delivering advice, is more specific about the "how." It also permits examining, if not "acceptance" and "rejection" per se, the patterned ways in which recipients respond to advice (Costello 1990; Heritage and Sefi 1992; Perakyla and Silverman 1991; Silverman 1994; Silverman et al. 1992; Silverman and Perakyla 1990). Prominent among these studies is Heritage and Sefi's (1992) analysis of the delivery and receipt of advice in interactions between home health visitors and first time mothers in Britain. Characteristically, health visitors initiate a majority of advice episodes, and mothers rarely ask for advice. When they do, they use either direct or indirect forms. Direct requests for advice initiate simple question-answer sequences. Often, the mother "manages" these direct requests to display her knowledge and competence and "thus circumscribe the scope of the advice requested" (Heritage and Sefi 1992, 370). Indirect requests for advice take the form of mothers describing an "untoward state of affairs" in such a way as to show that advice might be relevant (Heritage and Sefi 1992, 373).

When mothers did not ask for advice, Heritage and Sefi (1992) found a stepwise entry whereby health visitors (HV) could collaboratively construct with the mother (M) a "problem requiring advice." The full stepwise entry consists of five components:

1. HV: Initial inquiry
2. M: Problem indicative response
3. HV: Focusing inquiry into the problem
4. M: Responsive detailing
5. HV: Advice giving

The stepwise approach has several significant features, according to Heritage and Sefi (1992, 380-1). First, it allows for a potential problem and the means for dealing with that problem to "emerge as a joint construction of the participants." Second,
this entry allows the health visitor to give advice that is sensitive to the mother’s account and supports and reinforces that account. Third, the advice is given in a way that does not overtly point to the mother as being “ignorant or at fault.”

Home health visitors do not always use this full five-step sequence when initiating advice. Often the sequence is truncated by skipping various steps, resulting in a total of four variations. Two of these variations are pertinent to our data. One variation occurs when there is no problem indicative response by the mother. Then, the health visitor “sustains a ‘problem orientation’ as the basis for giving advice by herself detailing a possible or potential problem and then going on to offer advice on how to deal with it” (Heritage and Sefi 1992, 385). In this variation, the “warrant for advice” is provided by the health visitor on behalf of the mother. Another variation presents itself when neither mother’s nor the health visitor’s initial inquiry is overtly problem oriented. In this case, the health visitor sometimes proceeds to give advice without even a minimal warrant. The recipient is a completely “unprepared” recipient and the advice may often be irrelevant or redundant (Heritage and Sefi 1992, 387).

In Heritage and Sefi’s (1992) data, the advice concerns mothering and the needs of babies. The HIV clinic is both different from and similar to this situation. First, mothers know something of what to expect when health visitations occur, whereas clients at the HIV clinic do not know that they would be counseled or of what the counseling would consist prior to visiting the clinic. Second, whereas visitors to the HIV clinic have definite concerns about their HIV status, at the time of testing they are not embedded in a change of life as major as that of the mothers. Finally, as Heritage and Sefi (1992) show, to give advice in this circumstance is difficult interactionally because mothers are concerned with displaying their competence at being mothers. If they show the need for advice, it calls this competence into question. Although clients at the HIV clinic may be shown to be more or less knowledgeable regarding the topic of safer sex, their competence is not at issue in the way that it is for the mothers.

On the other hand, the clinic situation is similar to that of the home health visits in at least two respects. First, just as health visitors wish to draw out and give advice on problems—actual or potential—that the mother may not desire to bring up or may not know she has, counselors must work to elicit actually or potentially problematic behaviors that may be putting the client at risk for contracting HIV. It is rare for a client to reveal such behaviors or concerns about them. In both situations, then, tactics for uncovering problems are very delicate. Second, even if problems are volunteered or uncovered, giving advice is far from a straightforward matter. In both settings, neither negotiating the delivery of advice nor obtaining some demonstration of understanding and acceptance are straightforward matters.

A study much closer to ours in terms of setting is that of Silverman and colleagues (Silverman 1994; Silverman and Perakyla 1990; Silverman, Perakyla, and Bor 1992), who in Britain have also tape-recorded counseling sessions in HIV testing clinics. They analyze how it is that counselors and clients approach “delicate issues” such as sexual practices, manage embarrassment as an interactive phenomenon, and attempt to minimize uneasiness and maximize client participation in the talk. Furthermore, building on Heritage and Sefi (1992), Silverman et al. (1992) compare advice giving in Britain between HIV counselors and clients to that of the health visitors and the mothers. Like Heritage and Sefi (1992), they also found that the counselors initiated a majority of the advice-giving episodes. Additionally, they note that counselors sometimes gave advice in a manner related to the first type of variation discussed above, where the health visitor details a possible problem on behalf of the mother. Silverman et al. (1992) refer to these episodes as “hypothetical advice sequences.” These episodes are concerned, they say, “with the advice the counselor would give if ‘someone’ (i.e., not necessarily this patient) had a particular test result” (Silverman et al. 1992, 185, original emphasis). Finally, of the counselor-initiated episodes, the vast majority (thirty-five out of fifty-nine) embodied the second type of variation we discussed above, where counselors give advice with no seeming warrant (Silverman et al. 1992).
Using both Heritage and Sefi (1992) and Silverman et al. (1992) as baselines, our conversation analytic investigation is concerned with structures of giving and receiving advice in HIV counseling. We examine advice giving and receipt as they occur through the collaboratively structured interaction of the counselor and client.

