

AIDS / REPRESENTATION AND PSYCHOLOGICAL PRACTICE:  
(INTER)SUBJECTIVITY IN HIV COUNSELLING

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## ABSTRACT

This study undertakes a discourse analysis of a counselling session with an HIV positive man. Literature, informed by post-structuralism, on the representations and practices that surround the HIV/AIDS epidemic is examined as a background to the study. Self psychological theory concerning mourning, the psychodynamic consequences of having AIDS and selfobject phantasies is examined. This theory is criticised for ignoring the content of phantasies as well as the imbrication of the subject within the social. In an attempt to address these gaps theorisation of stigma and gendered development is introduced, as well as Hollway's (1984) broadly Foucauldian notions of investment in subject positionings. A multiple theoretical position conceptualising counselling as (inter)subjective process re-producing particular subject positionings is developed. The relations between various subject positions are described, drawing on self psychological theory to consider the investments the participants in the session may have had in each position. The analytic reading suggests that in the elaboration of particular selfobject phantasies the HIV positive client is able to cohes his sense of self and to disavow a knowing of himself as a stigmatised person with AIDS. The counsellor, through subject positionings which are in conjuncture with those of the client, disavows a knowing of the client as a person with AIDS. Through these positionings a necessary allusion of attunement is produced, allowing the counsellor to mirror the client. From this analysis various implications for consultation, supervision and training are drawn. The study suggests that multiple ways in which HIV/AIDS is represented requires psychologists to explore their own positionings with regards to salient HIV/AIDS related issues, as these positionings have effects in work in this field.

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## CONTENTS

CHAPTER 1: INTRODUCTION: HIV/AIDS, REPRESENTATION AND PSYCHOLOGY	1
Knowing the Process of Counselling	1
A Note About First and Third Person Voice	2
Selves, Subjectivity and (Inter)subjectivity	3
Subjects, Subjectivity and (Inter)subjectivity: Some Definitions and Uses of Terms	3
AIDS and Representation	5
HIV Counselling: From Self-Contained Individualism to (Inter)subjectivity	6
CHAPTER 2: SELVES, SUBJECTIVITY AND (INTER)SUBJECTIVITY	8
Self Psychology: Knowing a 'Sense of Self'	8
The Elaboration of Selfobject Phantasies	9
Intersubjective Attunement, Transitional Spaces and Illusion	11
Coping, Selfobject Phantasy, Mourning and HIV/AIDS	13
Phantasy and the Forms of Representation	14
Theoretical Contrasts and Bridges: A Caveat and a Motivation	15
Representing AIDS: Stigma and the Dynamic of 'The Other as Diseased'	16
Gendered Subjectivity and HIV/AIDS	18
Defence, Investment and Subject Positions	19
Selfobject Phantasies, Representation and Investment	21
CHAPTER 3: METHODOLOGY	22
Theoretical Tensions and Questions: Knowing, Developing Knowing and Erasing Knowing	22
Method	23
CHAPTER 4: ANALYTIC READING:	
AIDS/REPRESENTATION AND (INTER)SUBJECTIVITY	25
Initial (Inter)subjective Exchange: Pragmatics, Rationality and Disavowal	25
A Disavowal, an (Inter)subjective Conjunction and a Shift in My Representation of Phillip	26
Phillip as Other, as the 'AIDS Patient'	30
Phillip's Subjectivity: Father-With-Family	31
The Unsaid Voiced and Disavowed: Self as an AIDS Sufferer	33
The Gendered Nature of Phillip's Selfobject Phantasies	35
It's Not the Sickness: Otherness and Aloneness	36
Finding a Responsive Selfobject Milieu	38
Attunement and Disavowal	40

CHAPTER 5: AIDS/REPRESENTATION AND PSYCHOLOGICAL PRACTICE	42
HIV/AIDS and Psychological Practice	42
Potential Roles of Psychology in HIV/AIDS	42
Implications of the Analytic Reading for Consultative, Supervision and Training Work	43
1. Implications of the Model of Mourning and Coping	43
1.1. The Relation of Counselling to Advocacy and Development	43
1.2. The Model as a Framework of Knowing	44
2. Implications of Viewing Counselling as an (Inter)subjective Process	44
2.1. A Corollary: There is Not One Process for People with HIV/AIDS	45
2.2. There is Not One Process for the Counsellor	46
2.2.1. Implications for Counsellor Coping	47
2.2.2. Follow Up and Contracting	47
2.3. Counselling Does Not Equal Information Exchange	48
CHAPTER 6: CONCLUSION	49
REFERENCES	52
APPENDIX	

## CHAPTER 1. INTRODUCTION: HIV/AIDS, REPRESENTATION AND PSYCHOLOGY

**The stories are tokens of the man, talismans of the salient and defining history which has shaped him. They are not, on that account, unique to this occasion, but are invoked as touchstones of his presence.**

Katherine Young (1989:162)

### Knowing the Process of Counselling

While working as an HIV/AIDS counsellor I became conscious that certain aspects of my experience in working in this field were not able to be articulated within the available discourses of counselling practice. I was constantly made aware, in the fragments of moods before, during and after counselling sessions, that central and important aspects of the experience, for myself as well as for the clients, were erased. My awareness of the fragments, contradictions and splits in the experience of counselling was in part due to my training as a psychologist, and the theoretical spaces through which I had come (feminist theory, post-structuralist psychology and self psychology). Drawing on these experiences as an HIV/AIDS counsellor, this study undertakes a detailed analysis of the process of an HIV/AIDS counselling session I ran with an HIV positive man ("Phillip"). The work originated while working in public clinic dealing with HIV/AIDS related work, during the internship component of my clinical psychology training. In this context, contacts with clients are often brief, with little follow up for most clients, who may return only after several months.

Ussher (1993), writing about a parallel experience, has argued that aspects of her clinical psychology training, which positioned her as a scientist practitioner (where as a counsellor she was objective and value free) left a gap in knowing about the issues of power and gender that she encountered in her HIV/AIDS related work. Ussher found feminist therapy as a solution in her struggle to know and work with these aspects of herself and her clients. Conceiving of my work in rational objectivist terms (i.e. that as a counsellor I was a scientist practitioner, uninvolved in the session, and that the process in the session had nothing to do with non-rational or relational processes) led in part to the erasures of knowing in my experience. In some ways understanding the experience of counselling in these rational objectivist terms made it manageable, and certainly representing myself as understanding the processes of counselling in these terms made it accessible and presentable to biomedically dominated ward rounds. Various writers, from divergent theoretical positions, have criticised the notion that psychologists are objective and uninvolved in the work they do, emphasising the intricate involvement of psychologists within their work (Henriques, Hollway, Venn, Urwin and Walkerdine, 1984; Thomson, P.G., 1994; Maw, 1996; Slochower, 1996). The study draws on the intersubjective perspective,

which considers therapy as a interactive process in which the subjectivities of both participants contribute to the unfolding therapeutic relationship (Stolorow, Brandchaft and Atwood, 1987; Stolorow and Atwood, 1992). Part of what the study will demonstrate, through the analysis it develops, is that an understanding of the processes of counselling can be usefully informed by theory developed in the context of therapy (Grace, 1994). The study will not examine the debate that exists concerning the differentiation of counselling and therapy (Lindegger, 1994).

The process of becoming a counsellor is a struggle, which in many ways was repeated during the analysis that became this study. The process of understanding the session in some ways has been a microcosm of the experience of counselling more generally. In the session I experienced a shift from being anxious and wanting to contain, to becoming a listener, and left the session feeling that it had little to do with HIV or AIDS. Yet, when transcribing the session I became sad and felt that it would be wrong to analyse it. As will be shown through the study, these experiences reflect and are produced in the process of the session. While most research contains struggles for the researcher, these are usually (especially within an empiricist paradigm) not articulated in the research (Pilgram, 1990). I have attempted to make this struggle part of the research. Peter Thomson (1991 and 1994) argues for the utility of integrating one's own struggles, one's countertransference, into an understanding of one's work. Countertransference is understood in this study as the experiences a counsellor or therapist has in relation to a client, produced both by the interaction with the client, as well as by the issues and positionings one brings to the work (Thomson, P.G., 1994).

#### A Note About First and Third Person Voice

In this study I am engaging with my own feelings and responses in the session, my countertransference. The session is about Phillip's life, it is about our two subjectivities. The analysis is also about a reading, a knowing of this session, that is intimate and personal. To word this in a language that presents the author (myself) as non-identified and uninvolved in the session and the analysis, neutral and value free seems false, for I am not these things in the session, and the analysis works crucially on the level of both our subjectivities. We are two people, who's experiences together make what transpires in the session. I am not a neutral value free observer, and it is questionable whether that is a desirable, let alone attainable, goal (Ussher, 1993). For these reasons I use the first person voice in this paper. It is crucially important to see the effect of one's positioning in the session, not to pretend it has no effect, or that what the person brings has no effect on the counsellor. This is fundamental in the intersubjective approach (Thomson, P.G., 1994).

## Selves, Subjectivity and (Inter)subjectivity

Chapter 2 develops theory which makes the intersubjective analysis of a counselling session possible. Self psychological theory concerning the elaboration of selfobject phantasies, mourning and the psychodynamic consequences of having HIV or AIDS is examined and critiqued. Various shortfalls in the theory, concerning its treatment of gender and the content of phantasy, are noted. Other theory, concerning the gendered nature of development is introduced in an attempt to address these gaps. Theory around the dynamics of stigma is introduced and critiqued. Hollway's (1984) discussion of the investment in particular subject positions as producing particular forms of relating is introduced in order to examine how subjectivity is re-produced in the intersubjective exchange of the session. This theory is useful in exploring how subject positionings produce both the ways in which we manage the experience of Phillip having 'AIDS' and the unfolding of the counselling work. The background of the theoretical position developed in this study is provided by a body of literature, influenced by post-structuralism, that has examined the meanings and practices around HIV/AIDS. A brief exposition of some key concepts in this writing, and which are employed in the study, is useful.

## Subjects, Subjectivity and (Inter)subjectivity: Some Definitions and Uses of Terms

Models of counselling, as well as much psychological theory, have long presupposed that persons are self-contained individuals - self-contained, self-possessive, original, independent and self-reliant (Henriques, et al, 1984; Sampson, 1989). Such a model of subjectivity presents people as in rational control of themselves and as relatively unaffected by social or relational factors or processes and certainly with a division between the individual and the social (Henriques, et al, 1984; Shotter, 1989). The use of the terms 'subject', 'subjectivity' and '(inter)subjectivity' in this study are grounded in the deconstruction of the notion of the subject as self-contained, which has been effected by post-structuralist and social constructionist writers (Foucault, 1977, 1978 and 1980; Gordon, 1979; Parker, 1989; Sampson, 1989; Shotter, 1989) and the similar displacing of this representation of subjectivity in psychoanalytic theory (Kohut, 1984; Wolf, 1988; Flax, 1990). Psychoanalytic theory provides useful accounts of the continuity of subjectivity (a continuity that may be contradictory) and certain post-structuralist work provides useful accounts of the historical, political and social contingencies of selfhood (Henriques, et al, 1984). The decentering of self-contained individualist conceptualisations of subjectivity does not imply that subjects are illusory - that selfhood is an illusion, constructed by and existing only in particular discourses. This would be to posit a social determinism, or that the discourse, out of context of the social forms of which is a 'part' or a 'reflection', determines the subjectivity (Hollway, 1984; Parker, 1992; Parker and Burman, 1993).

One sense of the term subject is that to be a subject (to have a subjectivity, a selfhood) is to be a self known through, or presented within a discourse. One might say one speaks through or within a discourse. Certain appropriations of discourse analysis, embodying this sense, thus regard discourses as resources, which can be drawn on in narrating a self (Potter and Wetherell, 1987). Thus one might say "he presented himself as a patriarch, speaking within a particular discourse of masculinity". The second sense of subject is to be subjected within a discourse. This implies that a subject is produced within discourses. One is spoken by a discourse (Foucault, 1977 and 1980; Henriques, et al, 1984). In this perspective a self that 'draws on' a discourse has already been positioned, made subject, within a discourse. One is always already positioned within a discourse, as one speaks. As one speaks one is made a subject - language produces a way of being and knowing, it produces a subjectivity (Shotter, 1989). Our talking of a self drawing on a discourse could thus be seen as the result of positioning within a particular (individualist) discourse of selfhood, which tends to imply the existence of an asocial self, out of the discursive realm of the (inter)subjective. In this study the sense of the term subject is multiple in that a self that speaks is already spoken within a discourse. Subjectivity, in the post-structuralist sense, is always already delimited, produced by one's positioning within discourses, and is always already social and political. This multiple sense of subjectivity is missing in self psychology's use of the term subjectivity. Subjectivity, in self psychology, is more the sense of self, an individual selfhood (Wolf, 1988), without the sense of the selfhood having been produced as an effect of one's subjection within discourse, within the social matrix.

Similar comments can be made about the term 'intersubjectivity'. Intersubjectivity, in self psychology, means the intersubjective field produced by the interaction of two subjectivities (Stolorow and Atwood, 1992). This sense of intersubjectivity may revert to an asocial rendering, a meeting of two disparate selves, out of any political and social context. I have bracketed the 'inter' in (inter)subjectivity in the sections employing post-structuralist theory to regain the multiple sense of subjectivity - that is, that the subjectivities both speak and are spoken within discourse. There is another meaning in this word-play, that is that subjectivity is re-produced within a relational context (such as an HIV counselling session). Every subjectivity is an (inter)subjectivity, in that the discourses through which we speak and are spoken are known and re-produced within a relational context. The discursive practices within which we are subject provide the 'voices' in which we 'speak', as well as the positions within and from which we are able to relate to others. Through our being always already spoken within particular discourses we are able to 'speak', to know and represent ourselves in particular ways. This re-produces certain relationships. In this sense, we can regard the discursive as shaping the (inter)subjective, shaping forms of practice, shaping our ways of knowing, being and relating. Discourses

provide subject positions - 'places' to take up within discourse, voices from and through which we speak and are spoken (Henriques, et al, 1984). Positioning is however complex and contradictory - over time we are positioned in multiple ways (the contradictions between subject positions are often important in understanding the investments in positions, revealing as they do the split off or unarticulated in other positions). The theorisation of subjectivity presented by Foucault and others is not without problems (for example a tendency to relativism that may be at odds with politically committed theory, like feminism (Hekman, 1990; McNay, 1992), but these criticisms are beyond the scope of this study.

