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Overcoming Truth Telling as an Obstacle to Initiating Safer Sex: Clients and Health Practitioners Planning Deception During HIV Test Counseling

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This article considers how deception, as a strategy for handling delicate interpersonal situations, is raised and responded to during HIV pretest counseling sessions. Two cases are presented in which clients (CLs) formulate extrarelational sexual encounters as potential obstacles to initiating safer sex practices with long-term relational partners (because reinitiating safer sex with such partners would entail admission of the extrarelational encounters). Close analysis of spoken interaction reveals that CLs display their resistance to initiating safer sex by animating, through hypothetical dialogue, their long-term partners' requests for explanation of the disruption in their usual intimate behaviors; health practitioners attempt to overcome this obstacle of "truth telling" by suggesting deception in its place. This study extends current understandings of the formulation and planning of deceptive messages in the course of actual health promotion interactions. The implications of this investigation suggest that deception may pose a viable, albeit controversial, option when promoting disease prevention behaviors, especially in delicate interpersonal interactions such as not wanting to admit an extrarelational affair.

The counseling that accompanies HIV testing can be an important factor in influencing people to practice safer sex to avoid AIDS (Beardsell & Coyle, 1996). This article examines HIV test counseling encounters in which health practitioners (HPs) present deception as a compliance-gaining strategy for clients (CLs) to use in

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initiating safer sex with a long-term partner. Deception is occasioned by the CLs' formulation of "telling the truth" as an obstacle to practicing safer sex because truthfulness would involve admission of extrarelational sexual encounters. Although the phenomenon of deception has received much attention in the literature (Buller & Burgoon, 1996; Burgoon, Buller, Guerrero, Afifi, & Feldman, 1996; Miller & Stiff, 1993; Seitter, 1997; Vrij, Semin, & Bull, 1996), its relevance as a compliance-gaining strategy in health care contexts has not been extensively explored. Therefore, this study extends current deception literature by attempting to understand how deception, as a strategy for handling delicate interpersonal situations, is raised and responded to during dialogue promoting safer sex. Detailed examination is offered of how CLs' resistance to telling the truth about extrarelational sex is formulated, how it constitutes an obstacle to initiating safer sex, and how the HP attempts to overcome this obstacle. Implications of this investigation for the future of deception research and health promotion practice are also discussed.

REVIEW AND CRITIQUE OF RELEVANT DECEPTION LITERATURE

A vast body of literature considers deception and the related issue of nondisclosure in health interactions and other interpersonally oriented situations. However, the use of deception as a compliance-gaining strategy in these situations has not been extensively studied.

Deception in Health Interactions

Three relevant areas of health research include doctors communicating difficult diagnoses to patients, disclosing an affair to a partner, and sexual partners not disclosing their HIV status.

Communicating difficult diagnoses. Even though most patients prefer to be told that they have a serious or life-threatening disease such as cancer or motor neuron disease (Johnston, Earll, Mitchell, Morrison, & Wright, 1996), and various professional guidelines recommend it (Masera et al., 1997), physicians sometimes choose not to share the diagnosis because of the poor prognosis, lack of significant treatment, and their own negative perceptions of the disease and the patient's situation (Annuziata, Talamini, Tumolo, Rossi, & Monfardini, 1996; Righetti & Giogio, 1994). This constitutes a form of deception that may be justified by physicians.

Disclosing an affair. Research on the disclosure or nondisclosure of an affair to a partner suggests that disclosure in the form of an account of the affair (e.g., excuse, justification) is provided only when the partner already knows about the

transgression (Mongeau, Hale, & Alles, 1994; Mongeau & Schulz, 1997); otherwise, the affair is not disclosed. Also, relational goals seem to drive the production of accounts for affairs (McLaughlin, Cody, & O'Hair, 1983; Mongeau & Schulz, 1997). That is, when there is a high motivation to maintain rather than terminate the relationship, and the partner knows about the affair, mitigating accounts (i.e., excuses, apologies) are more likely to be presented. Dillard, Segrin, and Harden (1989) explained that one's primary goal of changing another's behavior is influenced by the secondary goals of maintaining the relationship. When asked to recall and write the dialogue of a persuasion attempt, participants' concern for the relationship was associated with the use of positive messages. Therefore, long-term (i.e., secondary) goals seem to provide the impetus for the planning and execution of short-term (i.e., primary) messages. When applied to motivations for deception, the long-term goal of maintaining the relationship may provide vindication, in the sender's mind, for lying to a partner in the short term.

Nondisclosure of HIV status. The ethics of deception as a strategy to maintain a relationship, however, have been challenged in a growing body of literature that advocates and, in some cases, mandates the notification of sexual partners in the event of positive HIV and AIDS test results (West & Stark, 1997). In this view, failure to disclose HIV infection to sexual partners interferes with risk reduction (Niccolai, Dorst, Myers, & Kissinger, 1999; Rutherford et al., 1991) and has been considered by some a moral or legal offense (Holt et al., 1998; Stein et al., 1998). Still, many who test positive for HIV do not disclose their serostatus to any or some of their sexual partners. Perry, Ryan, Fogel, Fishman, and Jacobsberg (1990; see also Rogers, Tross, Doino-Ingersol, & Weisfuse, 1998; Stein & Samet, 1999) found that of the gay men they interviewed, 66% notified all of their current sexual partners of their positive HIV status, but 90% made no attempt to notify past sexual partners. In general, those who are HIV positive disclose their serostatus to their primary sexual partners but are not likely to inform casual sex partners (Marks et al., 1992; Schnell et al., 1992; Stein et al., 1998). Also, there is an inverse relation between the number of partners and disclosure of positive HIV test results (Marks, Richardson, & Maldonado, 1991). Furthermore, in Niccolai et al.'s (1999) study, approximately 23% of the participants reported not using a condom with a person to whom their HIV positive status was not disclosed (see also Marks et al., 1991).

A variety of reasons are reported for not disclosing HIV status to sexual partners. Many men cite a disruption in their intimate relationships and negative reactions from partners as reasons for not disclosing their HIV status (Derlega, Lovejoy, & Winstead, 1995; Schnell et al., 1992). Fear of discrimination, concerns about upsetting family members, and need for self-protection have also been noted as reasons for nondisclosure by men (Hays et al., 1993). Women do not disclose being HIV positive because they fear physically violent retaliation from their partners (Gielen, O'Campo, Faden, & Eke, 1997; Neighbors, O'Leary, & Labouvie,

1999; Rothenberg, Paskey, Reuland, Zimmerman, & North, 1995) or stigmatization and discrimination in housing, employment, health insurance, and custody of their children (Kimberly, Serovich, & Greene, 1995).