DATA AND METHOD

The data were collected over a period of six months when the second author was a participant observer in the clinic, which was open two evenings per week. The researcher often worked as a receptionist at the front desk, and this facilitated permission requests to audio-record counseling and informing sessions. Permissions (including signed releases) were obtained from both clients and counselors (who were lay volunteers) before any recording was done. Clients signed permissions slips with an anonymous code used to track their blood sample and test results. (Clients were assigned codes when they called for an appointment and these codes were retained for identification purposes throughout the testing process.) Counseling sessions lasted from approximately fifteen minutes to over an hour. The researcher placed a tape recorder—activated if counselor and client had given permission—in the rooms with the participants. The counselors were four males, while there were twenty-one male clients and four female clients. Approximately sixty-six pretest counseling sessions were recorded during the research period. The first twenty-five of these sessions were transcribed according to normal conventions (see appendix for an explanation of transcription symbols). These twenty-five sessions contained seventy-two episodes of advice delivery, which were transcribed in detail following conversation analytic procedures (e.g., Jefferson 1974). In part, we assembled this collection of seventy-two episodes according to practical considerations. We felt it was large enough to contain sufficient variation in the details of giving and receiving advice such that interactive structures would be available for reliable description and analy-

sisis. At the same time, the collection was not too large so as to be an unmanageable transcription task.6


<table>
<thead>
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<th>TABLE 1: Strategies of Giving Advice</th>
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<td>1. Client initiated</td>
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<td>a. Full stepwise entry (Heritage and Sefi 1992)</td>
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TYPOLOGY OF ADVICE-GIVING EPISODES

Following the research of Heritage and Sefi (1992) and Silverman et al. (1992), we first classified episodes of advice giving according to whether they were client or counselor initiated. Then, based on previous research and our own inspection of the data, we subclassified the counselor-initiated episodes according to four patterns. Table 1 shows numbers associated with each pattern.

The counselors, like Heritage and Sefi's (1992) home health visitors, initiated most of the advice delivery episodes, while clients very rarely asked questions and, accordingly, occasioned few advice-giving episodes. Furthermore, of the counselor-initiated episodes, types 2b, 2c, and 2d add up to sixty-two of the sixty-seven instances (see Table 1). Only five episodes involved the full stepwise entry (2a). Overall, these numbers mean that counselors very rarely tailored their advice to the individual client. That is, only client-initiated advice giving and full stepwise entry involved counselors giving advice that was closely fitted to the client. These were just 10 of 72, or 14%, of the total. We shall describe each of these advice-giving modes in detail.

CLIENT-INITIATED EPISODES

Clients initiated sequences of recommendations by asking a question. In the following example, the client requests a recom-
COUNSELOR-INITIATED EPISODES

Full Stepwise Entry into Advice

If clients do not directly ask for advice, the counselor can employ a full five-step sequence to initiate recommendations. This alternative would insure that the advice is tailored to the client's specific problem and needs. However, as stated above, the counselors very rarely employed a full stepwise procedure as described in Heritage and Sefi (1992) when giving advice. The following segment is an example of one of the few such episodes (arrows and boldfaced numbers indicate correspondence with Heritage and Sefi's five steps: 1 > initial inquiry, 2 > problem indicative response, 3 > focusing inquiry into problem, 4 > responsive detailing, 5 > advice giving).

(1) [B58B2.PRT] (CO: counselor, CL: client)
1 CL: One thing you forgot to mention was - (0.4) the other one was
2 oh - (.) not to use natural lambskin?
3 (1.0)
4 CO: That's very true? Good point. Uh::m (0.4) we recommend that
5 you use g::ly::: .hh uh::: lat[sex:: ] condoms.
6 CL: [Latex?]
7 CL: [Mm kay]
8 CO: [hhhh ] Because the natural skins do: have pores.
9 CL: [Mm kay]
10 CO: [And it ] 's possible for the virus to pass through those
11 pores. .hh So use latex condoms only.
12 CL: Mm[' kay ]
13 CO: [Good] point. Thank you.

In this episode, the client's request (lines 1-2) operates as a reminder to the counselor to discuss the use of natural lambskin condoms. The counselor acknowledges the reminder (line 4), produces and explains the recommendation (lines 4-11), and then thanks the client (line 13). Notice that the client in asking for the recommendation nonetheless presents himself as a knowledgeable person. The actual recommendation that will be done is already stated by the client within the request. Nevertheless, in asking the counselor's advice, the client preindicates receptivity to it.

 episodes (arrows and boldfaced numbers indicate correspondence with Heritage and Sefi's five steps: 1 > initial inquiry, 2 > problem indicative response, 3 > focusing inquiry into problem, 4 > responsive detailing, 5 > advice giving).

(2) [B21A2.PRT]
1 1 > CO: hhhh When the two of you (0.1) engage in 't in any type of
2 sexual activity do you use safe sex.
3 CL: mtU::m meaning like a condom?:
4 CO: [mmhmm
5 2 > CL: No we don't.
6 3 > CO: Okay. .hh What? to you constitutes safe sex.
7 4 > CL: mtU::m (0.5) I believe knowing (0.3) who you are with, and 't
8 (.) you know being with? just one person,
9 CO: Mmm, (0.1) "okay". .hhhh
10 CL: (s'ler me.)
11 5 > CO: And that (.) from where you're coming from, you know I can hear
12 what you're saying. .hh The thing we need to look at though is
13 that even though you're- were with one person at a time. .h You
14 don't know like in your situation now who he's been with, or who
15 those people were with. .h And it sorta becomes a snowballing
16 effect. .hh so we really recommend .hh u:m to expand that s-
17 those safe sex practices to include not only one partner, and
18 knowing the partner, .hh but to avoid the exchange of any fluids
19 .hh uh for at least a good year into the relationship and until
20 both people have a chance to get tested a couple of times to make
21 sure. .hh Because . . .