## AIDS and Representation

HIV touches lives in multiple, complex and fragmented ways. Because of this, the range of issues within which it is imbricated is diverse. The ways in which it has articulated with existing social forms have been similarly complex (Watney, 1989; Frankenberg, 1989; Patton, 1990). An important body of literature has developed which examines the ideological, social and political dimensions of the epidemic as well as the genealogy of current discourses regarding HIV/AIDS. Much of this literature has been influenced by post modern and post-structuralist discussions about subjectivity and discourse. This literature has examined the relation of discourses of AIDS to discourses of other illnesses - such as cancer, syphilis, or tuberculosis (Sontag, 1983; Alcorn 1988; Gilman, 1988). This body of literature has shown a constant emphasis on the socio-political dimensions of the epidemic (Plummer, 1988; Weeks, 1989) - in the contexts of gender and sexuality (Watney, 1989 and 1993; Patton, 1990 and 1993; Wood and Foster, 1995), identity (Silverman, 1989; Watney, 1993) and race (Patton, 1990). The social construction of scientific research in HIV/AIDS (Horton and Aggleton, 1989; Patton, 1990) and news reporting of HIV/AIDS (Weeks, 1989; Lupton, 1994) have also been examined. This literature is valuable in providing a historic and contextually rooted analysis of the socio-political dimensions of the epidemic. The genealogies of HIV/AIDS discourses are illuminating and powerful, politically aware, critical, and radical. The ways in which HIV/AIDS is known and represented, and the consequent forms of practice (be these within hospitals, in counselling, in relationships) have crucial effects in many spheres - including in how people relate to HIV positive persons (in discriminatory or caring ways), in how people with HIV/AIDS know themselves, in how persons know and practise their sexualities, in governmental responses to the epidemic, and in forms of counselling practice (Plummer, 1988; Silverman, 1990; Waldby, Kippax and Crawford, 1993; Watney, 1993; Ussher, 1993; Gilmore and Somerville, 1994; Thomson, K., 1992).

## HIV Counselling: From Self-Contained Individualism to (Inter)subjectivity

Much of the literature on representing AIDS presents an image of subjectivity that is quite different from that embodied in counselling discourse. In counselling literature the image of self contained individualism is often paramount (Henriques, et al, 1984; Grace, 1994). In such a model counsellors and their clients are rational (unless the rationality is compromised in some way, for example by mental illness). The role of non-rational, non-individual or relational factors or processes in counselling and in mediating health behaviour is not considered (Henriques et al, 1984; Grace, 1994). Grace (1994) suggests that while counselling practice has certainly begun to move from a model presupposing the participant's behaviours are solely rationally motivated (implying that an exchange of information is enough to promote behaviour change) HIV counsellors are often still highly active and focus on the giving of information. Conceptualising counselling in ways which ignore the complex motivations of persons, and the relations of persons to their social, community and political contexts will lead to ineffective counselling (Balmer, 1993; Grace, 1994; Bor and Meursing, 1994; Fee and Rajani, 1995; Asthana and Oostvogels, 1996). Theorising about therapy and counselling is typically blind to issues of power, ignoring psychology's relation to the existing order (Henriques et al, 1984; Ussher, 1993). The relation of counselling, and psychological practice more generally, to socio-political processes, needs to be considered. Chapter 2 examines theory that makes such an examination possible.

Although there have been analyses of the social meaning of HIV testing, counselling and medical encounters (Silverman, 1989 and 1990; Patton, 1990) few studies have addressed the social construction of HIV testing and counselling. Lupton, McCarthy and Chapman (1995) in examination of the symbolic meanings of having an HIV test, conclude that for many the symbolic meaning of the test (producing a clean, free from HIV status) was more salient than the educational component of the testing, in that people often did not change their sexual behaviours. Rather, the test was a social marker, often used to signify to a new sexual partner one's freedom from infection. In other studies it has been suggested that for heterosexual couples the use of condoms signifies a lack of trust, and that as a couple's sense of trust of each other increases so they feel less necessity to use condoms (Waldby et al, 1993). Waldby, et al (1993) suggest that the discursive meaning of condom use (which is bound up in discourses of who is at risk and who not) is a more salient factor in condom use than information about safer sex practice. For some gay men, practising 'safer sex' has been seen as an articulation of gay identity, in resistance to homophobic images of gayness (Patton, 1990). These sorts of study suggest the value of examining HIV counselling in a way which problematises the notion that it is about a rational exchange of information. It would seem that the ways in which people experience and know HIV testing and counselling are in important ways produced through positioning in particular discourses of AIDS and sexuality (Patton, 1990;

Lupton et al, 1995; Wood and Foster, 1995), as well as people's positioning in regards to discourses of race, gender and social class. This sort of examination can be extended to the ways in which people cope with being HIV positive, or with having AIDS. This clearly has implications for psychological practice in this area. Counsellors need to take cognisance of the ways in which their practice is either resonant with or in contradiction with the ways in which people are knowing and practising their sexualities, and the implication of this for the effectiveness of their model of work. These questions about the impact and effectiveness of counselling are important, and incorporate concerns which have been identified as needs in HIV/AIDS research in South Africa (Steinberg and Abdool Karim, 1993).

The issues raised in the literature on AIDS and representation form a background of the analytic reading developed in chapter 4, which examines the unfolding of a session with an HIV positive man, with an emphasis on how counselling re-produces and is re-produced within particular discourses, re-producing particular forms of subjectivity. The analytic reading focuses on an understanding of the session as (inter)subjective, as produced by the interaction of two variously positioned subjectivities. The study then draws implications of viewing counselling as an (inter)subjective process, for psychologists working as supervisors, trainers and consultants to persons doing counselling work. The implications discussed concern the consulting relationship as well as processes that counsellors and clients might experience. The role of a consultant is examined because of the relevance this has in current attempts to find more relevant forms of psychological practice.

## CHAPTER 2: SUBJECTIVITY, (INTER)SUBJECTIVITY AND HIV/AIDS

Various writers have applied self psychological concepts in understanding the psychodynamic consequences of having AIDS. This chapter examines this literature, as well as certain aspects of self psychological theory regarding the development of a sense of self, selfobject phantasies and transitional spaces. These notions are useful in conceptualising the (inter)subjective dynamics involved in being HIV positive or having AIDS. The chapter then turns to a discussion of theory influenced by post-structuralism in order to further the development of a theoretically useful position from which to read the session. The theory which is examined and developed informs and elucidates the analytic reading to which the study turns in chapter 4. Although concepts about development are both referred to and are implicit in these explorations, this is not the place to discuss a theory of development.

### Self Psychology: Knowing a 'Sense of Self'

In this study "the term selfobject refers to an object experienced subjectively as serving certain functions - that is, it refers to a dimension of experiencing an object in which a specific bond is required for maintaining, restoring or consolidating the organisation of self-experience" (Stolorow, et al, 1987: 16-17). When a self gains strength, so to speak, selfobject needs are felt to be part of the sense of self, as though they were integrated into the self (Kohut, 1984; Brooke, 1992). The integration is through an internalisation of a representation of self-in-relation to an object (Bacal and Newman, 1990). This representation, or phantasy, of self-in-relation may involve the self in receipt of or giving selfobject functions (Brothers, 1992). In a sense then, a coherent self is one which has internalised a representation of a trust in its ability to have its selfobject needs met. Kohut (1984:207) suggested that "one of the conditions for the maintenance of a cohesive self as one faces death is the actual or at least vividly imagined presence of empathically responsive selfobjects". The ability to 'vividly imagine' the presence of a selfobject depends on this sort of internalised sense of trust, as well as a representation of self in relation to selfobject. If particular selfobject needs were not integrated into these phantasies of self and these needs were revived later, they may be experienced as alien, as other, and thus as traumatic (Bacal and Newman, 1990). If, as for example in the loss of someone who had come to provide selfobject functions for a person, the selfobject was removed, and the bereaved person had internalised such a trust, (s)he would be able to sustain him/herself in the face of such a loss. (S)he would not disintegrate (although would go through a stage of disintegration [Hagman, 1995]). These issues, as will be seen later, are germane in the counselling session which is examined in chapter 4. How are we to understand such processes?

## The Elaboration of Selfobject Phantasies

Ulman and Brothers (1988), Brothers (1992) and Ulman and Paul (1990, 1992) develop the notion of selfobject phantasies in their writings on trauma and addiction. These authors argue that persons develop central organising phantasies, which are images of the self in relation to selfobjects. Ulman and Paul (1990:2) argue that selfobject phantasies are "affect-laden mental images symbolically depicting one or more of three prototypical scenes or scenarios" relating to the selfobject functions of mirroring, idealising and twinship. Implicit in these images is a sense of self-trust: "the hope or wishful expectation of obtaining from others and providing for others ... the selfobject functions necessary for the development, maintenance and restoration of self-experience" (Brothers, 1992:77). Brothers (1992) describes four senses of self-trust, in relation to selfobject phantasies. The first, **trust-in-others**, involves a confidence that others will serve as a selfobject. **Trust-in-self** involves a trust in one's capacity to elicit needed selfobject experiences. **Self-as-trustworthy** involves a sense of oneself as being able to serve as a selfobject for others. Finally, **others-as-self-trusting** involves a trust that others can meet their own selfobject needs. Having a sense of self trust is important in being able to experience a selfobject relationship (Bacal, 1994). Having central organising selfobject phantasies allows persons to integrate affect and organise self-experience (Ulman and Brothers, 1988), allowing persons to negotiate times when they are alone, or when they are under stress. Over the course of development, these selfobject phantasies change qualitatively from archaic to more mature forms, with criteria for self-trust becoming more abstract, differentiated and complex (Brothers, 1992).

Bacal and Newman (1990), Bacal (1994) and Ulman and Paul (1992) place emphasis on the use of selfobject phantasies in shoring up a self in a deficient selfobject milieu. Bacal and Newman (1990:254) suggest using the term for "one end of a continuum where the experience of selfobject relationships is minimally influenced by actual experiences of care-takers, but predominantly determined by the elaboration of phantasy". Ulman and Paul (1992) use a similar sense of the term, in their work on addiction. They develop a theory around how addictive substances and activities form 'transitional selfobjects' for the person. This describes an elaboration in phantasy, which serves a protective function, allowing a person a sense of cohesion by fulfilling selfobject needs in phantasy.

There is value in looking at how phantasy relates in other relationships, development and crises - how an aspect of all relationships and experience depends on selfobject phantasies - how they allow us to organise experience, be coherent, and how they form an underpinning of self-experience. Gilbert (1994), in a study of selfobject relationships across the life span, examines how people fulfil selfobject needs in various ways, for example

through finding situations or relationships which symbolise previous fulfilling selfobject experiences (what she calls sustaining selfobject experiences). One example, relevant to the session to be examined, is the area of mourning. Hagman (1995) argues that bereavement involves a disruption of selfobject phantasies in relation to the deceased person, who previously was a significant provider of selfobject functions. Mourning can be understood as a process of a gradual reworking and transformation of selfobject phantasies in relation to the deceased person. The mourning process "involves the gradual transformation of the nature of the psychological experience of the essential other (selfobject) into a form that no longer requires the other's presence" (Hagman, 1995:193). Mourning is thus not about a decathexis of an attachment, but an internalisation of a representation of the self in relation to the deceased person, that allows for a restoration of self-trust. The process of mourning is best achieved in an ambience where the person's affects and feelings of disintegration can be held by responsive persons. Part of the process of mourning can be understood as an elaboration of selfobject phantasies for a protective function, as during the initial phases of mourning, where persons may "deny" having lost someone. This represents a person's "reflexive fortification of the self in response to an attack on its integrity" (Hagman, 1995:196). The mourning person initially maintains a sense of self through connections with the deceased person, both in phantasy and in ritual (such as visits to the grave site) (Shelby, 1993). Later, within a responsive and supportive selfobject milieu, the mourner gradually incorporates the loss into their representation of self (Shelby, 1993).

It seems then that implicit in normal functioning is the organisation of experience in terms of central organising selfobject phantasies. Brother's (1992) work is illustrative of this emphasis in the concept of a selfobject phantasy. It is thus valuable to examine the role played by phantasy in events and persons other than those whose selves were compromised by early deficits in their selfobject milieu. Of course, the distinction between those considered "ill" and those "healthy" is both relative and context dependant, as it can be assumed that everyone has archaic selfobject needs to some degree, and that these emerge at particular times in one's life (Gilbert, 1994).

Elaborating selfobject phantasies assures that our need for selfobjects are met, as we have trust that we will receive them, and we are able to act to receive them - in forming relationships for example. In relationships

"the "selfobject experience" depends partly upon the capacity for illusion, or phantasy, and partly on the quality of the presentation of the object that is experienced as fulfilling "selfobject functions" and neither one alone constitutes a secure, substantive basis for the development of a strong and vital self" (Bacal and Newman, 1990:196).

Selfobject phantasies are sustained by, and through their allowing us a capacity to relate, sustain the selfobject milieu we need. Even as they are internalised, they depend on the selfobject surround. They are clearly intersubjective phenomena, as interrelation with primary care-givers forms the basis for their development, and a responsive intersubjective milieu is required for their maintenance (Stolorow, Brandchaft and Atwood, 1987; Bacal and Newman, 1990; Brothers, 1992; Hagman, 1995). Thus, if a person were to be removed from their selfobject surround, placed in a place where s/he was alone, the person would still be integrated, as their core sense of self would be unaffected (although they might still feel slightly disoriented, a mini-fragmentation [Wolf, 1988]). However, if this surround were disrupted in a traumatic way, that is in a way which shatters the person's selfobject phantasies and self-trust (in themselves, or in the surround) the person would face disintegration, and would need to develop ways of shoring up the self, using the intersubjectively enacted "internal resources" (an elaboration of phantasy) and "interpersonal resources" (the selfobject milieu).