Some scholars have argued that the planning of disclosure or maintaining nondisclosure of positive HIV status allows individuals personal privacy and a sense of control over their disease (Derlega et al., 1995; Holt et al., 1998). The benefits and risks of disclosure are weighed and, to balance this dialectic tension of revealing and concealing (Baxter & Montgomery, 1996; Rawlins, 1983a, 1983b, 1992), individuals choose to whom they will disclose their HIV positive status to gain social support, but avoid the negative ramifications of disclosure (Greene & Serovich, 1996; Hays et al., 1993; Mason, Marks, Simoni, Ruiz, & Richardson, 1995). The justification for keeping a positive HIV test secret notwithstanding, nondisclosure of HIV status does present a potentially serious health threat to naive partners.

Deception in Other Interpersonal Interactions

In other interpersonal contexts, the phenomenon of deception has encompassed three research foci: (a) nonverbal (Ekman, 1985; Ekman & Friesen, 1969, 1974; Zuckerman, Amidon, Bishop, & Pomerantz, 1982; Zuckerman, DeFrank, Hall, Larrance, & Rosenthal, 1979; Zuckerman, DePaulo, & Rosenthal, 1981; Zuckerman & Driver, 1985) and verbal correlates of deception (Cody, Marston, & Foster, 1984; Knapp, Hart, & Dennis, 1974; Kraut, 1978; Stiff & Miller, 1986; Zuckerman et al., 1981; Zuckerman & Driver, 1985), (b) deception detection (Brandt, Miller, & Hocking, 1982; DePaulo, Zuckerman, & Rosenthal, 1980; Ekman & Friesen, 1974; Ekman & O'Sullivan, 1991; Kalbfleisch, 1985; Kraut, 1980; Zuckerman, Koestner, & Alton, 1984), and (c) deception as a compliance-gaining strategy (Neuliep & Mattson, 1990; Schenck-Hamlin, Wiseman, & Georgacarakos, 1982). Recently, Buller and Burgoon (1996; see also Burgoon et al., 1996) integrated much of this interdisciplinary scholarship into their theory of interpersonal deception, which emphasizes how information is managed during the design and evaluation of deceptive messages. The development of a theory of deception is encouraging, but what continues to be missing from previous conceptualizations of deception is how this taboo topic is broached and how a deception strategy is planned during naturally occurring interactions.

Although it appears that planning has little influence on nonverbal correlates of deception (Miller, deTurck, & Kalbfleisch, 1983; Zuckerman & Driver, 1985), the effects of planning on deception detection are still unclear because researchers have not measured the detection accuracy of planned and spontaneous deceptive messages (Cody et al., 1984; Greene, O'Hair, Cody, & Yen, 1985). Similarly, scant research has considered deception as a special case of strategic compliance-gaining communication (Schenck-Hamlin et al., 1982). The only empirical study that explored deception as a compliance-gaining strategy appears to be

Neuliep and Mattson (1990) in which significant differences in the types of persuasive messages generated were found between truth tellers and deceivers in a quasiexperimental design. However, this research did not assess the planning that went into formulating the deceptive messages.

The use of deception has been directly and indirectly considered in the context of health care; however, these studies have not focused on the use of deception as a disease prevention compliance-gaining strategy that is proposed when an obstacle to healthy behavior is anticipated. Also, it seems that previous deception research within and outside health care settings shares a functionalist, variable-analytic bias that ignores the social construction and uses of deception. The goal of this study is to provide a detailed description of actual interactions in which deception is planned as a strategy to overcome perceived obstacles posed by telling the truth in a health-related situation.

METHOD

Site and Participants

The research setting was a large university health center in the southwestern United States. Although this health center primarily served students, the anonymous HIV testing service was available to anyone who made an appointment. There were two state-certified HPs who performed the HIV tests at this site. The pre-HIV test counseling sessions included elicitation of the CL's reason for having the test, an HIV risk assessment, identification and negotiation of safer-sex (or safer needle-sharing) behaviors, discussion of the CL's coping mechanisms for handling a positive HIV test result, and the CL's informed consent to have blood drawn. The data for this study were collected as part of a larger field study evaluating HIV test counseling (Mattson, 1999). For this analysis, two cases were drawn from a total of 45 transcripts of audiorecorded pre-HIV test counseling sessions. These two cases were chosen because they contained references to using deception as a safer-sex strategy.[1]

[1]Advising clients (CLs) to deceive their partners to practice safer sex was recommended in just 2 cases in this series of 45 CLs. The health practitioners (HPs) in this sample did not feel they could provide an accurate estimate of how often they advised CLs to use deception. Note, however, that offering a deception strategy to other CLs was alluded to by the HP during the counseling session with CL 1202 (see Excerpt 7, line 442). Furthermore, the state HIV test counseling trainer reported that HPs were not taught this strategy during training.

Several HPs observed and spoken to in other health contexts reported using deception to aid in persuading CLs to adopt a recommended action (e.g., telling a CL that the practitioner also used an inhaler for symptoms of asthma). Although they do not remember this strategy being formally taught in training, they reported their instructors sometimes modeled it. None of these practitioners reported ever advising CLs to deceive another for health reasons.

Analytic Approach

Each clinic visit used for this analysis was transcribed in detail based on conventions presented in Jefferson (1974; see the Appendix for transcription conventions used for this study). Once the visits were transcribed, analysis was undertaken using the techniques and principles of conversation analysis (Sacks, Schegloff, & Jefferson, 1974), which is an "analytic technology" (Heritage, 1988) for unpacking the sequential and substantive organization of stretches of talk. Within this framework, sequential organization is a central concern (Pomerantz & Fehr, 1997; Sacks et al., 1974; Schegloff & Sacks, 1973) and the approach privileges the finely detailed, empirically verifiable aspects of talk in interaction.

ANALYSIS

In this analysis, one counseling session (CL 1202, HP 1) is followed in detail across excerpts in which deception is occasioned and formulated as a strategy for gaining compliance with safer-sex practices. Germane excerpts from another counseling encounter (CL 0007, HP 2) are provided as supporting evidence.[2]

CL 1202 has come into the clinic to be tested for HIV because his relational partner of the past 1½ years has been worried about his "bad past." The CL acknowledges that he and his long-term partner have been having unprotected sex and that, unbeknownst to his partner, he has also had two extrarelational sexual encounters while in the relationship: One was 7 months earlier and another was within the last month. Because the current HIV test will not cover any possible infection from the recent encounter, the CL should technically use condoms with his partner and retest in 6 months. This is what the HP advises the CL to do, but it raises a problem for the CL: The couple has been having unprotected sex for 1½ years and only recently began using condoms while waiting for the female partner's birth control pill to become reliable. If the CL were to now insist on continuing safer sex practices for 6 months longer than necessary, his partner would want to know why, which could, of course, entail admission of the recent extrarelational sexual encounter.