This excerpt occurs near the beginning of the counseling session before there has been any talk about transmission of the virus or means of prevention. The excerpt starts with the counselor's general initial inquiry (step 1) about the client's sexual activity and use of safe sex (lines 1-2). The client responds first by asking for a clarification of the general term "safe sex" by proposing that safe sex means using condoms (line 3). After the counselor (line 4) agrees with this formulation, the client replies with a problem indicative response (step 2), "no we don't" (line 5). At line 6, the counselor builds on the question of what is safe sex with a focusing inquiry (step 3) into what the client means by the term safe sex. The client elaborates with a responsive detailing (step 4) that safe sex does not mean condoms but means knowing one's partner and only being with one partner
at a time (lines 7-8). The counselor acknowledges the client's point of view at lines 9, 11, and 12 before proceeding with step 5, which is the advice giving (lines 12-21). The initial part of this advice consists of the counselor suggesting a problem in the client's prior detailing, and the recommendation is carefully tailored to this version of what safe sex is. The counselor builds on the client's own knowledge to recommend that the client "expand" (line 16) his safe sex practices to also include avoiding the exchange of any fluids (line 18). Using the full stepwise entry here, the counselor is subsequently also able to set up a recommendation to use condoms as the best way for avoiding the exchange of fluids (approximately four minutes later) while still upholding the client's image as a competent person.

Advice Giving after Information

Another strategy, recommendation after information (2b), corresponds roughly to a variation described in Heritage and Sefti's (1992) research and to which we referred earlier: giving advice with no interactional warrant. Instead of eliciting or constructing a problem to which advice could relevantly be addressed, the counselor produces advice directly after the giving of information. Often this information concerns how the virus is transmitted, as in the following example:

(3) [B16A1.PRT]

1 CO: ...hh Okay. ...hhhh U:m hhhhh mt like we said unprotected
2 anal or vaginal sex is the high?est risk. ...h because any
3 penetration usually ruptures some Blood vessels. ...h
4 They (0.3) could be very very small. You don't have to
5 see blood to mean that there are some (0.1) blood
6 vessels ruptured. That again is a direct entry (.) into
7 the blood?stream. ...hhh U:m hh mt some of the things that
8 are considered safer. ...h Uh obviously if you use a
9 condom, that's safer. A:n you just gotta (0.3) (sound
10 of desk drawer moving) look around and find one that you
11 like. ((sound of plastic wrappers)) I can give you a couple
12 different samples, h of different ones that we have here?
13 (0.4)
14 CO: U:m hh ...hn an you jus gottaahhh experiment and find one
15 that (.) that you Like. that works for ya.=
16 CL: =okay.

17 CO: ...hh Uh we recommend latex condoms. ...h because the natural skin:ns:
18 have p[ores] in them. And it's possible for the virus
19 CL: [pores]
20 CO: to pass through the pores.

The information that the counselor gives the client concerns what kind of sex is the highest risk (lines 1-2, "unprotected anal or vaginal sex"), the reason for its high risk (lines 2-7), and activities that are "considered safer" (lines 7-9). Following this information, the counselor proceeds to give several recommendations beginning with the advice that the client look around and find a condom that he likes (lines 10-11) and that he experiment and find one that works (lines 14-15). The client acknowledges these initial recommendations with "okay" at line 16. Another recommendation to use latex condoms follows at line 17.

This form of advice giving is abstract and assumptive; it is done not in relation to the client's exhibited needs or problems but in relation to the counselor's information about the transmission of the HIV virus and what is assumed relevant to the client's particular situation. The interactional risk here, as Heritage and Sefti (1992) have argued, is that advice can be irrelevant or redundant to its recipient. Indeed, the client exhibits his own knowledge about condoms in line 19, overlapping the counselor (line 18) to name the reason why one should use latex rather than natural skin condoms: "pores."

Advice after Proposing a Hypothetical Situation

The other major way that counselors initiate advice delivery (2c) roughly corresponds to another variation as described in Heritage and Sefti (1992) wherein a counselor sustains a problem orientation by proposing a hypothetical situation. As Silverman et al. (1992) argue, such "hypothetical advice sequences" allow for ambiguity; that is, it is not readily apparent whether the counselor is advising this client in particular or just providing information that could and would be given to any person. In Peyrot's (1987) terms, this is using "oblique reference." A counselor either makes propositions concerning "some people"
doms on them, and changing the condoms (lines 5-13), the counselor has infused that advice with an informational quality. The advice is for people who do use toys, an identity that the client does not acknowledge for herself. Similarly, in lines 17-19, there is a reversion to the "you" term within a hypothetical "if" statement. The recommendation is delivered but its relevance to the client is contingent upon whether the client is involved in the hypothetical scenario.

Proposing a hypothetical situation for the delivery of advice may be more interactionally problematic than giving advice after information because the client has the opportunity to reject the proposed hypothetical situation and thereby the basis upon which advice may be given. This can be seen in the next example.