#### Intersubjective Attunement, Transitional Spaces and Illusion

Winnicott argues that there are three realities to which persons have access - the internal, external and the transitional (Winnicott, 1971). A transitional space has the character of illusion, it is a space of re-making and of play, "an intermediate area of experiencing, to which inner reality and external life both contribute. It is an area ... that shall exist as a resting place for the individual engaged in the perpetual human task of keeping inner and outer reality separate yet inter-related" (Winnicott, 1951:230 in Bacal and Newman, 1990:195). The conceptualisation of illusion has parallels with our characterisation of selfobject phantasy. Bacal and Newman (1990:196) argue "that the personal meaning of the interpersonal relationship, or object relationship, *always* depends to some extent on illusion, and that workable illusion draws from one's experience of the responsiveness of an environment that has been optimal to the development of a stable and vital self" (emphasis in the original). Both the phantasy selfobject and the transitional space develop intersubjectively. Thus in the description of the person's coping using internal and external resources, through an intersubjective space, we are implicitly describing the use of a transitional space. Here the person's contribution to the intersubjective transitional space is their ability to elaborate selfobject phantasies. In such a space a person is able to re-organise and re-elaborate central organising phantasies, within the context of a responsive selfobject milieu.

This suggests that relationships, therapeutic ones for example, are in important ways transitional spaces, and that the selfobject transferences that emerge and develop have the quality of being products of transitional selfobject phantasies (Ulman and Paul [1992] provide a useful review of instances of the use of the concept of a transitional selfobject, including in the work of Kohut). The selfobject phantasies that emerge in relation to the

therapist (image of the self in relation to the therapist-as-selfobject-provider) are transitional in that they are intersubjectively elaborated - "played" out and changed. Through engaging in a transitional space, the intersubjective field between therapist and client, these phantasies are re-organised and re-integrated, when experienced with the responsiveness of the therapist and with the new meanings that are offered (the interpretations) (Ulman and Paul, 1992; Bacal, 1994). The selfobject experience is transitional in that, corresponding to the shift from a child's toy back to human selfobjects, the person is able to shift back the focus of their selfobject needs and phantasy to objects or people, who can provide it (Ulman and Paul, 1992). Hence, in a successful therapy, the person is able to have more sustained and fulfilling relationships. This does not involve phantasy disappearing. Being able to relate and the organisation of experience depend less on a fragile elaboration but more the integration of a sense of trust within central organising phantasies, that both allows for and is sustained by interaction. The issue in this discussion is not on whether there is a degree of phantasy (implying that some relationships would involve phantasy to a lesser degree), rather it is on the nature of the phantasy, and the relation of the phantasy to the person's prior and current intersubjective milieu, which involves the person's prior and current selfobject phantasy organisation.

In a similar vein, Slochower (1996) has argued that the holding function of the therapist depends on an "illusion of analytic attunement" (Slochower, 1996:326), in which the client is able to be held, and the therapist is able to hold the patient, through both parties developing an illusion that the therapist is optimally responsive. This involves, for both therapist and client, a disavowal of more complex aspects of the relationship (such as times when the therapist is not optimally responsive, or aspects of the frame that might signify unresponsiveness - the ends of sessions, breaks and so on). The client develops an illusion of the therapist as holding. This sort of illusion would seemingly involve an elaboration of a selfobject phantasy of the therapist as selfobject, drawing on earlier sustaining selfobject experiences. In the analytic reading presented in chapter 4, a key focus is on how the intersubjective exchange allows for the re-production of particular selfobject phantasies, which, in their elaboration allow both participants a cohesed sense of self. Importantly, this involves a disavowal of particular aspects of the experience, which allows for key selfobject phantasies on the part of the client to be mirrored.

## Coping, Selfobject Phantasy, Mourning and HIV/AIDS

Implicitly what has been discussed here are the ways in which persons cope, particularly with losses. This clearly has significance for the field of HIV/AIDS-related work. For an HIV positive person or person with AIDS disruption of selfobject bonds occurs for many reasons. People with HIV or AIDS face discrimination and prejudice: "rejection, often motivated by fear or prejudice, by those who once fulfilled selfobject functions (lovers, family, friends, caregivers) may deprive a ... [person with HIV/AIDS] of urgently needed mirroring at a time of heightened need" (Cohen and Abramowitz, 1990:162, insertion my own). People may become shame prone - lesions are stigmatising, disrupting the persons sense of their body self (needed for a sense of self cohesion) (Cohen and Abramowitz, 1990). Disruption of selfobject bonds is seen to occur also through the multiple losses and grief persons with AIDS face. People with HIV or AIDS very often have to mourn the loss of persons who previously supplied selfobject functions, thereby threatening self cohesion (Cohen and Abramowitz, 1990; Shelby, 1993). People with HIV or AIDS may have to mourn whole communities (Schietinger, 1992; Paradis, 1993). The person's sexual and intimate relationships, through which person may have received selfobject experiences, are disrupted and the person is forced to negotiate new ways of being intimate (Paradis, 1993; Dansky, 1994). In these and many other ways the person's selfobject relations are threatened.

From the above theorisation it could be expected that one of the ways that persons with HIV or AIDS will cope with their situation is through an elaboration of selfobject phantasy. The mourning process of the bereaved HIV positive person is often complicated (Shelby, 1993; Dansky, 1994). Since the person faces disruption of selfobject bonds, as well as having to consider their own mortality, a reintegration of selfobject phantasy is difficult. People with HIV or AIDS may feel isolated and have difficulty re-engaging with their relationships, families or communities (Shelby, 1993). The person may remain angry, embittered, and withdrawn (Shelby, 1993; Paradis, 1993). This can be understood as part of the persons attempt to bolster a self that has been threatened in powerful ways, and which is caught in a mourning process which has been complicated. "In the treatment of dying patients" Knoblauch (1995:217) writes, "impending loss of all ties and relatedness is universal. During such a period of dying the critical dimension of selfobject experience for the patient is the acceptance and understanding of her or his need to sustain the self". As in other mourning, the person may elaborate a connection with the deceased person, that allows a sense of cohesion. These needs of the person with HIV/AIDS need to be understood and acknowledged (Shelby, 1993). These dynamics will be illustrated in the process of the session examined in the detailed analytic reading in chapter 4.

The study has argued thus far that it is in an intersubjective space that selfobject phantasies are able to be transformed. Describing selfobject phantasies as intersubjectively developed and sustained allows a view of interrelation as allowing the development of an ability to experience selfobject needs, and with the development of selfobject phantasies (within which are imbricated a sense of self-trust) as underpinning this ability. Being a self is contingent on one's intersubjective contexts. It is selfhood that is re-made by, and re-makes, relation with others. It is potentially within a supportive and responsive surround, that the person's central organising phantasies are able to be re-organised. Part of this process would involve an elaboration of transitional selfobject phantasies. In the context of mourning the elaboration in phantasy and ritual of a sense of connectedness with the person, previously regarded as a denial of the reality of the loss, can be seen as the elaboration of a transitional selfobject phantasy. In the context of supportive and responsive surround, the lost person "may eventually be integrated into the self, maintained intact as fantasy (perhaps experienced as spiritually present) to be evoked as necessary to assist in the maintenance or repair of the self, or obtained from other relationships" (Hagman, 1995:199). Self psychological writers have thus argued that work with people with AIDS and HIV involves bolstering the person's selfobject bonds (and this may involve family, couple work or individual work) (Cohen and Abramowitz, 1990; Paradis, 1993; Shelby, 1993).

Clearly phantasies embody and cathect real experiences - they are the stories, tales and images about which selves are woven. Certain aspects of the experience, which may be disruptive of the crucial selfobject phantasies may perhaps be disavowed, or split off, in the selfobject phantasy. Perhaps later, when the person has been able to integrate the experience more, other aspects may be tolerated. In other words, a person may elaborate a selfobject phantasy, in relation to a selfobject milieu, which disavows particular aspects of their experience, because those aspects might come to disrupt certain central organising phantasies, causing more fragmentation. "Because every traumatic betrayal holds the spectre of disintegration anxiety, strenuous efforts must be undertaken to heal damaged self-trust and, concomitantly, to restore selfobject fantasies" (Brothers, 1992:78). The elaborated selfobject phantasies may involve an image of self that allows an experience of trust in a selfobject.

#### Phantasy and the Forms of Representation

In presenting a theory that posits internal psychological processes, like phantasy, we are relying on (are subject within) particular discourses pertaining to individuality. Being subject within these discourses has the political effect of maintaining certain institutions (counselling and psychology in this instance) (Venn, 1984; Parker, 1992). Examining these sorts of political effects of our theorisation and practice is important because in many

ways these are the sorts of factors that shape changes in the forms of psychological practice, rather than progress in scientific knowledge (Pilgram, 1990; Rappaport, 1992).

The theory examined selfobject far ignores the structuring of representation, the forms of phantasy, by processes 'beyond' the intersubjective - presenting an asocial, ahistoric and apolitical view of the processes by which our selfhood's are constituted (Henriques et al, 1984; Flax, 1990). There is for example a blindness to the gendered nature of development in selfobject theory. Little consideration is given to whether there is a gendered structuring of phantasy and representation. The self psychological theory drawn on presents a "generality about psychic representation and a lack of detail as to how the unconscious intersects with the self's relational landscape" (Elliot, 1995:38). Relying on the notions of selfobject phantasy might reduce to a presentation of isolated persons, with (biologically determined?) selfobject needs, requiring the connection with another only in so far as this provides for the fulfilment of the needs. This leads to a presentation of intersubjective exchanges in a way that ignores the role of these exchanges in the reproduction of systems of differential sedimentation of power in society - a differential sedimentation that has definite effects on disadvantaged persons affected by HIV/AIDS (Patton, 1990; Sherr, 1993). This sense of intersubjectivity may revert to an apolitical and asocial rendering. In the sort of theorisation above there is an implicit presentation of a homogenous social order. Knowing our work in the field of HIV/AIDS in terms of self psychology could lead to an erasure of knowing in regard to how these sorts of issues might emerge in clinical work (Ussher, 1993) and how clinical work might reproduce or change them - how the practices of HIV counselling may in fact produce particular forms of subjectivity, gendered or otherwise (Foucault, 1978; Silverman, 1990). Understanding this process is important in working towards better services for HIV positive persons. Chapter 5 takes these issues up in an examination of the implications of this sort of analysis of HIV counselling for psychologists working as supervisors, trainers and consultants to HIV counsellors.

#### Theoretical Contrasts and Bridges: A Caveat and a Motivation

I turn now to an examination of a theory of the representation of illness, and then to post-structuralist theory which has more systematically examined the relation between subjectivity and representation. Addressing the gaps in the theory of selfobject phantasies is not a simple process of just adding post-structuralist theory (which is by no means a homogenous body of work). Parker (1992) provides a useful review of writers who have used discourse analysis, post structuralism and psychoanalysis. Discussing 'psychological process' alongside 'discourse' might obscure crucial differences and emphases in the notions, collapsing important distinctions and producing caricatures of the theories. For example, there is a danger that the term phantasy might be conflated

with representation (as this is used in a discourse analytic sense), or vice versa. The theoretical position developed in this study is thus multiple, producing a dialogue, rather than a unification, between two bodies of theory. Also, it does not purport to be a completed theoretical position. These questions and tensions emerge in part from using two theoretical schemas which in certain ways have different epistemological underpinnings. This needs to be 'borne in mind', in a similar way to our need to be reflexive when producing a discourse analytic reading (Stenner, 1993; Parker and Burman, 1993). These comments are by no means complete, as a fuller treatment of the question of a post modern psychology is beyond the scope of this study.

In pondering these questions I am returned to considering the questions that first motivated the idea of the research, and in particular the experiences I had during, after and in the process of transcribing the session to be examined below. There is value in producing accounts which contrast the relation between subjectivity and discourse, in order to produce a knowing which is useful in the context of ongoing work with persons with HIV and AIDS. This is because, as noted above in the review of literature discussing AIDS and representation in chapter 1, the knowledge practices around the pandemic have crucial effects in many spheres, including in how people with HIV/AIDS know themselves, how others relate to them, in how persons know and practice their sexualities, in governmental responses and in forms of counselling practice. Extending this examination into the psychological practices around AIDS and HIV is important, both for the practitioners and for the clients.

#### Representing AIDS: Stigma and the Dynamic of 'The Other as Diseased'

If we are to address the particular ways in which the representations and practices around HIV/AIDS play out, our theories and practice will have to recognise the reasons why particular forms of representation exist. Theory that has been developed about stigma is useful in this attempt. According to Gilmore and Somerville (1994) stigma has at least four characteristics. Firstly, the problem that is stigmatised needs to be locatable, away from those doing the stigmatising - it needs to be controllable. This means, secondly, that the stigmatised person, who will carry the stigma, needs to be identifiable (via a group membership for example). Thirdly, the stigma must be associated with the stigmatised persons or groups. Finally, the stigmatised are related to in such a way "that the stigmatized ... and therefore the problem, is distanced, disempowered, excluded or otherwise controlled by the stigmatiser" (Gilmore and Somerville, 1994: 1342, omission my own). In representations of the ill, discourses of otherness - that the ill are different as well as damaged - are thus central (Gilmore and Somerville, 1994; Levett, 1995).