Formulating Resistance to Practicing Safer Sex

The issue of practicing safer sex with the long-term partner is raised about 11 min into the discussion, after the CL says that he would be seeing his partner in 1½

[2]The single case analysis demonstrates the "machinery of production" in this particular instance and is valid for this instance (see Psathas, 1995, on the "method of instances"). The recurrence of the phenomenon in the other case does not prove the adequacy of the single case analysis, but it is a means for noting and exploring variation (Benson & Hughes, 1991).

months. He intimates that he is reluctant to continue condom use with her because it would entail admission of the extrarelational sexual encounter. At line 308 of Excerpt 1, the counselor moves to confirm the CL's apparent intention to have unprotected sex with the partner.

Excerpt 1 (CL 1202 and HP 1):

308	HP:	+And you are gonna have unprotected sex with her is that your intention?+
309	CL:	.HHHH ((loud, prolonged out breath. A "sigh" relative to other out breaths))
310	HP:	That's what—I get the sense that's where you're leaning [towards.
311	CL:	[PUT IT THIS
312		WAY, I'M NOT GONNA BE ABLE TO just sit there and sa:y, well (.) I
313		have to wait another six months.= Cuz then she's gonna be like (.) weh why do you hafta
314		wait another six months?
315		(0.5)
316	CL:	Ya know what I mean? Li::ke,
317		(1.0)

Not surprisingly, the CL orients to the HP's question in line 308 as problematic in some way. His sigh at line 309 fills the slot of a response but turns the floor back to the HP without providing any new information. In the local context of the immediately preceding discussion about risks of HIV infection, to voice an intention to engage in unsafe sex would be extremely awkward and controversial, and the CL clearly displays such an orientation.

In his turn (line 310), the HP in fact treats the heavy sigh as an expression of discomfort and as an insufficient answer because he pursues the topic by reformulating his original confirming question, downgrading it as a more mitigated opinion ("I get the sense that's where you're leaning towards"; line 310). This provides a second opportunity space for the CL to refute the damaging characterization that he is leaning toward unsafe-sex practices.

The CL's response (lines 311–314) to this turn in progress takes precedence as he overlaps the HP's talk and increases the amplitude of his utterance. His turn, initiated with "Put it this way," is difficult to characterize, but it seems to be a formula that frames a particular discursive project, namely a euphemistic response, a story to come that will serve as an answer. Indeed, the CL's account (lines 312–314) comes in the form of an imaginary interaction. First, he quotes what he could not say to his long-term relational partner, should the topic of condom use come up. He would have to tell her that he has to "wait another six months" (to forgo using condoms).

The emphasis on the first person pronoun "I" (line 312) is prosodically marked as in contrast to some prior pronominal or nominal reference (for social and linguistic discussions of contrastive stress, see Lakoff, 1971, and Sacks, 1995) adding further weight to the sense that this CL is imagining a dialogue with his relational partner and quoting what would be his response to her. (The formulation of the CL's response as imagined dialogue is particularly important in that it is ech-

oed in another encounter discussed in Excerpt 2.) In line 313, the CL contrasts his personal situation ("well I have to wait") with what the partner may perceive as their situation as a couple. This is the situation the CL wishes to avoid because, as his turn continues, he points out that his partner will require an explanation for why he has to wait 6 months to have sex without a condom. What must be kept in mind is that the CL has not actually had this conversation about safer sex with his partner; the CL is simply projecting a potential conversation that might occur.

Although his turn is prosodically and grammatically complete (Ford & Thompson, 1996), the CL tacks on the imaginary demand for further clarification ("cuz then she's gonna be like"; line 313) and animates (in the sense of Goffman, 1974) the character of his relational partner by voicing a question he would expect from her: "she's gonna be like weh why do you hafta wait?" (lines 313–314). Therefore, his current inability to commit to practicing safer sex is contextualized by him as hinging on some future event; the hypothetical interchange (lines 312–314) serves to account for his inability to answer the HP's question in the medically preferred way. That is, he is not admitting that he will engage in unsafe sex, but the formulation of this future event serves as a reported fact that must be confronted and dealt with in some way before he can make that commitment. Note that the CL leaves the partner's projected "why" question unanswered—leaving the implication or upshot to be drawn by the HP. Broadly outlined, we see the CL fabricate a strip of "reported" speech to create a current context that can account for his apparent resistance to practicing safer sex with a particular partner. He also leaves the upshot of his reported dilemma in the hands of the HP.

This quotative formulation is used in another HIV test counseling session in which a woman is thinking of reinitiating a sexual relationship with a long-term partner but has, in the meantime, had unprotected sex during the breakup. In that instance, CL 0007 brings up this dilemma very near the end of the session. (Note that this is a different HP than the one meeting with CL 1202.)

Excerpt 2 (CL 0007 and HP 2):

584	CL:	What about um the guy that I was with for three years.=If I wanna
585		ha-have sex again with him now,
586	HP:	Well whadda you think you [should do
587	CL:	[Then-
588		(1.0)
589	CL:	Wear a condom, (.) but he's gonna say why do you ☺ whanna wear a
590		chondhom ☺ .hh hhh
591	HP:	Well, are you and him boyfriend and girlfriend?

At line 589, the CL gives the medically correct answer—that she should use condoms with the former partner—then introduces her concern about doing so by animating her partner's question "but he's gonna say why do you whanna wear a chondhom?"

In both of these cases, CLs 1202 and 0007 animate the character of the absent partner and frame the obstacle of initiating safer sex as a conversational reality they are likely to face. It is this animation or enactment of a potential intimate dialogue that redirects the resistance to safer-sex practices from the CL to an absent partner. It is important to note that by leaving the dialogue open ended (the why question left unanswered), there is a space in which the HP can propose a solution.

Returning to the extended analysis of CL 1202, after the CL lays out the expected dialogue with his long-term partner, there is no response from the HP and a brief gap of silence takes shape.