Here, the proposed hypothetical situation begins at line 2 and continues to line 13. There are two devices within the proposal that help accomplish the ambiguity between information and advice. The counselor starts at line 2 using a marker of supposition ("if") and the term "you," which is indefinite as to whether it refers to the client or to a category of people who "use any kind of toys." Then, following a very small pause (line 3), the counselor shifts from the "you" reference to third-person reference, "some people," and indicates approval of toys in a way that is possibly responsive to the client's lack of talk. When proceeding to give advice about not sharing toys, using con-

Prior to this excerpt, the counselor had been talking about ways that the virus may be transmitted, and has discussed problems concerning oral sex, but made no recommendation. At line 1 of this excerpt, he continues by proposing a hypothetical situation concerning the use of sex toys. It is connected to the previous
topics through “the other way” and puts the matter hypothetically with the “if” term plus use of an indefinite “you.”

There is a pause of .3 seconds (line 2) after the proposed situation. This is a point at which the client could indicate receipt through a continuer (see note 9). However, there is no response from the client. The counselor continues (line 3) by clarifying the reference to “sex toys.” This indicates that the counselor interprets the previous pause as exhibiting a lack of understanding on the part of the client (Pomerantz 1984, 154-6). In overlap with “dildos” (line 3), the client says “no” (line 4). If this “no” is a delayed response to the proposed situation, it may indicate that the pause at line 2 was not due to the client’s lack of understanding. The “no” appears to be a display of resistance on the part of the client to the proposed situation of her using sex toys.

Following the counselor’s clarifying utterance, the client repeats the “no” (line 5) and produces a formulaic disclaimer, “if you weren’t born with it get it away from me,” thereby showing that the situation does not apply to her. The counselor at line 6 acknowledges the client’s rejection (“ohka(hh),”) but he does not drop the topic. Instead, after a slight hesitation (“.hhh u::m”) the counselor invokes third-person or categorical reference with “for people who do think” (line 6). The transition proposes that what is to come is informational for a hypothetical group of people possibly exclusive of the client, and it provides for the subsequent “you”s at lines 15-17 as categorical rather than personal. The recommendation at line 17 is therefore also hearably informational rather than personal. However, the counselor does not go directly into a recommendation here but elaborates on the previously proposed hypothetical situation with another hypothetical situation (lines 8-14) using the general reference terms, “a lot of women” (line 9), “one” (line 10), and “the partner” (line 10).

In this example, the counselor proposes a hypothetical situation as a base from which to give advice only to find that it is irrelevant to the client. The counselor is able to proceed with the advice, however, by recharacterizing the proposed hypothetical situation as simply general information that the counselor is giving the client. In this way, the counselor works to produce the episode as one of offering information rather than personal recommendations. It is advice relevant to some women in general. Why the counselor proceeds to give advice not particularly relevant to this client is an issue we discuss below.

Advice as Information

Proposing a hypothetical situation may engender resistance from clients. A way for counselors to circumvent potential resistance from the very beginning of talk about safer sex is to characterize advice as information that “we the clinic” give to “clients in general.” Silverman (forthcoming) refers to this type of delivery as an “advice as information” sequence. Unlike example (3) above, wherein the counselor gives information and then produces a recommendation, advice as information is an organization of talk for packaging advice as information in the first place. In the following excerpt, the counselor produces a recommendation to use latex condoms as information about what the clinic tells people in general. The client is a woman.

(6) [B02A1.PRT]
1 CO: .hh U::m (0.5) we we (.) strongly recommend that people use:
2 (0.3) latex rubbers a(h)nd I personally strongly .hhh recommend
3 that women don’t assume that a man will always carry a rubber
4 with him . .hh (0.3) I think that (0.5) if yer gonna be sexually
5 active, it is (1.0) just as (0.3) important for you: to have a
6 supply of rubbers,
7 (0.3)
8 CL: yeah=
9 CO: =as as it is for your pahartner .hhh u::m so that there can be no
10 excuse.

In line 1, the counselor’s use of “we” in formulating a recommendation and reference to “people” as the target of this recommendation is hearably impersonal in a way the “if you . . .” of a proposed hypothetical situation is not. At lines 2-3, the counselor continues with the impersonal tone, although the advice now reflects the counselor’s “personal” stance and the target is “women” rather than “people.” At line 4, the counselor
changes to the indefinite "you" and to a mode where the advice could be heard as particularized to the client. Still, the counselor prefaces his recommendation with "I think" (line 4), a kind of "position report" that mitigates the force of the advice (Maynard 1984, 81).

Two matters are significant in this excerpt. First, the advice-as-information device heightens ambiguity between talk as advice for the client or as information, and provides more latitude for the client to hear the talk as generally rather than personally relevant. The device therefore may foster less displayed resistance. Second, starting with advice as information may represent a way for the counselor to approach matters that are closer to the client's own circumstances. Notice how there is referential movement across the counselor's turn of talk in excerpt (6). He starts by referring to "people," then invokes "women," and finally the indefinite "you." Each of these is conceivably a closer referential approximation to the client herself. Therefore, advice as information may be a cautious way of initiating an advance toward personally relevant recommendations. Advancement occurs when, as in this excerpt, the client shows no resistance to the beginning formulations.10

CLIENT RESPONSE TO ADVICE

In Heritage and Seff's (1992) research, mothers responded to advice in three different ways. The first was through a "marked acknowledgment" such as "oh, right," which acknowledged the talk as advice and as informative, and conveyed acceptance of the advice offered. Occurring mostly after client-initiated advice, they were also comparatively rare. The second way of responding was with an "unmarked acknowledgment" such as "mm hmm," "yeh," or "that's right," which avoided acknowledging the advice as informative and avoided overtly accepting the advice. As "continuers" (Schegloff 1982), these items often simply allow for the counselor to keep talking, although home health visitors treat them as resistive. Unmarked acknowledgments were the most frequent response to health-

visitor-initiated advice. The third way that mothers responded to health visitor advice was through an assertion of knowledge or competence, in which the mother indicated that the advice was redundant.