Gilman (1988) has argued, along similar lines, that people have a need to locate and isolate illness in an other, to project the anxieties invoked in us by illness in an other. The images of AIDS, Gilman argues, have a continuity with images of other sexually related illnesses, such as of syphilis. Images of the ill often include stigmata - marks of difference - skin marks or thinness for example (see appendix A, figure 1). The ill are often portrayed as separate, isolated and, in the case of illnesses which are sexually transmitted, are often stereotyped as sexually deviant. Hence the image of the AIDS patient as thin, gay and black (see appendix A, figure 2). A prevalent image, Gilman argues, is of the AIDS patient as melancholic - worrying over the sickness (see appendix A, figure 3). In these images there is often a prospect of cure (the musicians in figure 1, or a doctor, as in figure 2), but at a distance (the ill are separate and isolated).

These images form representations which, re-occurring in the media, in conversation, in medical practice and countless other ways, colour our perception of the HIV positive person. Representing illness in these ways allows us to project the anxieties evoked by the ill onto an Other, keeping the contagion, chaos and death at bay. Seeing the person with HIV in this way ossifies concerns about vulnerability to illness, about our sexualities, and about otherness and makes them manageable, locatable, and isolable (Gilman, 1988). Gilman argues that the need to project these concerns onto an Other comes about because illness recalls in us our anxiety at the moment of separation from our primary caregiver: "our internalised sense of difference is a product of that primal moment in everyone's experience when we first became aware that we were different - different from the caregiver, unable to control our world. We need to project the fantasised source of our anxiety about our original loss of control" (Gilman, 1988:5). This need is however, Gilman argues, read through culturally given channels - it is the socially marginal or disempowered that become the screens for our projections (thus black people, women and homosexuals often become the object of the projections). Through an internalisation of this sense of being Other - being the contagious - the social marginal, already Other, are made doubly Other (Levett, 1995). People with HIV/AIDS thus often carry this double Othering - being socially marginal and carrying a highly stigmatised disease (Dansky, 1994; Gilmore and Somerville, 1994; Goldin, 1994). This sense of othering is crucially related to the person's history and ongoing positioning within the social (Levett, 1995). The following sections will examine theory which focuses on the relation of subjectivity to a person's social and personal contexts and history. These points are taken up in chapter 4 in an examination of the ways that Phillip knows himself as a person with HIV. Certain of the images Gilman notes recur within the session. In many ways, the session involves an intersubjective outplaying of dynamics around a sense of Otherness, of being HIV positive. The ways in which the participants are able to know this Otherness is crucial in the unfolding of the session.

## Gendered Subjectivity and HIV/AIDS

Gilman's theorisation, especially in the breadth of the examples he cites, is persuasive. It is however universalistic and tends to an intrapsychic reductionism (the evocation of the 'primal moment'), which may lead it to ignore whether, or how, it is in (inter)subjective sites (such as counselling) that forms of representation are re-constructed. We need to leave space for contradiction - how new meanings and representations may come about (Henriques et al, 1984) - something for which Gilman's theorisation does not account. Gilman's positing of a 'primal moment' of separation as the root of the dynamic of seeing 'the other as diseased', has implicit within it notions of gendered development. This has implications for the conceptualisation of subjectivity, and thus for the unfolding of an (inter)subjective process like an HIV/AIDS counselling session. This implicit theory of gendered development, around an oedipal separation (Maguire, 1995), is not above critique.

Current theorisation suggests that gendered development need not be about a repudiation of identification with mother, the painful 'primal moment' of difference (Benjamin, 1995; Sweetnam, 1996). Although separation-individuation may be a marker of gender identity, and does involve a loss of a sense of control of the primary care-giver, there is an ongoing identification with both parents. Benjamin (1995) argues that initially the child overinclusively identifies itself as both male and female, with both parents. Benjamin (1995) argues that identification with father - or an other who represents a separate subjectivity - comes to provide the child with a sense of autonomy. This occurs both defensively (through the identification anxieties about separation from mother are made tolerable) and productively (the identification produces for the child a sense of being loved and capable of loving). At the same time ongoing identification with mother provides a sense of basic trust. Benjamin places emphasis on an ongoing ability of persons to return (unconsciously) to the pre-oedipal position of identification as both male and female, which exists alongside later more fixed or rigid oedipal identifications of the self as male or female. This, she argues, allows a person to be able to tolerate difference (Benjamin, 1995). Certain people, for particular reasons, may find it difficult to tolerate difference and may need to split off ambiguity and to project aspects of themselves into an other (Sweetnam, 1996). The reasons for representing illness in the ways Gilman describes would seemingly be more complex than his theorisation suggests, and are certainly not an inevitable product of development. These points will be taken up again in the analytic reading in chapter 4, when considering the gendered nature of the session. Emphasis will be placed on both the defensive and productive effect of identifications in coping with having HIV/AIDS. This discussion suggests that coping with HIV or AIDS and the representation of illness is a more complex process than just a projection of anxiety into an other. The way in which people represent HIV/AIDS, and the relation of this to the coping we have discussed in the previous section, needs examination.

## Defence, Investment and Subject Positions

In this work I draw on Hollway's (1984) Foucauldian work on gendered subjectivity. Examining gender is important because issues to do with gender are central in the lives of people with HIV and AIDS (Ussher, 1993). Gender, in all its transformations, effects and productions, is imbricated within a person's behaviour and knowing of themselves, for example in how couples negotiate safer sex (Patton, 1993; Waldby et al, 1993; Watney, 1993). As will be seen in chapter 4, the ways in which Phillip copes with his situation are gendered. That is, the meaning of HIV/AIDS for him is read through his gendered subjectivity.

Hollway (1984) suggests the notion of investment in discourses - that there is a reason, a motivation, a gain, in taking up particular subject positions in discourse at particular moments. This investment is not rational or voluntary. It is unconscious and is produced in and through a person's life history. The investment is understood in terms of defences (such as repression). Being invested, being subject in a discourse in a particular way, allows/produces a form of relation in which certain aspects of the relation are disavowed. Particular subject positions allow a person to know and be, in relations with others, a certain kind of person. This produces particular forms of relationship. Hollway regards defence mechanisms as relational, allowing certain kinds of relation. A man, for example, positioned within a discourse which presents his sexual desire as biologically driven, is able to split off aspects of his feelings, perhaps in regard to vulnerability, in relation to a woman (saying that he does not need her, he just needs sex). The woman, positioned in discourses such that she needs to have a man (with her own investments in this positioning), is placed in an unequal power relation with the man. It is through the man and woman's positioning in these discourses that the man's splitting off is enabled. In a sense the woman carries this split off material: "repressed desires do not go away. The defence mechanisms of introjection and projection - the means through which they are expressed in displaced ways - are intersubjective, that is they are relational. This means that they are dependant on the participation of another" (Hollway, 1984:258). By positioning themselves in these opposite ways a relation between them is re-produced, one which is subject within particular hegemonic gendered discourses, presenting men as rational and woman as emotional, for example. Understanding these sorts of dynamics in relationships between the genders is important, for example in campaigns around safer sex (Hart, 1993; Watney, 1993), and research on condom use has increasingly adopted this sort of focus (Wood and Foster, 1995). While this example is general and somewhat unspecific, it illustrates Hollway's point that subjectivity is articulated in relation to another, through particular defence mechanisms. This conceptualisation is useful, because it allows an examination of the relation between people's subject positions in an (inter)subjective exchange. In the session to be examined in

chapter 4, a key focus is on how the way in which Phillip and I are positioned crucially affects the unfolding of the intersubjective exchange.

Hollway's work gives importance to the uniqueness of individuals, with an emphasis on their own particular developmental histories, while relating these histories to a social and historical production. Conversely it is an account also of how the individual histories of persons are in important ways the histories of the times and relationships in which they lived, both in the sense of the times and relations being reflected in their subjectivities, and also in how their lives re-produced those times and relations. Being a person, having a self, depends on being contingent within one's historical time. This is not a static selfhood but one which is complexly re-made, as one re-makes one's time in history.

This discussion suggests, echoing Elliot's (1995) comment quoted above, that in the current theorisation of selfobject phantasies there is a lack of specificity with regard to their content and the relation of this to the social in which one is imbricated. Similarly, there is little consideration of what is disavowed and the implication of this disavowal for the person's relationships. "There is no account of how ... changes in content are produced in subjects' positions in multiple discourses; of what is suppressed and expressed; and of the content of splits" (Hollway, 1984:256). Hollway argues that psychoanalytic theory has tended to regard the insertion of content as happening early on, perhaps in the oedipal phase (compare this with Gilman's [1988] theorisation discussed above). This ignores the person's ongoing insertion within relationships and the social. This is not to displace the importance of early relationships, but can lead to an ignoring of the ways in which these dynamics play out and are re-produced throughout the life span, within particular re-current social forms. Can the selfobject phantasies have, in their form and elaboration, the effect of structuring a gendered subjectivity? Can we read in them the history of the subject as a 'man' or a 'woman', and all the repressions, desires, ambiguities, and contradictions that this entails?

## Selfobject Phantasies, Representation and Investment

Hollway's work suggests the importance of examining the content of the selfobject phantasies with regards to the aspects of relationship that are expressed and disavowed, and in the intersubjective exchange how defences are outplayed. "Significations are a product of a person's history, and what is expressed or suppressed in signification is made possible by the availability and hegemony of discourses" (Hollway, 1984:239). If we regard phantasy as signification, we might then consider the ways in which phantasy comes to represent the history of subjection within particular discourses, such as those of masculinity. Within selfobject phantasies can be read the history of the insertion of the subject within the discursive practices of patriarchal culture, for example. The selfobject phantasies of people with HIV or AIDS will reflect their attempts at managing a self that is stigmatised. The selfobject phantasies will reflect the persons history, as well as attempts at managing having a highly stigmatised illness (and this includes attempts at resisting being stigmatised [Levett, 1995]). These forms of phantasy will be articulated in and through an (inter)subjective context (how people with HIV know themselves, how others relate to and represent the 'person with AIDS'). The forms of phantasy, the central organising images of self in relation to selfobjects, will reflect and re-produce the relations between subjectivities.

Defining selfobject phantasies as intersubjective places them crucially in the realm of the socially constructed. This analysis places selfhood and intersubjectivity within the 'domain' of power/knowledge, as it is about a production of a way of being, and locates re-production of discursive practice in the realm of the intersubjective - in transitional spaces, phantasy and so on. This allows for an examination, through a discourse analysis for example, of the process of re-making, in a transitional space like therapy or counselling, of particular discursively shaped/produced selfobject phantasies. We could examine how, in a session, the intersubjective exchange reflects and re-makes personal histories of subjection within certain discourses. How the phantasy that is elaborated, the images of self that are invoked and evoked, reflect positioning (in complex and contradictory ways) within particular discourses. This is a conceptualisation of the intersubjective which goes beyond the meeting of two discrete subjectivities. This points to the intersubjective as crucial in the re-production of subjectivity, and how it is a socially and historically contingent (inter)subjectivity. It allows us to examine how subjectivity is re-produced in AIDS related work, how subject positionings affect and delimit the ways in which people cope with having HIV/AIDS and how subject positionings affect the unfolding of counselling work.

## CHAPTER 3. METHODOLOGY

### Theoretical Tensions and Questions: Knowing, Developing Knowing and Erasing Knowing

There is a dilemma in attempting a discourse analysis of a session. An analysis represents not a finding of the truth embodied in the text, the hidden meanings that were actually said but which we did not hear at the time. This is however how discourse analysis is often interpreted (Parker, 1992; Parker and Burman, 1993). Stenner (1993) suggests that discourse analysis is about producing a reading (which is more or less useful) rather than an interpretation (which is more or less true, based on an assessment of authorial intent). The sense of interpretation as seeking to find a truth is often found in case conferences, ward rounds and supervision - it is often how "sense" is made of sessions. The perspective that there is a true person to be unearthed obscures the intersubjective processes through which knowledge is constructed in sessions (Thomson, P.G., 1991; Stolorow and Atwood, 1992). This erases, for example in the context of therapy, the fact that interpretations and analyses are taken back into the sessions, into the intersubjective encounter, where they can be re-made, forgotten or remembered. And so the "truth", the knowledge that is constructed in the session or supervision, evolves through time (Cecchin, 1992). Events and material previously understood in a certain way, with particular implications, become re-known later in other ways. This process is among the reasons why an examination of one's countertransference is important (Stolorow and Atwood, 1992; Thomson, P.G., 1994) and why an examination of my countertransference experience has been central in producing the analytic reading.

Implicit in this discussion is Kohut's (1984) observation that while we may have a technical or theoretical knowing, this is less profound than the person's own knowing (or that which might develop in the course of a relationship [Stolorow and Atwood, 1992]). In important ways, this is the process of the development of theory as well: "psychoanalysis is a form of relational work in which theory and practice constantly inform, correct and depend on each other" (Flax, 1990:109). The articulation of theoretical constructs is often regarded as evolving or developing. Yet in important ways theoretical 'development' is a process of the re-elaboration of aspects of our (inter)subjectivities, within particular socio-historic conjunctures (Foucault, 1980; Thomson, P.G., 1991; Schafer, 1992; Chase, 1992). This is an issue which goes to the heart of the analytic enterprise, which is about an unending re-making: "the analytic attitude ... is characterised by a relentlessly deconstructive urge that allows no end points or perfect solutions, just living with ailments" (Elliot and Frosh, 1995:2). Discourse analytic research has a similar emphasis, encouraging a taking of the analysis back to the participants in a way which could potentially enrich both the analysis and the participants. This would be research true to the premise that the researcher and participants are co-constructors of the research discourse (Marks, 1993).

There are however various dilemmas in this, to do with, for example, different power positions of the researcher and participant (Maw, 1996). These issues are taken up again in Chapter 5, which discusses implications for the role of psychologists as consultants in HIV/AIDS related work.

Clearly then, this discussion is not simply theoretical as though these concerns could be divorced from a question of method. If we represent someone in a particular way (which we do all the time, unconsciously, through our being, always already, imbricated within particular ways of being and knowing) we relate to the person in particular ways. The representation of the other could become a self-fulfilling one, as our interaction with them may demand a response in that frame (Shotter, 1984 and 1989; Stolorow and Atwood, 1992). We are not neutral or absent, but address the client in particular ways, re-playing our particular positionings within ways of knowing and being, and in so doing demand a certain response from the person.