Excerpt 3 (CL 1202 and HP1):

312 CL: … Cuz then she's gonna be like (.) weh why do you hafta wait another six
313 months?
314 (.75)
315 CL: Ya know what I mean? Li::ke,
316 (1.0)
317 HP: ((clears throat)) .hhh BUT YA SEE …

The delay at line 314 can signal incipient disagreement or reluctance to engage in disagreement (Davidson, 1984; Pomerantz, 1984), and the CL pursues a response from the HP ("Ya know what I mean? Li::ke"; line 315), which is followed by another brief silence (line 316). This formulation invites the HP to draw a conclusion or to align with the CL. Implicit in the CL's enactment of the dialogue is the fact that telling the truth is out of the question.

As noted, the delay in the HP's response to the CL's story may be a signal of disagreement with the CL's implicit objection to telling his partner that they need to initiate safer sex. Indeed, in the HP's next turn, he initiates a disagreeing statement ("BUT YA SEE … "; line 317). This disagreement is never fully articulated, and the discussion culminates in a justification from the CL that the encounter he had outside of the long-term relationship was an extremely brief encounter (15 sec) of protected sex. Rather than agreeing that this is minimally risky behavior, the HP provides an upshot that places the CL in the position of facing his risky behavior as a threat to his long-term partner's safety (Excerpt 4).

Excerpt 4 (CL 1202 and HP 1):

328 HP: so, .hhh because you can't admit to her that you've had an encounter
329 you're gonna place her life at risk, (0.5) even if it's a small amount
330 because you think it's (.) pretty unlikely.

A disagreement ensues about the relevance of the brief encounter. The CL states his belief that the HIV test he is about to get will "clear" him, which is followed by another negative assessment by the HP (Excerpt 5).

Excerpt 5 (CL 1202 and HP 1):

352 CL: SO OTHER THAN THAT THE LAST EXPERIENCE WAS SEVEN
353 MONTHS AGO so I think this test will clear me out.
354 (1.0)
355 HP: I think you're trying to rationalize.
356 (1.0)
357 HP: You're tr- [very hard to rationalize.]
358 CL: [PUT IT THIS WAY I AM NO::T] I'll be ^honest^ I am not
359 gonna te:ll (.) my girlfriend (.) two- a month and
360 [a half]
361 HP: [weh]
361 CL: from now,

Again, as in Excerpt 1, the HP proposes a negative assessment of the CL's explanation (calling it a "rationalization"; line 355). He mitigates the inference with the phrase "I think," but after receiving no response from the CL, he reformulates the observation as a more direct accusation (line 357: "You're tr- [very hard to rationalize]"). The CL overlaps the incipient accusation by raising his voice and saying (using the same formula he did previously in Excerpt 1), "PUT IT THIS WAY … ." This functions as a quick response to the accusation, while at the same time it does not actually negate what the counselor has said. Again, the formula sets up the relevance of an answer without actually being one. A reformulation is coming that is intended to respond to the accusation. In this case, the CL actually admits (as he had not previously) that he will not tell his partner about the extrarelational encounter.

Introducing Deception as a Strategy

Faced with this on-the-record admission, the HP introduces the idea of formulating a deception that could help the CL overcome the obstacle of telling the truth to his partner and thereby, from the HP's point of view, overcome the obstacle of initiating safer sex (Excerpt 6).

Excerpt 6 (CL 1202 and HP 1):

362 HP: What you could tell her how could you present this in a way that
363 doesn't give awa:y your secret.=+I'm not saying go tell your girlfriend that
364 you cheated on her.+
365 CL: But y- but you are saying thou::gh er w[a- that
366 HP: [I'm saying protect your
367 girlfriend=+Take responsibility for yourself take responsibility for
368 your girlfriend.+
369 (0.5)
370 HP: +That's what I'm tellin ya to do+ Is there a way that you could present
371 that to her in a way that does not give away the fact that you cheated on her?
372 CL: Tell me a way and I'll I'll do it.

373 HP: .hhh Well I'm let's come up with a way together, I'm I'm can you think
374 of something can you think
375 CL: THE ONLY WAY I COULD PLAY THIS on her, w- would be: (1.0)
376 cuz she's not getting tested.
377 HP: Okay?

At lines 362 and 370, rather than offering a solution (a story that could be told), the HP tries to elicit from the CL a way that he could present the need for protected sex without admitting to cheating on his long-term partner. In this way, the HP affirms and reassures the CL that the truth can be put off or avoided. At line 372, the CL requests the solution from the HP who proposes that it be something they come up with together. This approach is consistent with Miller and Rollnick's (1991) discussion of placing the onus of responsibility on the CL in motivational counseling. The CL makes an attempt at a story he could tell (line 375: "THE ONLY WAY I COULD PLAY THIS on her … "), but this digresses to another disagreement about whether or not the recent encounter should be considered unsafe.

Finding a Solution

They eventually return to the problem of what kind of story to tell the long-term partner (Excerpt 7).

Excerpt 7 (CL 1202 and HP 1):

426 CL: +*So what solution could I come to.+*
427 HP: [Well,
428 CL: [THE ONLY SOLUTION IS I COULD TELL HER THAT (.75) uhm if sshe
429 doesn't wanna get tested, then we we're gonna hafta practice sex for another
430 six months.
431 HP: Until your [follow-up test.]
432 CL: [An an] till my follow-up test.
433 HP: She- wha- +in which c[ase SHE
434 CL: [THEN SHE-
435 HP: COULD TURN AROUND AND SAY OKAY WELL I'LL GO BE
436 ^TESTED.^ +
437 (.75)
438 Which you puts you right back in the same.=So that's a good? that's a good
439 thought. We're [getting there.]
440 [that's the] only one that I could-that's the [only wa
441 HP: [I'LL TELL ONE
442 THAT I I have told clients, male clients before who have been exactly the
443 same shoes that you have.
444 CL: Right.=
445 HP: Uhm,

At line 426, the CL again looks to the counselor for an answer to this problem and asks "So what solution could I come to," but quickly embarks on a proposal. The counselor marks a flaw in the CL's story (line 435), but encourages him to continue, saying that the CL has had "a good thought" and noting that "We're getting there." The CL falteringly admits that it is the only solution he can think of. In the course of this admission, the HP interrupts with a solution that he has advised other male CLs to use (lines 442–443), that is, the CL could tell his partner that he has urethritis, which the HP explains as a kind of male version of a yeast infection (data not shown). This is the same strategy (i.e., yeast infection) offered by a different counselor to CL 0007, the woman who wanted to return to a previous long-term partner (Excerpt 2).

To summarize, the HP tries to elicit from the CL a way that the CL could present the need for protected sex without admitting to cheating on his long-term partner (line 370–371). The CL clearly wants to get a solution from the HP (line 372), who again repeats that it is something they should come up with together (line 373). Eventually, the CL directly asks the HP for a solution but embarks briefly on the exploration of his own strategy (a solution that the HP notes is flawed). The CL then offers that it is the only solution he can think of, at which point the HP proposes the yeast infection deception.