In our data from the HIV clinic, very few marked acknowledgments occurred. They mostly occurred after requests for advice, as in example (1), and advice given after information:

(7) [B18A1.PRT]
1 CO: U:mm (0.4) the other thing is that (0.1) u:mm you may
2 wanna look at ($) using condoms for oral sex. (0.2) They may not
3 taste real good but ($) we'll get used to that, or:
4 there are now they're called u:mm I believe it's kiss of mint.
5 Which is a a mint flavored condom, so that it (0.2)
6 [It tastes okay].
7 CL: [This is all n]ew to me hhheheh .hhh heheheh

In this excerpt, the client marks the advice as being informative although there is no indication that the client will act on that advice.11

It is also rare for clients to give assertions of knowledge or competence, although sometimes clients would indicate circumstances that would also make the advice appear irrelevant or problematic:

(8) [B02A1.PRT]
1 CO: I will (0.4) strongly recommend though that you do take a
2 bunch of rubbers with you. hh a?:nd (0.3) I don't know if I
3 have any in here.
4 (2.2)
5 CO: No. hh Up front. We also have the ($) the lubrication,
6 .hh the lubrication that we have out in front also has non-
7 oxynal nine in it. .hh Um if you go to Walgreens or any (0.2) or
8 any drug store, if you find (0.2) the water based lubricants, you
9 will also find it that has wa- uh? non-oxynal nine in it. .hh
10 Strongly recommend you get some, hh and that you keep it with ye
11 in y'- your bag, a:nd uh,
12 (0.6)
13 CO: I mean who knows? "when" (0.4) the occasions going to arise?
14 and (0.3) and [Have it] with you and
15 CL: [hhheheh]
16 CO: it doesn't mean that you're some sort of low life, it
17 means that you're being cautious.
18 CL: U:mm my boyfriend like really really hates condoms with
19 lubrication.
In this example, the counselor proposes a hypothetical situation at line 1, which is immediately followed by the client’s continuance at line 2, “mmhmm.” At line 3, the counselor continues the proposed situation, which is also followed by a client continuance at line 4. The counselor then proceeds to give the recommendation (line 5). At this point (line 6) there is a silence before the counselor proceeds with more information/recommendations. Our point is that the advice-as-information delivery may occasion minimal acknowledgments that work to keep the talk going but that otherwise do not indicate whether or how the client is accepting the advice.

However, often clients do not provide even minimal acknowledgments. Our transcripts show relatively long stretches of counselor-produced turns of talk. These stretches are collaborative achievements, in that the clients have opportunities to talk and appear to decline them. Sometimes they might be minimal opportunities, as when the counselor interweaves information with recommendations:

(10) [B21A2.PRT]
1 CO: .hhh So we wanna avoid exchanging those fluids. .hh The best way
2 is with a condom.
3 Mkay?
4 for intercourse, .hhh condoms for oral sex,
5 or: avoiding (0.1) u:m having him actually ejaculate in your
6 mouth.
7 .h Or: you can focus on .hh just the shaft of the penis and
8 the testicles versus putting your mouth over the head of the
9 penis.
10 .hhh All of those ways reduce the risk of transmission.
11 It’s not one hundred percent?
12 .hh But until you know a baseline of where the person’s coming
13 from. .hh you really need to put those in pla?ce.
14 .hhh Kissing, mutual masturbation, massage, caressing,
15 those types of things are real safe.
16 .h You’re not gonna get it from sweat, you’re not gonna get it
17 from tears, you’re not gonna get it from saliva.
18 Okay?

Here the counselor produces an initial recommendation at lines 1-2, and then probes for an acknowledgment (mkay?) but does not get one (line 3). He then continues by giving more recom-
recommendations (lines 4-13) and information (lines 14-17). As in example (7), there are several transition relevance places where the client does not elect to speak. These points are after "...with a condom" (line 2), "mkay?" (line 3), "...oral sex," (line 4), "[in your] mouth." (line 6), "...penis." (line 9), "...risk of transmission," (line 10), "...hundred percent?" (line 11), "...in Place," (line 13), "...real safe." (line 15), and "...from saliva." (line 17). At these points, the counselor enacts the "current speaker continues" option of turn taking (Sacks, Schegloff, and Jefferson 1974), quickly producing a next utterance without pursuing a response from the client. (Of course with audio recordings, it is not possible to know if the client was engaging in nonverbal acknowledgments such as head nodding.)