The issue of a discourse analysis revealing a "truth" is a tension in my thesis. In some of what I argue I assume a relation between the words Phillip uses, and internal and intersubjective psychological processes. This is a theoretical knowing. The utility of this is for me to write about, to take into other sessions, as a frame, as a tool, a part of the dialogue in the ever changing conversation with theory and method. Other writers, with different concerns and positionings, might find other aspects in the session (and in the reading, for that matter) salient and produce other readings.

## Method

The method used in the study is clearly not separable from the theory which informed it. Similarly, as the analysis proceeded, the theory was reflexively modified. A session of about 45 minutes was taped and a transcript of six pages was prepared. The analytic reading (in chapter 4) produces a (de)constructing dialogue between the two bodies of theory, 'self psychology' and 'discourse analysis'. Meanings and knowings from each body of theory are contrasted and complemented, producing a knowing, an analytic reading, of the session. The analytic reading of the transcript was produced using a broadly Foucauldian discourse analysis. Parker's (1990, 1992) outlining of the 'steps' in such a discourse analysis formed a guiding schema for the analysis. The reader is referred to Parker's detailed accounts of these 'steps'. Broadly, subject positions, the relations between different positions and discourses were outlined in a reflexive way, with an emphasis on the productive effect, creating or erasing knowing, of these relations. The investments (Hollway, 1984) each of the participants may have had in these subject positions were considered in light of self psychological and post structuralist theory. As already noted, emphasis was placed on my experiences in and after the session, my countertransference, as a

guide to the intersubjective process. The participants are Phillip Jacobs (P in the transcript) and myself (R in the transcript). The name Phillip Jacobs is a pseudonym, and dates, places and other names have been changed to ensure confidentiality.

## CHAPTER 4. ANALYTIC READING: AIDS/REPRESENTATION AND (INTER)SUBJECTIVITY

### Initial (Inter)subjective Exchange: Pragmatics, Rationality and Disavowal

I am told by the matron that Phillip, who is HIV positive, "just wants somebody to talk to". I read the referral note from the TB clinic, which says that Phillip's wife has passed away from AIDS related illnesses and that his child is HIV positive as well. With no more history than this (not an uncommon situation in this counselling) I introduce myself to Phillip and we walk in silence to another section of the ward. I ask his permission to tape the session, explaining about my research and ensuring him about confidentiality. He says that this is fine. I put the tape recorder on, and ask him why it is that he wants to talk. He begins:

P: My eenigste probleem [My only problem], I have 2, now about 3 months ago my wife passed away. She passed away, my family, her family, took my children away from me. I had 2 children with her. I was married before, six or seven years. My family took my children away from me. Now the council says if I'm alone I can't stay in the house.

R: The council says that if you live alone, they won't rent you a house?

P: Ya

R: Um, what sort of house is it, a council house?

P: Ya, a council house.

R: And before, your your children lived with you?

P: Everyone, we were all together.

R: Mmm

P: My daughter, she's 4 years old, she has the same sickness. I don't have any contact with them, any. I haven't even heard from them over the phone. They're in Retreat.

R: Who are they staying with?

P: My wife's sister, she's looking after them. I went to the social worker in Caledon, she said the hospital can help me with a grant, so I came here.

R: Tell me, the social worker, who is she?

P: Mrs Able.

R: You don't have her number?

P: [Gets up] Ek sal [I will], I'll go and get it for you.

R: Dis okay, ons kan dit later haal [It's okay, we can fetch it later], uh um, because maybe the social worker there can help with things, the application. She said that you must apply and if you get a grant then you can?

As Phillip begins talking I feel anxious, wanting to assess if this is a crisis or not. I am very active initially, asking mainly informational questions, about the issue of the social worker and the reason for the apparent imminent loss of Phillip's house. Although I was exploring the problem, I had assumed he was in crisis - in need of a containing intervention. Reading the story about him in the referral note gave me an image of a

person in the midst of enormous difficulty. In this representation I position him as an AIDS patient in crisis. I contain my anxiety by being active and engaging. I am positioned as a knower, an explainer, an expert - who will organise things ("It's okay we can fetch it later") and I position Phillip as passive. This is painfully ironic, as it is not I who must live with the virus and what it means, not I who must go home after the session, cry, fight, contend with the difficulties of being HIV positive. In this discussion I am subject within a discourse positioning ourselves as rational self-contained individualities.

Phillip brings highly evocative material, talking of his wife's death and his child's HIV status. He says that his four year old daughter has the same illness (not naming it as HIV related or as AIDS) and shifts to the practical considerations concerning the loss of his house and not seeing the children. He frames this account within a familial discourse. He presents a picture of a harmonious and together family. He is able to warrant, through this representation, the wrongness of breaking such a family up. In these initial moments he has already disavowed the emotion around the things he talks of, and it is I who regard him as in crisis.

We engage quickly in a "pragmatic" discussion, to do with the house and the organisation of a disability grant. Phillip engages in this because of the way he has disavowed aspects of the feelings around the losses, and because of the practical urgency of attending to the issue of accommodation. My organisation of this experience through the positioning as an active rational counsellor leads me also to follow his discussion in a particular way, focusing on the 'pragmatic' aspects. In a parallel of the image of the melancholic syphilitic and the flute player (appendix A, figure 1) - I position Phillip as the melancholic (mentally ill, mentally incapacitated, irrational, in crisis) AIDS patient and I as the active carer, the prospect of cure. In this image is an omnipotent phantasy, a disavowal of death and contagion (Gilman, 1988). As we shall see, it is a disavowal which is repeated in the intersubjective exchange.

#### A Disavowal, an (Inter)subjective Conjuncture and a Shift in my Representation of Phillip

The session continues:

P: My circumstances are that at the moment, I don't see a way of staying on in the house.

R: Is the problem that you don't have any income?

P: Ya. [pause] This month it's a year since my wife was getting really sick. She fell pregnant, she collapsed and so she went for a medical check, she collapsed, that's when we found out about the sickness. Our daughter got this sickness from her, [pause] our son, 8 years old, there's nothing wrong with him, there's ...

R: How have things been for you?

P: In the beginning I was a bit sad about, probably about the, that I have a sickness that nothing can be done about, but my age shows me that, that that's just the way life life is. Why be sad, you've lived your whole life.

R: Mmm

I ask Phillip directly, for the first time in the session, what the experience has been like for him. Phillip's reply to this question contains a powerful expression of the ways in which he copes with this situation and how he has coped before. He represents himself as having learned, through unsaid hardships, that there is little point in being sad. This is like an unfinished sentence, with the unfinished and the implied being: 'be strong, do not be sad or become weak and vulnerable, it's of no help, you must be strong'. He is a rational copier, steeled by the years. I affirm this: "mmm".

This image of Phillip as a strong man, steeled by the years, represents a key central organising selfobject phantasy for Phillip. It has imbricated within it a strong element of trust-in-self - a sense that he is able to care for himself (Brothers, 1992). Phillip's statement hails me, it produces in me an "inward" reflective gaze, I ponder his statement. His statement addresses me in such a way that it is unchangeable, it has a quality of irrevocable truth and cohesion. He positions himself as separate, as not needing help. I become less anxious and I stop seeing him as in crisis. Still spoken within a discourse of rational individualism, I now see him as rational, as carrying stoically his enormous difficulties. In my representation of him is a sense of him-as-self-trusting. This soothes my anxiety. Seeing him now as not in crisis allows me to become less active and more empathic and I feel I can have access to him emotionally. As I am re-positioned I begin to listen more, and to speak more within a discourse of emotions (a discourse of therapy), which he partly takes up. I recognise and mirror the phantasy of him being the strong man, saying in effect 'you are this steeled man'. In this mirroring I affirm his core selfobject phantasy, leave it undisturbed. A shift in my subjectivity has occurred, producing a different way of knowing him. It is a shift which 'allows' me access to a discourse of emotions.

It might be argued that perhaps life has taught Phillip this, that perhaps he has been steeled by the years. Certainly this statement is a reflection of how he has coped in his life to date. It does seem that, within self psychological discourse, he is a relatively cohesive and individuated self. This, it deserves to be noted, is an image within a particular individualistic psychological discourse (Sampson, 1989), suggesting a personality which is unaffected by context. My 'access to emotions' is spoken within a similar individualistic psychological discourse. The process by which Phillip 'appears' to be cohesive and individuated is part of the complex interplay between culturally hegemonic discourses of subjectivity as rational and self-contained, and the

manner in which Phillip speaks/is spoken in these discourses (Henriques et al, 1984). Through being positioned within these discourses, I am able to know him in this way.

This representation of himself as stoic is Phillip's knowing and experiencing of himself. But he is also experiencing a trauma. Following the theory developed above, we could see the loss of his wife and children as having challenged his central organising selfobject phantasies. The phantasy described above presents him as an autonomous individual, it protects him by keeping the pain about the losses in his life isolable, keeping a sense of self trust intact. It has the effect of steeling his self, shoring it up and preserving a connection with needed selfobjects. This phantasy involves a powerful disavowal of the feelings that must be associated with the loss of his wife and children, and of his own illness and death. Within this phantasy can be read a disavowal of having AIDS. It is as though he says: 'I am a strong man, I can do nothing about having this sickness, therefore I don't worry about it. It is part of life that these things happen, therefore I must bear it'. He seems to define an acknowledgement of being an AIDS patient as being sad - melancholic, that he would worry about it, which runs contrary to the image of him as strong and steeled. In dismissing this image of himself, he disallows a representation of himself as an AIDS patient. Again, this serves as a way of keeping a sense of self trust and a connection with needed selfobjects intact.

These are disavowals which I, positioned in a discourse of self-contained rational individuality, similarly perform. This is a moment of intersubjective conjuncture, a situation when there is a correspondence or sharing of a defensive solution or organisation of experience or where structuring principles are similar between therapist and client (Stolorow and Atwood, 1992). By the end of the session I am left with a sense that the conversation had nothing to do with AIDS. The shift in my subjectivity leaves me with an urgent feeling of not wanting to disturb the image of Phillip as the strong stoic, and as I read the transcript later, I feel that it is somehow wrong to analyse the conversation. These feelings after the session are about not wanting to allow into consciousness the pain that we have disavowed. Imbricated within my representation of Phillip is a sense of him as Other, as separate. For me this is a turning away from an aspect of him that I find painful - the disavowed aspect that concerns his mortality, the sense of him as dying (the thin, frail, dying AIDS patient). I construct an image that has within it a sense of his autonomousness and separateness (the strong and stoic man). In this image I am able to split off the aspects of myself concerning mortality, separateness and dependency. I am thus able to preserve an image of myself in relation to selfobjects that are self-trusting, thereby disavowing feelings evoked in me about death, mortality and dependency. This contributes to the lessening of my anxiety as the shift in my subjectivity occurs. Phillip's selfobject phantasy, and the disavowal it involves, is spoken within a discourse of self contained individualism. My own positioning within these

discourses, and my need to split off this material, allows me to be hailed in the way I was by his statement. My recognition and mirroring of Phillip's central organising phantasy is thus intersubjectively produced and sustained. Imbricated within the intersubjective are my subject positions (within which are included the histories of my training as a psychologist). These positions produce a subjectivity which can know Phillip in these ways, and allow me to be hailed in the way I was, producing the particular knowing of him that I left the session with: Phillip as the strong and stoic man, and with the session having little to do with HIV/AIDS.

This reading allows a different knowing about what transpired in the very first exchanges in the session. Phillip's presentation of a harmonious family, belonging to him and now taken away, embodies the selfobject phantasy we have discussed earlier. In his initial comments can be read this sense of stoicism and the disavowal. Again, this is important in his coping, as it allows him to focus on the important need to sort out his finances and accommodation. Acknowledging and mirroring Phillip as a steeled, strong man is important, as this is how he is coping with a very demanding situation.

**Phillip continues:**

P: My closest family is my cousin, in Grabouw. I'm alone in Caledon.

R: And now you're sad because your children are gone.

P: I didn't have a choice. I couldn't [inaudible] them, for them to stay. They said that there was no one to look after the children. One of the clinic sisters was planning to come and look after the kids, but then they took them away.

R: Was it the welfare?

P: The welfare man, uh, Mr Thomson, the welfare in Caledon, he gave permission for the children to stay [pause] but then they decided that they should go to Retreat. [Pause] Now everyday one of the sisters comes round, apparently she's been promised the house by the council.

R: You've got many problems.

Having been mirrored and heard, Phillip refers now to being alone (part of the disavowed, the unsaid, in what he has just said). I pick up the theme of sadness. This question challenges what has been disavowed, challenging it into consciousness. He says he could not keep the children. This is an image at odds with the sense of him as strong and efficacious. Phillip needs to re-affirm the selfobject phantasy position. His talk about how the children were taken away is thus a displacement and a vertical splitting off (Wolf, 1988) of the sadness. Perhaps, needing to disavow the feelings of sadness - it is intolerable to explore this - he returns to the living arrangements and the issue of the house. I, spoken within these discourses, hailed by his discourse, and my own organisation of this experience, follow him in this.

My comment "many problems", an attempt to reflect back an understanding of the difficulty of his situation, is an embodiment of the shift in my subjectivity. I have moved to a position of thinking and reflecting that because there are so many problems I cannot solve them for him - I am no longer the active sorting-it-out counsellor of the initial stages of the session. He is the sad stoic, and I the silent listener. The comment is also a distancing, embodying my disavowal of mortality and dependency. I am still in an internal gaze, pondering his situation. If asked at the time I would have possibly have phrased, in a counselling discourse, this position as a realisation that at best I can facilitate his decisions on a particular path, not solve things. Being the active and organising counsellor is quite a different position to being the listener (and, to do the job of facilitation requires listening empathically - without listening and understanding the person's situation attempts at facilitation fall into unproductive advice giving). I am now in a position of hearing. It is as though my position as separate, acknowledging his position as strong man (the central organising phantasy) has allowed me to be with him in a way that allows him to begin to explore the disavowed. Having acknowledged the position, in him and in myself, seems to free us to explore more of the painful aspects. In order for me to mirror him, I have had to disavow aspects of my subjectivity, and in this disavowal, am able to become the listening therapist.