CL 1202 enthusiastically takes up the HP's idea but, as the session moves to a close, there is a slight faltering. The HP asks the CL whether he will be able to follow through with the deception (Excerpt 8) and thereby initiate safer sex with the long-term partner. The CL says he cannot "guarantee" it because he still believes that a negative result from the current test will be a signal that he is not HIV positive. He says that they will practice safer sex for the next month (because his partner has just gone on the birth control pill) but after that, there is no guarantee.

Excerpt 8 (CL 1202 and HP 1):

493	HP:	Okay? Does that sound like- do you think that in four months you could you
494		could say that to her an
495	CL:	Weh I I hhhhh ((audible as sigh)) I can *guarantee* for *sure* that we're gonna
496		have protected sex for the next month,
497	HP:	[Okay.
498	CL:	[I can guarantee for sure that I'll have my results back by then and if they are
499		hopefully thank God that they'll be negative
500	HP:	Mhmm?
501		(.75)
502	CL:	then (2.25) then I may the the I don't know I can't *guarantee* though, but the
503		I'll definitely really consider the the urithrarisis?
504	HP	Uretharitis.=[Jus tell her it's a male]
505	CL	[Uretharas]
506	HP	version of a yeast infection
507	CL	Right.
508	HP	So it's really no big deal. I'm not telling you that I think you're positive, I'm
509		just saying ya know there has been some risk there
510	CL	Right.

Thus, the CL makes no promise to the HP because he is still not convinced that the recent encounter (i.e., 15 sec of protected sex) could have infected him with HIV. Based on this, the CL believes that the test, if negative, will be the clean bill of health he needs to avoid initiating safer sex with his long-term partner, and therefore, avoid the challenge of how to explain the situation to her. He does say, however, that he will "consider" the yeast infection explanation when the time comes (lines 502–503).

DISCUSSION

In these pre-HIV test counseling sessions, CLs and HPs work together to manage a particularly sensitive dilemma: reinitiating safer-sex practices with a long-term sexual partner. In the CLs' estimation, the change in usual intimate behaviors would require explaining to their long-term partners that they had engaged in extrarelational sexual encounters. Consequently, the truth becomes an obstacle to their ability to initiate safer sex. However, this obstacle is never overtly stated by the CLs. Rather, they formulate their resistance to initiating safer-sex practices by invoking, through imagined dialogue, their partners' need for explanation about the change in their usual intimate behaviors. It is this imagined question, glossed roughly here as "well, why do we need to use condoms now?" (formulated as what the partner would say) that occasions the HP's mention of using deception as a compliance-gaining strategy (in the cases studied here, a yeast infection is the solution offered) and the planning of the deceptive message ensues. The findings of this study point to practical and methodological implications of studying deception in interpersonal health care situations and pose interesting possibilities for future research.

Practical Implications

For the HP, whose job is to provide CLs with strategies for practicing safer sex (Kinnell & Maynard, 1996; Mattson, 1995; Silverman & Peräkylä, 1990; Silverman, Peräkylä, & Bor, 1992), overcoming this CL-centered obstacle about truth telling becomes a central concern and necessitates a compliance-gaining strategy. The practitioner first encourages the CL to discover a way to get around the partner's imagined need for explanation, and then offers the solution of the yeast infection. The HP attempts to find a way to help the CL obscure the truth and in this way overcomes truth telling as an obstacle to initiating safer sex.

Initiating this strategy may be an important way to reduce the spread of AIDS and further emphasize the unique role of HIV test counseling in the risk reduction process. Planning a deceptive message gives counselors and CLs another avenue for addressing the concerns of CLs in practicing safer sex. Furthermore, incorpo-

rating this strategy into HIV test counseling sessions may help reduce the number of CLs who do not return for their HIV test results (Bell, Molitor, & Flynn, 1997; Valdiserri, Moore, & Gerber, 1993). If CLs leave the HIV test counseling session with an effective strategy for responding to their sexual partners, they may be more likely to return for their HIV test results because they would have been compliant with safer-sex recommendations. Noncompliance with safer-sex recommendations may be a reason why CLs do not return to receive their HIV test results (Molitor, Bell, Truax, Ruiz, & Sun, 1999; Tao, Branson, Kassler, & Cohen, 1999; Wiley, Frerichs, Ford, & Simon, 1998). Future research would need to address the association between using deception as a strategy to promote safer sex and CLs returning for HIV test results.

To establish this strategy as an option for HPs and CLs during HIV testing sessions, it may be beneficial to incorporate it into the training of HIV test counselors. Trainers could educate HPs only when it is appropriate to plan a strategy involving deception with a CL. Based on the findings of this study, deception as a compliance-gaining strategy is best utilized when CLs pose an obstacle to safer sex because truth telling threatens the stability of their long-term relationship. Transcribed excerpts from this research could then serve as the basis for developing role-playing exercises to be used during training. Therefore, the training would be grounded in actual health communication practices.

The findings of this study also fit in an interesting way with earlier research on deception detection that predominantly indicates that people are not very accurate at detecting the deceptions of their relational partners (Buller, Strzyzewski, & Hundaker, 1991; Comadena, 1982; DePaulo et al., 1980; Kraut, 1980). It may be that this lack of deception detection accuracy motivates relational partners to consider and plan the use of deception as a compliance-gaining strategy, especially in interpersonally delicate situations when telling the truth may jeopardize their relationships. Although people perceive themselves to be accurate detectors of the truthfulness of others, especially their intimate relational partners, they are not very good at detecting deception (Miller & Stiff, 1993). Therefore, this may partially account for why CLs respond positively to the HP's suggestion of using deception as a compliance-gaining strategy. On one hand, it allows CLs the opportunity to avoid divulging uncomfortable truths, and on the other hand, they may have an intuitive sense that "pulling off" such a deception will be relatively easy.

Methodological Implications

Deception research has rarely, if ever, studied communication about deception or the planning of deceptive messages in situ. To our knowledge, this is the first study to do so. By examining actual stretches of talk in interaction, we are able to better understand the situated, communicative practices of participants in so-

cial and institutional settings. These data provide a rich resource for understanding the ways in which HPs and CLs interact to produce the form and content of their visits. In these cases, we have seen how the taboo practice of deception can be formulated as a necessary and even desirable approach for promoting healthful intimate behaviors between partners, and as a way to help them maintain their long-term relationships.