If a client produces minimal acknowledgments, or if the counselor moves rapidly, the client's resistance may not be an issue. However, when large silences appear at the end of turns, this more clearly may imply unstated client opposition to the counselor's line of talk. Accordingly, in the next example, when large silences appear at the end of turns, it may exhibit client resistance. Again there may be nonvocal head or other gestures, but the lack of vocal turn transition is dramatic:

(11) [B10A1.PRT]
1 CO: .hhhh Um if you take those basic precautions,
2 (2.0)
3 CO: (thenthth) with intercourse whether it's vaginal or anal? that
4 that condoms be used?
5 (1.0)
6 CO: U:mm () here we would certainly recommend that (0.2) latex
7 () ()ver: u:mm .h lamb skin. be used because latex is .hh
8 less porous and usually it's u:mm (0.8) most guys claim that
9 its more comfortable.
10 (1.2)
11 CO: We would also: encourage people to use lots of lubrication
12 even if: (0.2) u:mm the condoms that they're using have
13 lubrication on 'em we would () encourage (0.3) more. .hhh
14 and we would certainly encourage that a person use something
15 that (0.2) has a water base to it. Anything with an oil base
16 will (0.2) destroy the:: the latex rubber.
17 (0.5)
18 CO: .hhhh u:mm
19 (0.6)
20 CO: A::ndd we would encourage (0.2) that () not only be it water

21 based but that there's lots 'n of:: (0.2) of lubrication
22 that's available now that ..hh is water based and also has
23 nonoxynal nine in it. ..h Which would then act as another
24 protection because that also kills the AIDS virus.
25 (0.8)
26 CO: Okay?
27 CL: Mmmhm?

Each time the counselor gives a piece of advice (lines 6-9, 11-16, and 20-24) there are substantial silences (lines 5, 10, 17, and 25). The result is a string of recommendations that emerge as one large turn of talk. Only after a prompting "okay?" from the counselor (line 26) does the client give even a token acknowledgment.

When large silences or other indications of resistance appear, it might behoove counselors to back off from their heavy use of advice. Instead we find a different pattern: counselors deal with potential client resistance by producing several variations of a recommendation. This most often happens in the advice giving involving the counselor's proposal of a hypothetical situation, as in the following example involving a male counselor and a female client.

(12) [B10A1.PRT]
1 CO: =yer avoiding body secretions supposedly if you're not
2 taking the head (0.5) into your mouth ..hh It:::
3 (0.4) If you're going down on a woman or: if a guys
4 going down on you a- (1.0) Ideally (0.3) to stay on
5 the outer lips of the vaginal entry.
6 (0.4)
7 CO: Okay?
8 CL: Mmmhm.
9 CO: Not to actually: enter; (0.7) with (th) tongue ..hhh
10 Those are ideal situations.
11 CL: (I know.)
12 CO: The reality here? iz: often times if (th) person's
13 involved in oral sex they're not there by accident.
14 (0.5)
15 [ and ] Its: because they want to really indulge.
16 CL: [Yeah]
17 CL: Mmmhm=
18 CO: =Okay? ..hh So if:: you're going to involve yourself in
19 oral sex and if it's with a male partner u:mm we would
20 then say if the other things aren't gonna work. (0.4)
21 U:mm (0.3) take care of yourself as best you can;; and
to best take care of yourself. If you don’t wanna have any (0.2) lesions or cuts or tears (0.2) on or around your mouth?

CL: Mmmhm.

Initially, the counselor proposes two situations (lines 3-4), the client “going down” on a woman, and a guy “going down” on the client. By linking the two proposed hypothetical situations, the counselor appears to be displaying some uncertainty as to the client’s sexual orientation. Indeed, the client has not indicated previously in the session whether she is heterosexual, homosexual, or bisexual, and the recommendation at lines 4-5 would appear to work for either case. In part, that the recommendation works for either case is an accomplishment of the counselor omitting the subject of action in the recommendation and the infinitive “to stay” at the start of the recommendation (lines 4-5). A pause (line 6) after the recommendation is at a point where the client could have elected to speak. The counselor notices this lack of transition by prompting the client at line 7, and obtains a minimal acknowledgment (line 8).

Next, the counselor appears to interpret the silence and minimal acknowledgment as resistive. He characterizes the recommendation as an “ideal” one, and then shows recognition of “the reality here” (lines 12-15) before producing a recommendation in line with this reality (lines 18-24). Relative to the initial recommendation, this is a weaker piece of advice—“take care of yourself” (line 21). As the counselor makes this move, the client provides acknowledgments more frequently and in close proximity (lines 17, 25) to components of the move.

We refer to the production of a series of recommendations as “chaining.” Chaining of recommendations using proposed hypothetical situations sometimes is more extensive than our brief example and helps accomplish two matters. First, a counselor can propose a situation that might fit the client and a recommendation that might work for the client in a situation where little is known about the client’s sexual orientation and practices. Second, and related to the first matter, is that chaining allows the counselor to tread delicately when talking about someone’s sexual orientation and practices. Instead of questioning the client as to her exact practices, the client’s sexual preference and whether she is the active or passive partner in oral sex is left ambiguous. That is, the recommendations are produced without potentially embarrassing questions. Once again, we see counselors being cautious in their approach to advice and recommendations.

**DISCUSSION**

Giving advice and making recommendations is interactionally difficult. One reason for this may be that the advice giver assumes an authoritative position and the recipient a position of uncertainty, ignorance, and/or even incompetence regarding the subject of the advice (Herritage and Sefi 1992). Beyond this, our data involve an area of human behavior traditionally regarded as private and personal, variations in which are also sometimes stigmatized. Participants in HIV counseling sessions show an orientation to these problems of sensitivity in several ways. First, clients very rarely asked for advice (Table 1). This should not be surprising, since the official purpose of the clinic visit is to obtain a test. Accordingly, the problem posed for clinicians in pretest counseling is that they seldom have a naturally propitious environment for the offering of safer sex recommendations, that is, one in which the relevance of the advice to a particular client is provided for.