#### Phillip as Other, as the 'AIDS Patient'

During most of the rest of the session I do not see Phillip as an AIDS patient. I feel that what he was talking about has nothing to do with HIV/AIDS, and even feel later that the session is not useable for my research. But there is a point later in the session when it becomes abruptly clear to me that he is *the* AIDS patient, in essence. I suddenly notice his thin wrists, obscured before under his jacket and think and feel that he does have AIDS, a direct contradiction with the dominant representation of him developed in the session, that the session was nothing to do with HIV, or AIDS. In the nature of that which is split off, the disavowed has returned (Chase, 1992). As I see his arms, he is the AIDS patient. When the conversation is not about AIDS he still is, we just do not talk about it, do not accept it into consciousness. In this I position him as unable to care for himself, as passive, frail, and in crisis - this was my initial representation of him. This is a moment of separation and Otherness. I focus on this "realisation" and lose track of what he is saying. In this moment he is irrevocably Other and I the active carer. He carries here my split off concerns (about my pain, loss, fragmentation anxiety). This splitting and projection is enabled by our respective positions. He is able to be, for me, the object of this image because of the disavowals we had (inter)subjectively produced. Through his positioning as rational and autonomous I am able to position him as separate. I position him as melancholic through a discourse of rational individualism - he has a compromised rationality (the illness has made him depressed, a problem locatable within him). In all of this a scene is replayed, a reproduction of historically recurring images of the ill: he

becomes the passive sufferer, alone, bearing stigmata marking his illness, and I the active but separate carer (Gilman, 1988). Paradoxically, the positioning of Phillip as Other has allowed me a connection with him. Becoming aware of the sense of separation startles me, and I repress these thoughts and images. Having disavowed this fragmenting material (through positioning him as other), I return more contained and cohesive. A selfobject phantasy, imbricated with a sense of trust-in-self (Brothers, 1992), is produced in this Othering. Having regained this selfobject phantasy I am able to be with him, re-enacting the shift in my subjectivity I have described above, allowing the positioning of him as strong and stoic. These positionings thus allow the production of an illusion of attunement to him (Slochower, 1996).

#### Phillip's Subjectivity: Father-With-Family

With the shift in my subjectivity and the changed representation of him, I am increasingly able to speak in a discourse of emotions. This reflects a reverse of the turn counsellors reportedly often make, where there is a resort to intellectualisation and information giving when the emotions become intense (Bor, Miller and Goldman, 1992) - a way of coping with difficult emotions. As we begin to explore the split off, I see him as rational - the strong stoic man. This reflects my need to see him as strong in order to disavow the pain - a need to shore up my self in an image of him-as-self-trusting. This recalls and repeats the glorification and romanticisation of the ill as male hero, which was a prevalent image of the sufferer in nineteenth century images of tuberculosis (Sontag, 1983; Alcorn, 1988). It is an image which preserves our sense of the ill as self-contained, as separate and not contagious. This is about not wanting to acknowledge aspects of ourselves that are evoked when sharing in the suffering that sometimes constitutes the human condition (Gilman, 1988). This is reflected and repeated in my not wanting to analyse the session, my feeling that this would somehow remove his dignity. Now feeling in tune with him (the illusion of attunement having been produced) I am able to ask/reflect to him that while he is alone, he thinks of his wife and children:

R: It seems to me that when you're alone like that you think of your children and your wife?

P: You know, my divorced wife lives nearby and I had three children with her. One's just finished school, one's in standard seven, the other's in standard ten. I've at least got for them and I see them every day. I don't want to be apart from from from what's mine. My brother and the rest of my family are staying in Grabouw and I could go stay with them, but to stay with them is too far, I want to be with my kids. I'm 40 years old, I want to see how my children grow up. To be apart from them, it's not right.

In Phillip's account he is a father and his place is with his family. To be away from them is wrong. He yearns for them. He defines himself via his family - through seeing his children grow up, through being with them. The phantasy in this representation is of self as efficacious carer, as father, in relation to his wife and children. A sense of being able to serve as a selfobject, of his self-as-trustworthy, is key here. This phantasy has presumably developed in this course of his life and in the relationships with the family and has sustained and allowed a connection with needed selfobjects. The investment in this position is provided by the sense of belonging and efficacy this allows - he is the capable and responsible father-with-family. The difficulty Phillip faces is that this phantasy of father-with-family is threatened - his wife has died and the children have been removed. The losses he is experiencing are a trauma, in Ulman and Brother's (1988) sense, shattering his selfobject phantasies - of himself in relation to the family in which he has invested so much, and who presumably provided him with needed selfobject experiences. Being apart from the children shatters this image. The loss of the children implies the loss of his wife and the impending loss of his child and perhaps then the recognition of his own impending death. His investment in the image of being a father, who should be with the children, allows a preservation of a link to needed selfobject experience. He needs to elaborate this phantasy, in order to stave off the threat to his self that the trauma constitutes. It is precisely as this key selfobject phantasy is threatened, that he needs to elaborate it further.

Through the elaboration of this selfobject phantasy Phillip is able to remain cohesive. Thus he is investing in a phantasy of self-with-family as a way of coping. I recall another man who responded to the news that he was HIV positive in a similar way. This man responded that having HIV was not so bad because his goals, which were to provide for his family and to make sure his daughter finished school, were completed. The phantasy that is elaborated, through a familial discourse, is one in which he is the patriarch/father, responsible for his family. This allows him a selfobject experience in phantasy, allows a shoring up of self and a preservation of needed selfobject experiences.

It is possible to understand why Phillip responds to my question, which is an enquiry into how he is feeling about the loss of his children, with an account of how things should be. Unsaid in this is again the pain of the loss of his family, as well as his facing his own mortality. This response is an expression of a need to repress these difficult emotions. In order to avoid the sense of loss and separateness, and the fear of fragmentation, Phillip invests in a selfobject phantasy of himself in relation to his family where he is the carer, therein preserving a sense of self-as-trustworthy (Brothers, 1992). In disallowing the notion of the children being away forever, and thinking of the children from his first marriage, his sense of self-trust is able to be maintained. In this representation Phillip shores up his self, allowing him to feel that he can still have his selfobject needs met.

This has a parallel to the stage in mourning whereby a person will in phantasy strengthen their connection with the deceased person, in order to retain the tie (Hagman, 1995) (as discussed in chapter 2). This is important, as it gives Phillip meaning and strength. It would provide him with motivation and cohesiveness such that he might, for example, be able to fight for the rights to have the children. If the image were shattered such that he lost a sense of self-trust, he might 'give up' - that is, be unable to sustain and organise motivation and action in ways that allow for needed selfobject experiences. In another sense, this discussion is thus about Phillip's capacity to remain hopeful.

#### The Unsaid Voiced and Disavowed: Self as an AIDS Sufferer

We discuss the difficulties of arranging to see the children. Phillip then says:

P: I'm missing my daughter, I want to see her

R: She's 4 years old?

P: 4 years ja

R: and the other, he's 8?

P: He's 8 ja. I've got 5 kids. My oldest son was born four-six-seventy-six, my oldest daughter was born twenty-one-six-eighty, the third was born the tenth of the eighth-seventy-seven. I had no more kids until the twenty-three, twenty-third of the fifth, eighty eight. My baby was born twenty-one-four-ninety-two. I can tell you, in six years I lost two wives [long pause]. Haai, if you can think how much hurt, hurts have happened, happened in your life, and it's not easy. [Pause] Now, these days, I don't sleep. [Pause] I'll anytime, come here and try to eat healthy and look after myself and a person gets old and as I get older I see who isn't thrown away. There's a lot of people that our, our case, our sickness, there's a lot of people that will [pause] you can't advertise your sickness because people reject you as soon as you are, like a, you know, contagious. They want to keep far away from you. If, if, so I chose to close my life [pause]. When will I see the doctor, 'cause you know, about the grant?

The emotion is palpable in Phillip's words. His detailing of the birthdays of his children is an embodiment and expression of the organisation of his subjectivity around the selfobject phantasy of father-with-family. As Phillip speaks, spoken within the representation of him with the children, he affirms his trust in his ability to be able to care, his connectedness. In this recollection, he is re-constituted as a father who belongs with a family that belongs with him. Through this re-collection of his self with his family, he is cohesed.

Part of becoming and being a father has been his life with two wives, both of whom he has lost. Phillip talks of the hurts in his life, the pain of losing two wives. The pain is intense. Seeing his life in this way - "life is painful" - has a quality of resolvedness, as in the phantasy of being the strong stoic. This talk is integrative and cohesive-making. A subtext in this, unsaid, is that he is worried about the death of his child and his own death.

After saying this he seems to vacillate a little, seeming to change topic. Is this a mini fragmentation, in the face of contemplating these enormous losses? He begins to voice very painful feelings, heretofore unsaid aspects of his experience. In the last section of this excerpt, unlike in other parts of the session, Phillip defines himself as a person with HIV, as a member of a group sharing "our sickness". Here he defines himself as contagious and as Other. He says how he will look after himself. He says how he sees that people with AIDS are thrown away, and that if you are open about having this sickness, you are rejected. Knowing this he closes his life. This is the unsaid voiced, saying that which was previously silent and unsayable, the split off sadness returned. This is his internalisation of a sense of being Other, different and damaged, stigmatised (Levett, 1995). The isolation and rejection re-evokes a knowing and feeling of the losses of his family, his wife and of himself. Here Phillip's sense of self-trust is fragile, under threat. It is clear why he needs to disavow a knowing of himself as rejected, in the same instant that it is voiced.

In this excerpt he speaks of, and enacts, the disavowal of a knowing of himself as an 'AIDS sufferer' - framed as the contagious, rejected and isolated. This a resistance to a positioning within a discourse of stigmatisation. Even as he says it he disavows - "so I chose to close my life" - and begins talking about the grant. For Phillip experiences of stigmatisation and rejection threaten his image of self, evoking losses, so he enacts the disavowal of self as the 'AIDS sufferer'. In this is again the distancing of the separation and loss - the sadness being split off. This seems to be about it being a fragmenting experience to feel the irrevocable loss of his wife, of her death, because of what it signifies for him, and for his children.

In conjuncture with him, I go with the discussion about the pragmatics, explaining about the disability grant. Then I suggest he has much on his mind:

R: The blood the nurses drew, that's for some tests, to see how things are with you. The doctor will tell you about that next week. Next week the doctor will go through the tests with you and will sign the grant form.

P: See the social worker said to me that apparently the patients with our disease get preference over others, like TB patients.

R: The doctor has to sign the grant application form and will do that next week, at the medical check up. It depends on how sick you are, so they have to have the test results.

P: [Nods]

R: It looks to me, that as you talk, that you've got a lot on your mind.

P: I've got too, uh, much on my mind. Like I say to you, at night I can't sleep. My thoughts, are all over the place, strek wragtig reg oor die Kaap [range right across the Cape]. I worry about myself. There's apparently nothing wrong, but then there's other things, like I don't go to church anymore. I've got to look at my life, I've got to start again, but I can't go to a third wife because I'm rejected now. But a life partner would be good, somebody that could look after me, make food, look after me. I must work but now there's some days then I'm pap [weak].

Phillip 'allows' himself here the thought that he needs connection. He is experiencing selfobject needs. He has a need for merger, to be held and cared for by a strong other. The nature of the object in this phantasy has the quality of being all protecting, all looking after - he is small with a need for an omnipotent other - or this is what he hopes for in the phantasy, because what has happened to him is terrifying. He now talks more and more about being alone, which he would probably have 'denied' earlier in the session. Phillip's positioning changes, becoming positioned now as in the receipt of care ("I need someone to look after me"), whereas before he was positioned as the carer ("I will care for the family"). In this shifting of subject position he is able to voice the aching sense of loss and aloneness. These are feelings that are disavowed in the image of self as the strong copier. In that image is of course the sense of self as trustworthy, and therein the maintenance of a selfobject tie (Brothers, 1992). The elaboration of the phantasy as a caring father-with-family, with a strong sense of trust in self, has the effect of allowing a connection and merger, in phantasy, with this selfobject other. In being the caring father he is able to be the cared for little boy. In this excerpt can again be read this disavowal, as he suddenly asserts 'I must work' - a self injunction to be strong. He is able to sit here with a sense of himself as rejected. It is as though he says because I am rejected, I chose to close my life. This is the rational copier who has experienced the pain, the disavowed, and who copes with it with a 'choice', the disavowal. Defining himself as Other, as contagious and rejected, a position from which he can cope with his choice, allows the disavowal described here. In this, the discourse of stigma articulates with the discourse of rationality. This, paradoxically, provides the investment for the positioning of self as Other and stigmatised. His positioning of self as copier, having been mirrored, gives him a sense of trust which enables the necessary illusion of attunement to me and of me to him (Slochower, 1996).