Limitations and Future Directions

Despite these intriguing results, suggesting and planning deceptive messages with CLs as a way to promote healthy behaviors is a relatively new and potentially controversial area of study. Therefore, clinical applications are presented with caution. The ethical ramifications of suggesting deception as a strategy to encourage CLs and their partners to practice safer sex may make this approach problematic.

For example, if CLs heed HPs' advice to tell their partners that they have a yeast infection to persuade them to use a condom, there is a risk that this deception will be discovered posing serious consequences for their relationships (e.g., termination; Shackelford & Buss, 1997), or CLs may experience negative psychological repercussions as a result of lying to their partners. Nevertheless, in attempting to mediate the concerns of self and other in communication with intimate partners, an individual may need to suppress personal beliefs or deceive the other to protect self and other. Rawlins (1983a) put it this way:

> Ironically, deceptiveness exhibits some of the identical personal qualities as are often found in responsible communication, that is, the self-conscious doctoring of message content by an autonomous individual with an eye to the interpersonal consequences. Thus, deceptive practices comprise the dark side of responsibly strategic communication in relationships, the morally questionable underbelly. (p. 166)

This inevitable existence of deception in relationships is balanced with an acknowledgment that some forms of deception (i.e., dark shams) are exploitative and destructive because they take advantage of the other and undermine the relationship (Rawlins, 1983a, 1983b, 1992). Revisiting Dillard et al.'s (1989) conceptualization of primary and secondary goals may clarify the difference here. In these cases, the short-term deception (i.e., primary goal) is clearly not ideal, but it may become more acceptable when considering the secondary goal of avoiding the negative outcomes (i.e., transacting HIV) associated with not practicing safer sex when the HIV status of a partner is in question.

Research in health care contexts has not sufficiently examined the use of deception as a compliance-gaining strategy to promote disease prevention behaviors. However, given previous research regarding the inaccuracy of deception detection in interpersonal relationships and research on primary and secondary goals, it

would seem that deception may pose a viable, albeit controversial, option when promoting disease prevention behaviors especially in delicate interpersonal interactions (e.g., not wanting to admit an extrarelational affair). Our findings indicate that deception may be comfortably introduced into a pre-HIV test counseling session as a strategy for initiating healthful behaviors. Also, given that some health research has broached the subject of deception in the communication of difficult diagnoses to patients and partner notification of positive HIV status, and that there is at least anecdotal evidence suggesting that deception is used in other health-related interactions (e.g., to resist peer pressure to use tobacco products or illicit drugs), it seems appropriate to expand the study of deception to other health related situations.

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REFERENCES

Annuziata, M. A., Talamini, R., Tumolo, S., Rossi, C., & Monfardini, S. (1996). Physicians and death: Comments and behaviour of 605 doctors in the Northeast of Italy. *Supportive Care in Cancer, 4,* 334–340.

Baxter, L. A., & Montgomery, B. M. (1996). *Relating: Dialogues and dialectics.* New York: Guilford.

Beardsell, S., & Coyle, A. (1996). A review of research on the nature and quality of HIV testing services: A proposal for process-based studies. *Social Science Medicine, 42,* 733–743.

Bell, R. A., Molitor, F., & Flynn, N. (1997). On returning for one's HIV test result: Demographic, behavioral and psychological predictors. *AIDS, 11,* 263–264.

Benson, D., & Hughes, J. (1991). Method: Evidence and inference-evidence and inference for ethnomethodology. In G. Button (Ed.), *Ethnomethodology and the human sciences* (pp. 109–136). Cambridge, England: Cambridge University Press.

Brandt, D. R., Miller, G. R., & Hocking, J. E. (1982). Familiarity and lie detection: A replication and extension. *Western Journal of Speech Communication, 46,* 276–290.

Buller, D. B., & Burgoon, J. K. (1996). Interpersonal deception theory. *Communication Theory, 6,* 203–242.

Buller, D. B., Strzyzewski, K. D., & Hundaker, F. G. (1991). Interpersonal deception II: The inferiority of conversational participants as deception detectors. *Communication Monographs, 58,* 25–40.

Burgoon, J. K., Buller, D. B., Guerrero, L. K., Afifi, W. A., & Feldman, C. M. (1996). Interpersonal deception XII: Information management dimensions underlying deceptive and truthful messages. *Communication Monographs, 63,* 50–69.

Cody, M. J., Marston, P. J., & Foster, M. (1984). Deception: Paralinguistic and verbal leakage. In R. N. Bostrom (Ed.), *Communication yearbook 8* (pp. 464–490). Beverly Hills: Sage.

Comadena, M. E. (1982). Accuracy in detecting deception: Intimate and friendship relationships. In M. Burgoon (Ed.), *Communication yearbook 6* (pp. 446–472). Beverly Hills: Sage.

Davidson, J. (1984). Subsequent versions of invitations, offers, requests, and proposals dealing with potential or actual rejection. In J. M. Atkinson & J. Heritage (Eds.), *Structures of social action* (pp. 102–128). Cambridge, England: Cambridge University Press.

DePaulo, B. M., Zuckerman, M., & Rosenthal, R. (1980). Humans as lie detectors. *Journal of Communication, 30,* 129–139.

Derlega, V. J., Lovejoy, D., & Winstead, B. A. (1995). Personal accounts of disclosing and concealing HIV-positive test results. In V. J. Derlega & A. P. Barbee (Eds.), *HIV & social interaction* (pp. 147–164). Thousand Oaks, CA: Sage.

Dillard, J. P., Segrin, C., & Harden, J. M. (1989). Primary and secondary goals in the production of interpersonal influence messages. *Communication Monographs, 56,* 19–38.

Ekman, P. (1985). *Telling lies: Clues to deceit in the marketplace, politics, and marriage.* New York: Norton.

Ekman, P., & Friesen, W. V. (1969). Nonverbal leakage and clues to deception. *Psychiatry, 32,* 88–106.

Ekman, P., & Friesen, W. V. (1974). Detecting deception from the body and face. *Journal of Personality and Social Psychology, 20,* 288–298.

Ekman, P., & O'Sullivan, M. (1991). Who can catch a liar? *American Psychologist, 46,* 913–920.

Ford, C. E., & Thompson, S. A. (1996). Interactional units in conversation: Syntactic, intonational, and pragmatic resources for the management of turns. In E. Ochs, E. A. Schegloff, & S. A. Thompson (Eds.), *Interaction and grammar* (pp. 134–184). Cambridge, England: Cambridge University Press.

Gielen, A. C., O'Campo, P., Faden, R. R., & Eke, A. (1997). Women's disclosure of HIV status: Experiences of mistreatment and violence in an urban setting. *Women & Health, 25,* 19–31.