Statements on safer sex counseling advocate, and counselors feel, that relaying advice to clients is very important. If counselors are to do this, usually they must initiate the advice episodes themselves; and they appear to employ four devices for doing so. Strategy 2a—a stepwise approach—is the closest approximation to answering a client’s request in terms of having a propitious environment for the delivery of recommendations. However, even though it collaboratively provides for the relevance of giving advice, it also appears confrontational and intrusive. Counselors seem to avoid such an approach in favor of two others. One of these is strategy 2b—giving advice after information in an abstract way that is not tailored at all to the
particular client. Strategy 2c—proposing a hypothetical situation—approaches giving personal advice but is produced in an ambiguous way; depending on the recipient's response, it can appear as impersonal information rather than personal advice. Strategy 2d embeds advice in an information package.

Overall, then, there is a very strong, organized tendency for counselors to relay information to clients rather than to tailor advice to their individual needs and problems. At best, counselors may approach giving more personal advice when they start with an informational delivery and progressively propose situations closer to the client's circumstances. The organized tendency for relaying information elicits very few demonstrations from the clients within the interviews that what they hear is usable and in fact informative. With respect to the clinical literature that suggests making recommendations personally relevant, we offer the following tentative observation. Counselors take what is an interactionally safer route in dealing with the topic of safer sex, and that is to be informational rather than advisory. But in so doing they are taking a route that probably maximizes the irrelevance to particular clients of the recommendations and advice they have to offer. This appears to be an embellishment of the "dilemmas" of advice giving that Heritage and Sefi (1992) identify. Instead of an advice giver seeking to be useful at the expense of rapport with her client, we have a situation where an advice giver observes the sensitivity of a situation by retreating from recognizably personally relevant recommendations.

To fully understand the articulation of this dilemma in our data, we suggest taking into account the goals of the organization that go beyond the immediate context of the pretest counseling session, or what Maynard (1984, 12) refers to as the "institutional mandate." Counselors' orientation to such goals help explain why they persist in providing recommendations when clients are resistive or even when clients state that advice is irrelevant (see example [6]). We know from ethnographic data gathered at the clinic that counselors were taught that it was important to relay information to the community through their clients, and that counselors largely respected this mandate.

Counselors sometimes expressed this in a counseling session, and hence it might be said that the mandate is "procedurally consequential" (Schegloff 1987) for the talk in this setting:

(13) [B32A1.PRT]
1 CO: If this isn't something that you're going to be using for
2 yourself you can pass this information on to your friends. =
3 CL: = Yeah, I kn- I was going to ask that =
4 CO: = Yeah.
5 CL: cuz I never
6 CO: Yeah
7 CL: ((cough)) was it that at a? ill,
8 CO: Right.
9 CL: and when I did hear that
10 CO: but =
11 CL: = people that were already =
12 CO: = yeah. =
13 CL: = greater risk.
14 CO: Right. So then you can just pass it on.

The counselor suggests that his advice is not necessarily based on its relevance to the client. It is based instead on a view of the client as a mediator between the clinic and the community at large. This view explains the prevalence of strategies 2b, 2c, and 2d. Strategy 2b, advice after information, and strategy 2d, advice as information, straightforwardly accommodate the institutional mandate for disseminating recommendations possibly relevant to a wider community. Strategy 2c, proposing a hypothetical situation, can bridge the goal of being personally relevant to the client and the goal of giving the client advice to pass on to others. If a proposed situation is applicable to the client, then the client can accept the advice, either explicitly or implicitly. If it is not applicable, the advice can be taken as information for dispersion in the community.

This study, then, along with those by Heritage and Sefi (1992), Jefferson and Lee (1981), and Silverman et al. (1992), suggests that there are similar difficulties and paradoxes across settings in the giving of advice. Yet differences occur as participants take into account the institutional and organizational context in which they are acting. With regard to HIV counseling, at a practical level, clinical literature that is specific about what content should be conveyed during HIV counseling but that is
vague in suggesting how this can be done needs to appreciate the concrete difficulties of the counseling task. We have demonstrated how counselors presently are embedded in a dilemma that results in impersonal, informational counseling. Perhaps because of this, clients appear largely unresponsive to the large amount of advice and recommendations they receive. If a goal is to increase client acceptance of safer sex practices, appreciation of the social organization of counseling discourse needs to be taken into account.

Further ethnographic conversation analysis of the type we have pursued in this article is relevant. Here we have emphasized conversation analysis complemented by ethnographic observations and characterizations of the setting. At least two directions are possible for future research on the interactional dynamics of giving and receiving advice. One direction would be to examine practices of giving and receiving advice across different types of institutional and more ordinary conversational settings. Such research would stress the context-free aspects of these practices and thereby provide knowledge of “advisory” language practices in social interaction generally. The advantage here would be to provide a comparative baseline from which to understand and assess the articulation of advice giving in particular settings. Another direction would be to do further ethnographic research in other clinics involved in HIV and AIDS counseling and testing. This would deepen the analysis of problems and contingencies that are unique to these settings. In barest terms, the issue here is whether future research should explicate the generic social organization of advice giving and advice receipt, or whether it should concentrate on HIV and AIDS interviews and, in particular, the difficulties intrinsic to making recommendations in regard to safer sex behaviors.