#### The Gendered Nature of Phillip's Selfobject Phantasies

These discourses, positionings and disavowals are gendered, reflecting Phillip's development within a patriarchal culture. If I had been a woman I may not have been hailed in the same way (and he may not have presented himself in precisely this way). A clearly different intersubjective transaction would probably have developed, one in which a female counsellor might have struggled to attune to him being simply "strong and stoic". The phantasy of being the caring father is gendered in that its object (which provides selfobject functions) is feminised - Phillip thinks of finding another wife. In the elaboration of phantasy as a strong man there is desire for the other, a desire perhaps for merger. The elaboration of this phantasy allows a merger with an omnipotent and caring other. In the phantasy, which has as a gendered object a woman (the third wife), can be read the oedipal splitting of attributes as gendered (a splitting of rational as masculine and feminine as

irrational, for example) (Benjamin, 1995). Phillip's positioning allows a repression of deep feelings of needing connection, which are feminised and split off. Through this positioning Phillip is able to repress the loss of his wife and children and to cohesively make his self. This repression could be seen, if we followed Gilman's (1988) theorisation, as a result of needing to disavow the primal terror evoked during the realisation of separateness from the primary caregiver. But we have seen that for Phillip the phantasy does not only involve a repression, it is cohesive making as well. It affirms his sense of trust-in-self (Brothers, 1992). Certain current theorisation on gender development (Benjamin [1995] referred to in chapter 2 as part of the critique of Gilman's work) suggests that identification with the father plays a role in serving to cohesively make the self. This identification serves a defensive function in easing anxieties about separation from mother, and productively in contributing to the child's sense of being able to love and be loved (analogous to a sense of self trust). Benjamin argues that "identificatory love [of father] is the relational context which, for boys, not only supports but also conforms the achievement of masculinity as a naturalised male destiny ... this gives the relationship with father an additional spin, making it ... crucial to the boys representation of gender identity, [and] his sense of self-cohesion" (Benjamin, 1995:131, omissions and insertions my own). As Phillip elaborates the phantasy of being the strong rational copier he is cohesively made, thereby repeating and re-enacting the oedipal cohesively making via identification with father, and the oedipal splitting of gender attributes.

Benjamin (1995) argues that the overinclusive phase of gender development, the phase of identification as both male and female, stays with us alongside oedipal identifications. This phase, a time of identification with both mother and father serves as a time of allowing self cohesion, as does the identification with father which eases the separation-individuation process. Within Phillip's sense of self-trust is this identification with father (strengthening self and easing separation) and the pre-oedipal overinclusive identifications. Thus the gendered nature of his selfobject phantasies reflect the oedipal splitting, repressing feminine aspects and his needy aspects, as well as the cohesive making identifications.

It's Not the Sickness: Otherness and Aloneness

I ask Phillip:

R: Do you worry that if you get sick that you will not be able to work?

P: About my sickness, no. I've got over worrying about my sickness.

R: It's really that you're alone?

P: I can tell you, honestly, I last had sex exactly a year ago. After my sickness, what's happened is that to be in the the, saamelewing [society] it's, it's not easy. Lately I've been having dreams like a guy who's fourteen, seventeen. But that's just how it is.

In much of the session Phillip talks as though the things that have happened are not about HIV (and I think this too as I transcribe the session). Phillip re-asserts this here - he does not worry about the sickness anymore, the difficulties he has are about being alone. This depends on a representation of having HIV as meaning worry over illness. Seeing being HIV positive in this way is, as we have noted, a dominant representation of HIV/AIDS - the AIDS patient as melancholic, worrying over the sickness. Seeing a person with HIV, or oneself, in this way makes these concerns manageable. Perhaps so it is for Phillip. He responds to my question about the effect of the illness on work, with a statement that he doesn't worry about the sickness anymore. To think of the day to day effect would mean thinking about what the signs of getting ill and tired might mean, which then might be evocative of the pain around the loss of his wife and family. Getting sicker brings a (forced) recognition that one is ultimately dependant (Dansky, 1994), not independent and autonomous as the patriarchal discourses of masculinity demand. Dependency is about realising our reliance on connection, and when that connection is broken or threatened, like for Phillip when he faces the prospect of losing his children, it evokes the feelings of loss. By locating a concern, which is about a day to day effect of the illness on him in this almost philosophical way, he is able to not think about how the illness may effect him on this day to day basis. He is able to split off the fact that he has HIV (and all that that implies), as though its effect on him was only in the period after he learned the diagnosis. In this he is not the AIDS sufferer, and the concerns are not about AIDS. We together frame the discussion as about an aloneness, resulting from the loss of his family. In this Phillip is able to keep central organising selfobject phantasies, that of himself as a strong copier and of himself as father-with-family, intact. The knowledge of the difficulties as about aloneness (not AIDS) is intersubjectively re-produced, as I, subject within my own need to disavow the knowledge of Phillip's mortality and my position with discourses of rational individualism, affirm and confirm Phillip's positionings. It is about aloneness, but it is not simply that - the aloneness comes from the AIDS, which has meant loss and need, which are renounced. In this excerpt is a sense of Otherness and stigma, the difficulty of living in society, but it is a sense that is silenced. It is perhaps uneasily disavowed in the position as stoic.

Linking with the topic of loneliness, Phillip's erotic dreams are seemingly about a desire for intimacy. Maguire (1995:151) suggests that, in a maternal transference, "male patients are more likely to retreat from love and dependency into overt expression of erotic desire". Within the sexual and sensual are many other needs and desires, which are structured in particular ways by the person's development and positioning within social forms (Hollway, 1984; Benjamin, 1995; Maguire, 1995). This retreat is made possible by men's positioning within gendered discourses, which position male sexuality as primal, biologically based, out of the man's control and with women the objects of male sexual urges (Hollway, 1984). Such a positioning allows a

disavowal of threatening aspects concerning intimacy, allowing men a disavowal of feelings of, for example, vulnerability (Hollway, 1984). Phillip's dreams perhaps provide expression and fulfilment of the need and desire for merger, to be held again in a space of safety and dependency. This need has been repressed in his phantasy of being the strong copier and now emerges in an eroticised form. The eroticisation, enabled and elaborated through Phillip's particular male subjectivity, in a splitting off of need into an objectified phantasy women, allows a disavowal of the feelings of dependency and need and a shoring up of the subjectivity.

#### Finding a Responsive Selfobject Milieu

In the session I had a primary goal the facilitation of social support. In the context in which I was working the person may not return to the clinic for some time so it is important to work with this level. Also, as social support - a responsive selfobject milieu - is crucial in mourning (Hagman, 1995) and in managing the crises associated with a chronic illness like AIDS, it is an important avenue to address. It is a topic addressed as a matter of course in this sort of counselling in this context (Viney, Clarke and Benjamin, 1985; Miller and Bor, 1988). In this session I was aware of Phillip's particular needs in this regard. The question of how Phillip, with his particular selfobject phantasy organisation, will use social support is paramount. His 'choice to close his life' comes from the particular way he is coping, which involves a disavowal of significant aspects of his experience. This is the way in which he is coping and this, as we have seen, needs to be heard and mirrored. The question is whether this manner of coping is leading him to isolate himself. Phillip says that he closes his life because of the rejection he sees people with HIV/AIDS experience. This discussion is not to suggest that real experiences of stigmatisation and rejection have not happened to Phillip since he became HIV positive. What is important is the meaning he gives these experiences, and the relation of this meaning to the ways he copes.

Shelby's (1993) discussion of the complicated mourning process a bereaved HIV positive person may experience is important here. Shelby suggests that the bereaved HIV positive person often experiences difficulties in re-engaging with the world of the living, because of an awareness of their own death (their experience of self becomes organised around their impending death), and feelings of guilt (for surviving, for failing the deceased) (Shelby, 1993; Dansky, 1994). This seems important in regard to Phillip, who it would seem, is unable to engage with mourning because of how this would signify his own death, hence the need to disavow these aspects of his experience. Also, being invested in being the father, he may be guilty about his surviving while his wife died, and perhaps about causing his child's illness. He says at a point later in the session that it was not him but his wife who had the sickness first and so it was she that passed it on to their

child, but I imagine that at some level there must be a feeling of having been culpable, especially given Phillip's sense of himself as responsible father. I did not explore the question of the transmission. It may be that Phillip's regarding himself as not culpable, as a disavowal feelings of being contagious. Either way, given the positioning as other, as the AIDS patient, Phillip is left with a sense of damaged difference (Levett, 1995). This position may lead to the difficulties engaging in mourning, and perhaps with feelings of guilt regarding his daughters HIV positive status. Phillip seemingly has little social support, although this seems complicated by the manner in which he is coping, which partly involves a distancing from engagement. The question of whether Phillip will use the resources available to him is open, as is common in this kind of counselling. Phillip did not return for the follow up appointment, and it is difficult to speculate on the reasons for this. It might be reasonable to speculate that his particular selfobject phantasy organisation, with a sense independence and stoicism could mitigate against him returning for further sessions. How factors like Phillip's economic situation relate to this (finding difficulty covering transport costs) is also in question.

Phillip sits with a sense of being alone and needy. I ask him:

R: I see that you are very alone, is there nothing you can do to remain in contact with people, maybe go back to church?

P: I must go back to church. At the moment the church could do a lot for me, like uh I would give a third to the church and the church does everything for the funeral. The church people can do a lot for you, give a lot of help. My neighbours have been good, they bring me food sometimes. I don't want to move out of my house.

And later:

R: When you come back next week, would you like to talk again?

P: I'd like that, we understand each other. It does a person good to talk. If I go back to church, then I'll talk my heart out, because they understand.

R: That'll be good, and if you don't want to talk about the heavy things, talk about just everyday things, but if you want ...

P: So next week I come back?

Phillip regards the church as being able to help him. Given the sense of self trust that has been evident in the session, it seems as though he may follow this up. It is hoped that if he does approach the church that he would find a responsive and supportive surround - the spiritual can serve a selfobject function (Knoblauch, 1995). Knoblauch (1995) argues that, in a way similar to how we have described an elaboration of selfobject phantasy, religious belief can come to serve such a function for a person, allowing a person selfobject experiences in phantasy. Given the selfobject needs that seem to have been expressed in the session so far, mirroring and merger in particular, it would seem that these selfobject functions would be paramount in Phillip's religious

experience. Beyond the phantasy selfobject dimension of religious experience is the fact that this often involves contact with others, that may be able to provide a supportive selfobject milieu.

#### Attunement and Disavowal

The session ends:

P: This morning I went to the wrong side of the hospital, I'll know where to go next time. Tell me, what is your name?

R: My name is Rob

P: Rob

R: My surname is Sandenbergh

P: The last Rob I knew was Rob Louw [laughs]. Rob, do you deal with cases like this a lot?

R: [nods]

P: Do it to your best, because one day anyone can be here.

R: [nods] Thank you

P: Thank you very much

The session seems to have provided Phillip with a sense of connection. Here he seems to associate me with prior experiences. The sense of me being attuned to him, the illusion of my attunement to him, has (as the analysis has shown) been (inter)subjectively developed. The final comments in the session speak of this attunement. The session, which has involved an affirmation and mirroring of certain of Phillip's central organising selfobject phantasies, has resonated with previous need satisfying selfobject experiences and so may have served as a sustaining selfobject experience for Phillip (Gilbert, 1994). The session has also been about the (inter)subjective process around Phillip being an other, disavowing aspects of Phillip as an AIDS patient. In the session there is a silencing of the sense of self as other - as ill and contagious, and in this is a resistance to the discourses of stigmatisation, and a bolstering of the self. The illusion of attunement depends on the disavowal and this resistance.

The process of writing the analytic reading has involved an attempt at articulating the complex and overdetermined experiences involved in the session. In this the process of writing mirrors the process of attempting to know the struggle of doing work in the field of HIV/AIDS. This returns me to the concerns that motivated the study in the first place, an attempt to understand the experiences of the HIV/AIDS counsellor. In important ways, this analysis is open and unfinished. Aspects of the analytic reading, for example around the gendered aspects of the session, could be broadened. In many ways, the selfobject phantasy theory relied upon has fettered the examination of these aspects, and it clearly is something that self psychology will need to

theorise in greater clarity. The open ended quality of the analysis reflects also the processes of being a counsellor, or of having HIV/AIDS. The meanings and experiences involved in the processes are fluid, contradictory and ambiguous. Given the ways that the knowledge practices around AIDS affect persons, psychologists involved in work in this area need to be aware of their imbrication within these practices and how their positionings affect their work. The next chapter takes up the implications of the conceptualisation of counselling as (inter)subjective in an examination of supervisory, training and consultative work.

## CHAPTER 5: AIDS/REPRESENTATION AND PSYCHOLOGICAL PRACTICE

### HIV/AIDS and Psychological Practice

The study now takes up an examination of the implications of the intersubjective analysis of HIV counselling for psychologists working as supervisors, trainers and in consultation with professionals, para-professionals and lay persons who are engaged in HIV/AIDS counselling work. This examination is not exhaustive, but is a part of the ongoing conversation about the role of psychology in South Africa, and particularly with regards to HIV/AIDS related work. South African psychology, along with many other institutions in our context of social and political change, has needed to reorganise itself and to search for more relevant forms of practice (Freeman, 1992). Debates concerning the role of psychology in South Africa have a long history, are complex and deserve a fuller treatment than is possible here (but cf. Anonymous, 1986; Dawes, 1986 and 1992; Vogelman, 1987; Seedat, Cloete and Shochet, 1988; Butchart and Seedat, 1990; Freeman, 1990 and 1992; Maw, 1996). Largely, these debates have involved examinations of forms and modes of psychological practice, which for the most part has been restricted to a privileged minority (Butchart and Seedat, 1990). Clearly, while HIV/AIDS impacts across all sectors of the population, for disadvantaged persons HIV/AIDS comes as an added burden on already existing hardship (Patton, 1990; Nyonyintono, 1992; Merson, 1993; Kusum and Jain, 1995). For a woman who has no job and lives in an informal settlement with 3 children, having HIV is perhaps experienced<sup>as</sup> 'more of the same' (Patton, 1990). The discussions around the relevance of South African psychology are clearly resonant with the issues within which HIV/AIDS is implicated. To the extent that it impacts on and compounds existing problems HIV "is not so much a new disease, but a new virus which highlights old problems" (Sherr, 1993:44). Any consideration of psychological work in this area in South Africa needs to be grounded in debates around and explorations of more relevant forms of practice.