Goffman, E. (1974). *Frame analysis: An essay on the organization of experience.* Cambridge, MA: Harvard University Press.

Greene, J. O., O'Hair, D., Cody, M. J., & Yen, C. (1985). Planning and control of behavior during deception. *Human Communication Research, 11,* 335–364.

Greene, K., & Serovich, J. M. (1996). Appropriateness of disclosure of HIV testing information: The perspective of PLWAs. *Journal of Applied Communication Research, 24,* 50–65.

Hays, R. B., McKusick, L., Pollack, L., Hilliard, R., Hoff, C., & Coates, T. J. (1993). Disclosing HIV seropositivity to significant others. *AIDS, 7,* 425–431.

Heritage, J. (1988). Explanations as accounts: A conversation analytic perspective. In C. Antaki (Ed.), *Analysing everyday explanation: A casebook of methods* (pp. 127–144). London: Sage.

Holt, R., Court, P., Vedhara, K., Nott, K. H., Holmes, J., & Snow, M. H. (1998). The role of disclosure in coping with HIV infection. *AIDS Care, 10,* 49–60.

Jefferson, G. (1974). Error correction as an interactional resource. *Language and Society, 2,* 181–199.

Johnston, M., Earll, L., Mitchell, E., Morrison, V., & Wright, S. (1996). Communicating the diagnosis of motor neurone disease. *Palliative Medicine, 10,* 23–34.

Kalbfleisch, P. J. (1985). *Accuracy in deception detection: A quantitative review.* East Lansing: Michigan State University.

Kimberly, J. A., Serovich, J. M., & Greene, K. (1995). Disclosure of HIV-positive status: Five women's stories. *Family Relations, 44,* 316–322.

Kinnell, A. M. K., & Maynard, D. W. (1996). The delivery and receipt of safer sex advice in pretest counseling sessions for HIV and AIDS. *Journal of Contemporary Ethnography, 24,* 405–437.

Knapp, M. L., Hart, R. P., & Dennis, H. S. (1974). An exploration of deception as a communication construct. *Human Communication Research, 1,* 15–29.

Kraut, R. E. (1978). Verbal and nonverbal cues in the perception of lying. *Journal of Personality and Social Psychology, 36,* 380–391.

Kraut, R. E. (1980). Humans as lie detectors: Some second thoughts. *Journal of Communication, 30,* 129–139.

Lakoff, G. (1971). Presupposition and relative well-formedness. In D. D. Steinberg & L. A. Jakobvits (Eds.), *Semantics: An interdisciplinary reader* (pp. 329–340). Cambridge, England: Cambridge University Press.

Marks, G., Bundek, N. I., Richardson, J. L., Ruiz, M. S., Maldonado, N., & Mason, H. R. C. (1992). Self-disclosure of HIV infection: Preliminary results from a sample of Hispanic men. *Health Psychology, 11,* 300–306.

Marks, G., Richardson, J. L., & Maldonado, N. (1991). Self-disclosure of HIV infection to sexual partners. *American Journal of Public Health, 81,* 1321–1323.

Masera, G., Chesler, M. A., Jankovic, M., Ablin, A. R., Ben Arush, M. W., Breatnach, F., McDowell, H. P., Eden, T., Epelman, C., Fossati Bellani, F. M. G. D., Kosmidis, H. V., Nesbit, M. E., Wandzura, C., Wilbur, J. R., & Spinetta, J. J. (1997). SIOP working committee on psychosocial issues in pediatric oncology: Guidelines for communication of the diagnosis. *Medical & Pediatric Oncology, 28,* 382–385.

Mason, H. R. C., Marks, G., Simoni, J. M., Ruiz, M. S., & Richardson, J. L. (1995). Culturally sanctioned secrets?: Latino men's nondisclosure of HIV infection to family, friends, and lovers. *Health Psychology, 14,* 6–12.

Mattson, M. (1995). *Reconceptualizing communication cues to action in the Health Belief Model: HIV test counseling.* Tempe: Arizona State University.

Mattson, M. (1999). Reconceptualizing communication cues to action in the Health Belief Model: HIV test counseling. *Communication Monographs, 66,* 240–265.

McLaughlin, M. L., Cody, M. J., & O'Hair, H. D. (1983). The management of failure episodes: Some contextual determinants of accounting behavior. *Human Communication Research, 9,* 208–224.

Miller, G. R., deTurck, M. A., & Kalbfleisch, P. J. (1983). Self-monitoring, rehearsal, and deceptive communication. *Human Communication Research, 10,* 97–117.

Miller, G. R., & Stiff, J. B. (1993). *Deceptive communication.* Newbury Park, CA: Sage.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford.

Molitor, F., Bell, R. A., Truax, S. R., Ruiz, J. D., & Sun, R. K. (1999). Predictors of failure to return for HIV test result and counseling by test site type. *AIDS Education & Prevention, 11,* 1–13.

Mongeau, P. A., Hale, J. L., & Alles, M. (1994). An experimental investigation of accounts and attributions following sexual infidelity. *Communication Monographs, 61,* 326–344.

Mongeau, P. A., & Schulz, B. E. (1997). What he doesn't know won't hurt him (or me): Verbal responses and attributions following sexual infidelity. *Communication Reports, 10,* 143–152.

Neighbors, C. J., O'Leary, A., & Labouvie, E. (1999). Domestically violent and nonviolent male inmates' responses to their partners' requests for condom use: Testing a social-information processing model. *Health Psychology, 18,* 427–431.

Neuliep, J. W., & Mattson, M. (1990). The use of deception as a compliance-gaining strategy. *Human Communication Research, 16,* 409–421.

Niccolai, L. M., Dorst, D., Myers, L., & Kissinger, P. J. (1999). Disclosure of HIV status to sexual partners: Predictors ad temporal patterns. *Sexually Transmitted Diseases, 26,* 281–285.

Perry, S., Ryan, J., Fogel, K., Fishman, B., & Jacobsberg, L. (1990). Voluntarily informing others of positive HIV test results: Patterns of notification by infected gay men. *Hospital & Community Psychiatry, 41,* 549–551.

Pomerantz, A. (1984). Agreeing and disagreeing with assessments: Some features of preferred/dispreferred turn shapes. In J. M. Atkinson & J. Heritage (Eds.), *Structures of social action: Studies in conversation analysis* (pp. 57–101). Cambridge, England: Cambridge University Press.