APPENDIX: Transcript Symbols

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
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<tbody>
<tr>
<td>::</td>
<td>Sound stretch</td>
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<tr>
<td></td>
<td>Overlap in speakers’ talk</td>
</tr>
<tr>
<td>(0.1)</td>
<td>Timed pause</td>
</tr>
<tr>
<td>(.)</td>
<td>Very brief pause</td>
</tr>
<tr>
<td>(o)</td>
<td>Transcriber’s comments</td>
</tr>
<tr>
<td>(text)</td>
<td>Empty parentheses denote nonunderstood utterance</td>
</tr>
<tr>
<td>.</td>
<td>Downward intonation, not necessarily the end of a sentence</td>
</tr>
<tr>
<td>?</td>
<td>Upward intonation, not necessarily a question</td>
</tr>
<tr>
<td>.hh</td>
<td>Audible inbreath</td>
</tr>
<tr>
<td>hh</td>
<td>Audible outbreath</td>
</tr>
<tr>
<td>WORD</td>
<td>Uppercase indicates especially loud sounds relative to the surrounding talk</td>
</tr>
<tr>
<td>word</td>
<td>Underlining indicates emphasis</td>
</tr>
<tr>
<td>-</td>
<td>Dash indicates cutoff</td>
</tr>
<tr>
<td>=</td>
<td>Equal signs indicate no gap between two lines of talk</td>
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<tr>
<td>(h)</td>
<td>Parenthesized “h” indicates plosiveness, often associated with laughter, crying, breathlessness, and so on</td>
</tr>
<tr>
<td>*</td>
<td>Talk between two of these asterisks is especially quiet relative to the surrounding utterances</td>
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NOTES

1. For example, see Moerman (1988) and the symposium on this book in a special issue of Research on Language and Social Interaction (Hopper 1990-91).
2. Counselors were careful to use the term “safer” rather than “safe” in regard to recommended sexual practices. The relative term was meant to remind clients that only abstinence was absolutely safe; any joint sexual activity posed some degree of risk, ranging from minor to major.
3. The British health-visitor service, as a part of the UK community-nursing program, focuses on “illness prevention, giving advice on health and social problems, and case finding for other more specialized agencies” (Dingwall 1977, 21). As part of their work, they visit first-time mothers at home in order to address any problems the new mother may be having and to give advice on baby care.
4. The stepwise approach to giving advice can be compared to what Maynard (1992) calls the “perspective-display series” as a device for delivering diagnostic news. Through this device, a clinician asks for the recipient’s views about some condition. After the recipient displays a perspective, the clinician may have a propitious environment for delivering the diagnosis and can present it in a publicly affirmative and nonconflicting manner.
5. Costello (1990), in his study of doctor-patient recommendations, describes a structure for dealing with delicacy that roughly corresponds to this variation. He notes that when physicians make recommendations to patients, accounts are required to serve as “justification” for these recommendations. One type of account is a “contingent
structure." Here, an "if" clause works to justify a recommendation by tying it to the patient's analysis of the situation. According to Costello (1990, 36), "the recommendation... [following the if-clause] is operative only if the patient judges the two conditions [of the if-clause] to be satisfied." Not only must the doctor sustain a "problem orientation" (Heritage and Shiffrin 1992) as a basis for giving advice, the patient must agree that the basis is applicable to them in order for the talk to be heard as relevant advice.

6. For further discussion of procedures involved in the analysis of recorded data from field settings, see Maynard (1984, 17-24).

7. Numbers in brackets identify specific counselor-client sessions.

8. Peyrot's (1987) study concerns psychotherapy, and besides third-person ("some people") and indefinite ("you") oblique reference, he suggests a third form, which is first-person reference or self-disclosure. The latter form is a way to propose similarity between the client and the psychotherapist. Counselors use such an hypothesis as a basis for making suggestions about the client (i.e., "if this situation applies to you, then I am like you, it probably applies to you as well").

9. This is a place where the client could have produced a "continuer" (Schegloff 1982), as in the following example:

[B33A1.PRT]

1 CO: Ideally (0.3) if: a woman's going to go down on You.
2 CL: [Mmhmm].
3 CO: [ And ] give you head. Alright?
4 CL: Mmhmm.
5 CO: Ideally you'd be wearing a rubber.

In this example, the counselor proposes a hypothetical situation at line 1, which is immediately followed by the client's continuance at line 2, "Mmhmm." At line 3, the counselor continues the proposed situation, which is also followed by a client continuance at line 4. The counselor then proceeds to give the recommendation.

In example (4), line 3, there is no receipt by the client at the conclusion of the proposed situation. This lack of receipt may indicate some resistance to the proposed situation by the client. That is, the counselor may hear the brief silence as indicating client resistance because he immediately produces a disclaimer (line 3) for the proposed situation.

The client does produce a minimal response at line 4, "uhhuh." It overlaps with the counselor's start of the categorical reference. It is possibly a delayed receipt in that it might have occurred at the completion of the proposal but instead occurs past its projected completion point. Also note that the counselor ends the disclaimer with upward intonation and what would seem to be a request for a response from the client, "y'know?" (line 5); however, he leaves no time for a client response before taking an inbreath and concluding with the recommendation that the client should not share the toys with his partner (lines 5-6).

10. As Drew and Heritage (1992, 45-7) have suggested, cautiousness of this sort is a regular feature of talk in institutional or organizational settings such as clinics. For instances of caution in the delivery of diagnostic news and in the "labeling" of children with developmental disabilities, see Gill and Maynard (1995, 16-9).

11. The client states several times during the counseling session that he feels he is not going to be infected even if he does not change his present sexual behavior.

REFERENCES


KINNELL, Maynard / SAFER SEX ADVICE

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