Pomerantz, A., & Fehr, B. J. (1997). Conversation analysis: An approach to the study of social action as sense making. In T. A. Van Dijk (Ed.), *Discourse as social interaction* (pp. 64–91). London: Sage.

Psathas, G. (1995). *Conversation analysis: The study of talk-in-interaction.* Thousand Oaks, CA: Sage.

Rawlins, W. K. (1983a). Individual responsibility in relational communication. In M. Mander (Ed.), *Communications in transition* (pp. 152–167). New York: Praeger.

Rawlins, W. K. (1983b). Openness as problematic in ongoing friendships: Two conversational dilemmas. *Communication Monographs, 50,* 1–13.

Rawlins, W. K. (1992). *Friendship matters: Communication, dialectics, and the life course.* New York: Aldine de Gruyter.

Righetti, A., & Giogio, G. (1994). Factors influencing the communication of the diagnosis to patients who have cancer. *Journal of Cancer Education, 9,* 42–45.

Rogers, S. J., Tross, S., Doino-Ingersol, J., & Weisfuse, I. (1998). Partner notification with HIV-infected drug users: Results of formative research. *AIDS Care, 10,* 415–429.

Rothenberg, K. H., Paskey, S. J., Reuland, M. M., Zimmerman, S. I., & North, R. L. (1995). Domestic violence and partner notification: Implications for treatment and counseling of women with HIV. *Journal of the American Medical Womens Association, 50*(3/4), 87–93.

Rutherford, G. W., Woo, J. M., Neal, D. P., Rauch, K. J., Geoghegan, C., McKinney, K. C., McGee, J., & Lemp, G. F. (1991). Partner notification and the control of human immunodeficiency virus infection: Two years of experience in San Francisco. *Sexually Transmitted Diseases, 18,* 107–110.

Sacks, H. (1995). *Lectures on conversation.* Oxford, England: Basil Blackwell.

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language, 50,* 696–735.

Schegloff, E. A., & Sacks, H. (1973). Opening up closings. *Semiotica, 8,* 289–327.

Schenck-Hamlin, W., Wiseman, R. L., & Georgacarakos, G. (1982). A model of properties of compliance-gaining strategies. *Communication Quarterly, 30,* 92–99.

Schnell, D. J., Higgins, D. L., Wilson, R. M., Goldbaum, G., Cohn, D. L., & Wolitski, R. J. (1992). Men's disclosure of HIV test results to male primary sex partners. *American Journal of Public Health, 82,* 1675–1676.

Seitter, J. S. (1997). Honest or deceitful?: A study of persons' mental models for judging veracity. *Human Communication Research, 24,* 216–259.

Shackelford, T. K., & Buss, D. M. (1997). Anticipation of marital dissolution as a consequence of spousal infidelity. *Journal of Social and Personal Relationships, 14,* 793–808.

Silverman, D., & Peräkylä, A. (1990). AIDS counseling: The interactional organisation of talk about 'delicate' issues. *Sociology of Health & Illness, 12,* 293–318.

Silverman, D., Peräkylä, A., & Bor, R. (1992). Discussing safer sex in HIV counseling: Assessing three communication formats. *AIDS Care, 4,* 69–82.

Stein, M. D., Freedberg, K. A., Sullivan, L. M., Savetsky, J., Levenson, S. M., Hingson, R., & Samet, J. H. (1998). Sexual ethics: Disclosure of HIV-positive status to partners. *Archives of Internal Medicine, 158,* 253–257.

Stein, M. D., & Samet, J. H. (1999). Disclosure of HIV status. *AIDS Patient Care & STDs, 13,* 265–267.

Stiff, J. B., & Miller, G. R. (1986). "Come to think of it … ": Interrogative probes, deceptive communication, and deception detection. *Human Communication Research, 12,* 339–357.

Tao, G., Branson, B. M., Kassler, W. J., & Cohen, R. A. (1999). Rates of receiving HIV test results: Data from the U.S. National Health Interview Survey for 1994 and 1995. *Journal of Acquired Immune Deficiency Syndromes, 22,* 395–400.

Valdiserri, R. O., Moore, M., & Gerber, A. R. (1993). A study of clients returning for counseling after HIV testing: Implications for improving rates of return. *Public Health Reports, 108,* 12–18.

Vrij, A., Semin, G. R., & Bull, R. (1996). Insight into behavior displayed during deception. *Human Communication Research, 22,* 544–562.

West, G. R., & Stark, K. A. (1997). Partner notification for HIV prevention: A critical reexamination. *AIDS Education and Prevention, 9*(Suppl. A), 68–78.

Wiley, D. J., Frerichs, R. R., Ford, W. L., & Simon, P. A. (1998). Failure to learn human immunodeficiency virus test results in Los Angeles public sexually transmitted disease clinics. *Sexually Transmitted Diseases, 25,* 342–345.

Zuckerman, M., Amidon, M. D., Bishop, S. E., & Pomerantz, S. D. (1982). Face and tone of voice in the communication of deception. *Journal of Personality and Social Psychology, 43,* 347–357.

Zuckerman, M., DeFrank, R. S., Hall, J. A., Larrance, D. T., & Rosenthal, R. (1979). Facial and vocal cues of deception and honesty. *Journal of Experimental Social Psychology, 15,* 378–396.

Zuckerman, M., DePaulo, B. M., & Rosenthal, R. (1981). Verbal and nonverbal communication of deception. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 14, pp. 1–59). New York: Academic.

Zuckerman, M., & Driver, R. (1985). Telling lies: Verbal and nonverbal correlates of deception. In A. W. Siegman & S. Feldstein (Eds.), *Nonverbal communication: An integrated perspective* (pp. 129–147). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Zuckerman, M., Koestner, R., & Alton, A. O. (1984). Learning to detect deception. *Journal of Personality and Social Psychology, 46,* 519–528.

Appendix A
Transcription Symbols

.	Falling, "final" intonation as at the end of a sentence
,	Continuing, "comma" intonation as in speaking a list
?	Rising intonation
:	Sound stretch; usually elongation of a vowel
CAPS	Louder than surrounding talk
* *	Reduced volume between these signs
+ +	Faster speech between these signs
___	(underline) Stressed element
^	Speech between these signs is hearable as higher in pitch
☺	"Smiling voice"—vocalic cues indicate speaker is smiling as they speak
(.)	Untimed "micropause" (less than half of a second)
(1.0)	Timed pause, represented in seconds
=	Talk that is latched, quick continuation, no pause between the utterances
[	Marks onset of overlap
-	(hyphen) Speaker cuts own speech
( )	Transcriber doubt
((sniff))	Untranscribed sound
…	(horizontal or vertical) ellipsis