### Potential Roles of Psychology in HIV/AIDS

The involvement of psychology within HIV/AIDS related work expanded greatly through the eighties, with various calls for and analyses of the role of psychology and related disciplines in various aspects of the AIDS pandemic (cf. Coates, Temoshok, and Mandel, 1984; Baum and Nesselhof, 1988; Morin, 1988; Plummer, 1988; Squire, 1993; Ussher, n.d. and 1993; Grace, 1994; Mkhize, 1994). Roles discussed and implemented have included a diverse range of forms of practice - including direct work with clients (on individual, family and group levels), consultation work, supervision work, training and research. Various writers, including several reporting on work done in South Africa, have called for HIV/AIDS related work to take a community

participation approach (Borges, 1992; Schietinger, 1992; Green, Zokwe and Dupree, 1995; Mathews, Everett, Binedell and Steinberg, 1995; Asthana and Oostvogels, 1996). Working as consultants, supervisors and trainers are roles that psychologists will take up in South Africa and so the implications focus on these roles.

## Implications of the Analytic Reading for Consultative, Supervision and Training Work

### 1. Implications of the Model of Mourning and Coping

The model of coping and mourning developed here involves the intersubjective re-organisation of selfobject phantasies. A key implication of this is clearly that people need ongoing support during their time of mourning, they need a responsive selfobject milieu in order to sustain and re-organise their selfobject phantasies. Clearly for Phillip the issue of social support was paramount. The provision of ongoing support of the sort discussed by Shelby (1993) (i.e. ongoing therapy) is feasible for a only small minority of South Africa's population. A role psychologists could seemingly adopt is to become involved in facilitating the support systems that exist already (non-governmental organisations, churches and so on). In this field, the role of the psychologist might involve an activist position, along the lines of the social action model in community psychology (Perkel, 1988), focusing on issues of empowerment (Rappaport, 1981).

#### 1.1. Relation of Counselling to Advocacy / Development

Phillip's moving from the issue of the loss of his wife and children to the issue of the house in the initial part of the session illustrates the point that for an HIV positive person, concerns like loss and mourning may often be subsidiary to other pressing concerns around survival (Dansky, 1994; Panos Institute, 1988; Kusam and Jain, 1995). Clearly, work which attempts to address HIV/AIDS will have to be aware of and attempt to integrate wider issues of development (such as access to resources). In other developing countries such approaches have been fruitful (Kusum and Jain, 1995). When working as a consultant these sorts of issues need to be considered when attempting to understand the contexts of the counsellor and their clients. In HIV related work the issue of medical support is clearly of enormous significance as well. This area is fraught with difficulty, as issues of empowerment are complicated by broad economic considerations (Serrano-Garcia, 1984). For example, the new anti-viral medications currently under development carry financial costs which are prohibitive in South Africa's economic climate (Pegge, 1993). This suggests a role for psychologists within organisations which lobby government, in policy making and so on.

## 1.2. The Model as a Framework of Knowing

This model of coping provides a useful framework which may be of assistance to counsellors in understanding what it is that their clients are experiencing. However, leaving the understanding at the level of selfobject phantasy theory may lead to a lack of knowing with regards to issues around gender and stigma, as well as of the involvement of the counsellor in the (inter)subjective processes around these issues. Other theory, which attempts to grapple with gender and stigma has been needed in this study. Consultants, supervisors and trainers need to be aware of the ways in which the theories they suggest construct particular ways of knowing and obscure others.

Theory about gender and stigma will be needed in consultant's and supervisor's attempts to understand the work counsellors are engaged in, as well as in understanding their relationship to the counsellor. Consultants or supervisors need to find ways of grounding the understanding of these processes in the experience of the counsellor and the clients. To adopt a position of knower, perhaps imposing a knowing on the counsellor, may lead to a lack of consideration of the (inter)subjective process that constitutes the consultation or supervision, and a silencing of knowing of the processes the counsellors are engaged in with their clients. This demands that the psychologist examine their own positions in the consulting or supervision relationship. This involves an examination of positioning in regard to issues of gender, stigma, and difference and involves "prior work from the ... [consultant] with regard to their own sense of self and place in the social matrix" (Levett, 1995:10; insertion my own).

## 2. Implications of Viewing Counselling as an (Inter)subjective Process

The analytic reading has developed a knowing of counselling which decenters the notion of the participants being rational unitary subjects. The focus is on counselling as an (inter)subjective process, imbricated within particular social forms. Counsellors cannot be seen as objective and neutral facilitators. Counsellors are intimately involved in the process of counselling. Conversely, the client cannot be seen as irrational, unempowered and so on. In important ways, clients know themselves more deeply and profoundly than counsellors can. This point is illustrated by the shift in my subjectivity, to a position that enabled me to hear and mirror Phillip. My acknowledgement of Phillip's key selfobject phantasies depended on the decentering of my initial positioning of Phillip.

This view of the process has an implication not only in the actual process of counselling, but in how the psychologist approaches the relationship to the consultee or supervisee. There is value in focusing on the

intersubjective exchange between psychologist and consultee or supervisee, in order to understand how it is that particular knowledges are developed in consultation or supervision discussions (Katz, 1995). An awareness of the intersubjective context of consultation and supervision is important as issues like power and hierarchy in organisations, gender, race, culture and so on are complicated and highly salient within South Africa's post-apartheid context (Mkhize, 1994; Maw, 1996). Issues of power and professional status also complicate these relationships (Maw, 1996). The psychologist needs to find a balance between respecting the consultee's or supervisee's experience and knowledge, and at the same time acknowledging and working with issues of differential access to power and knowledge. There is a need for ongoing attempts at "re-framing powerful and complex terms such as community, culture, race, class, gender and language in such a way as to make sense of these within the intersubjective field between consultant and consultee" (Maw, 1996: 80). This involves a process for the psychologist of examining his/her own positions, the ways these do and don't resonate with the counsellor and the effect of this in the consulting or supervision relationship (Mathews et al, 1995).

### 2.1 A Corollary: There is Not One Process for People with HIV/AIDS

A corollary of the view of counselling as an (inter)subjective process is an awareness that, while there may be commonalities, the meaning of having HIV or AIDS is not homogenous (a seemingly obvious point) (Patton, 1990; Thomson, K., 1992). Just as there is no HIV patient in prototype or essence, there is no prototypical 'news' of having HIV (Patton, 1990). There is a danger in assuming that a particular person will be pre-occupied with particular issues. Patton (1993) has noted that a reliance on a 'coming out' model (that is, an assumption that adapting to having HIV as about an adjustment to a new role, a new identity as a person living with HIV) is specific to particular cultures, genders and socio-economic classes. While for certain people it may be important to define themselves in this way, it may be an experience/process that is quite divorced from what a person has to confront and what they may have to face in themselves. It ignores the fact that people may have good reasons for not acknowledging their status (Hart, 1993; Patton, 1993). Defining oneself as a person with HIV/AIDS may involve a risk of being stigmatised, through an internalised sense of Otherness or having such a sense socially ascribed (Levett, 1995). As the analytic reading has shown, the reasons that Phillip has for not ascribing the label 'AIDS patient' to himself are complex. Considering this as a denial (with an assumption of pathology) could potentially lead to a situation where the counsellor confronts the client, leading him/her to either avoid treatment, or to resorts to a further elaboration of the means of coping - in Phillip's case perhaps further elaboration of selfobject phantasies of stoicism and perhaps further isolation. Certainly, there is a paucity of research on how people in South Africa are coping with being HIV positive or with having AIDS and research in this area is urgently needed. Consultants, supervisors and trainers need to be aware of these issues in their work.

## 2.2 There is Not One Process for the Counsellor

Another corollary of the view of counselling developed in the analytic reading is that just as adapting to having HIV or AIDS varies, so the process of becoming a counsellor varies from person to person. The questions that motivated me to embark on this research, as well as the act of writing it are part of my (ongoing) process of becoming a counsellor working in the HIV/AIDS related field. This process of becoming will be intimately linked to the (inter)subjective contexts of the counsellor. This means that as a consultant or supervisor one will need to be aware of the context of the work.

Training someone is not simply about the once off impartation of skills. It is important for a psychologist in a consultation, supervisory or training role to be aware of counsellors commitments to and investments in models of the processes HIV positive people go through. These models may, like the blindness to gender in selfobject phantasy theory, lead to elisions in knowing about what clients are experiencing. This means that part of the role of consultant, supervisor or trainer may be in facilitating counsellors through the perhaps unsettling task of changing positions which have come to serve as containers for anxieties evoked in their work. Again, this process needs to be grounded in the experience of the counsellor and must not be an imposition of the psychologist's positions. Becoming a counsellor is a process that needs ongoing support, as the counsellor continually grapples with new and challenging aspects, both in themselves and in the work. Actively engaging in this sort of process may come as yet another burden to counsellors, for the persons chosen to work as HIV counsellors in places like day hospitals or clinics may already have high workloads. Such persons may find themselves unwilling to embark on processes which are personally demanding (in terms of time or emotional resources) (Seedat and Nell, 1992). This brings up the difficult question of who will do this sort of work. Typically, these tasks fall to already burdened persons, like nurses (Berman, Gwatkin and Burger, 1987). With counsellors who are overburdened, embattled, and dealing with heavy issues, these dynamics may play out in staff relations, in ways in which clinics are organised, and in the dealings with patients (Silverman, 1990; Seedat and Nell, 1992; Barbour, 1993; Horsman and Sheeran, 1995). These are issues which need to be given consideration in proposals of who it is that will do HIV/AIDS counselling.

### 2.2.1 Implications for Counsellor Coping

The analytic reading illustrates how in the intersubjective process of the session I developed a particular knowing of Phillip, that the session was not about HIV and that he is a strong stoic copier. After the session I was left with feelings of sadness and an urgency not to disturb the session. How do other counsellors manage their anxieties in sessions? It may be that the sort of process articulated in the analytic reading, an intersubjectively produced disavowal, is one of the processes through which counsellors cope. This sort of disavowal can lead to stress or acting out in sessions (Slochower, 1996). This process of disavowal may be implicated in the high rates of burnout reported in the HIV/AIDS related field (Barbour, 1993). Clearly a consultation implication is to find ways to help counsellors understand the processes they go through - to facilitate their finding a responsive selfobject milieu within which they can re-organise their experience, where they may articulate difficult feelings and experiences encountered in their work. Part of this may involve a mirroring of these experiences, which may not be articulateable within other discourses, for example those positing counsellors as rational and objective.

### 2.2.2 Follow Up and Contracting

A related point concerns the issue of follow up. Although Phillip and I set a follow up appointment, he did not arrive. There was no telephone number given to contact him. It is not unusual for persons in this context not to return for follow up sessions, or to return at a much later point. Yet, in the sessions emotionally powerful matters are discussed. Having no follow up can leave counsellors feeling uncontained. Had I not had the opportunity to examine the session in-depth I imagine the representation of Phillip as stoic and coping (with a sense of him as self trusting) would have served to integrate the questions that remain about what is happening with him. Having examined the session closely this representation is less fixed. The process of writing this has perhaps served that selfobject function, allowing myself a stoic position of my own, that not knowing is the nature of this work. An implication of this is in the area of contracting for more sessions in a clearer way. Setting contracts allows a containment for both counsellor and client. There will always be times that persons do not arrive for sessions. This again brings up the issue of the need for support for the counsellor, as this sort of not knowing is an ongoing part of the work.

### 2.3 Counselling Does Not Equal Information Exchange

The analytic reading suggests that conversations in counselling are overdetermined by the (inter)subjective exchange. Talking about safer sex in a session will thus not just be about information, it is crucially about a re-negotiation and re-production of particular subjectivities. This, along with the numerous studies and reviews that suggest the processes by which persons come to change their sexual behaviours are only partially mediated by 'having information' (Schurink and Schurink, 1990; Patton, 1990; Hart, 1993; Stephenson, Breakwell and Fife-Schaw, 1993; Waldby et al, 1993; Nicholas, 1994; Lupton et al, 1995; Wood and Foster, 1995), suggests that counselling is not about an exchange of information. Such a view ignores the constraints on, within and emerging from the counselling. Thus, counselling that is prescriptive and which fails to engage with people's experience will result in little change in behaviour (Miller and Bor, 1988; Silverman, 1990). Negotiating intimacy and sexual behaviour is an ongoing process, there is no one true knowable sexuality and practice that can be taught, no gold standard. Rather counselling should engage with the person's ongoing negotiation with the demands of changing patterns of intimacy, sexuality and identity (Waldby et al, 1993; Watney, 1993). Grounding the discussion in a person's experience, rather than assuming a particular standard of behaviour to which the person must adapt, is more likely to help the person make decisions about sexuality and sexual practice. It would seem that understanding counselling in terms of the kind of (inter)subjective perspective developed here would allow psychologists and consultees or supervisees a way of understanding sessions in which there are difficulties in engaging persons about topics like sexuality. This means the counsellor needs to drop the position as a knower, and adopt a position as a co-constructor of knowledge (Cecchin, 1992). This is important for many persons find it difficult to practice their sexualities in the ways the safer sex literature suggests. Many women, in disempowered positions with regard to their sexual partners, cannot easily demand the use of a condom, for example (Tapping, 1991; Goldstein, 1994; Scheper-Hughes, 1994). Encouraging counselling that focuses on facilitating choices, rather than prescribing unworkable solutions is needed. Of course, as suggested above, this may be difficult as a position as expert and knower may function to hold counsellors through difficult and demanding work - allowing them a surety and cohesion. Similarly, counsellors who resort to giving medical information and advice may do so as the adoption of a position as an expert knower allows them a way of managing demanding and difficult work (in a way similar to my adoption of this sort of position in the initial part of the session with Phillip). Consultants and supervisors need to be aware of the sorts of investment counsellors have in the particular positions they hold and styles of working they adopt.

## CHAPTER 6: CONCLUSION

The idea for this study emerged from my experience that while working as an intern HIV/AIDS counsellor at a public HIV/AIDS clinic certain aspects of the work were silenced and not knowable within counselling discourse which presents counsellors and clients as rational unitary selves. In the development of a theoretical position from which to understand this experience, a dialogue between self psychological and post-structuralist theory was explored. From within these theoretical positions a session, that I conducted with Phillip, an HIV positive man, was analysed. The background of this study was provided by a body of literature, largely informed by post structuralism, which has examined HIV/AIDS in terms of the knowledge, representations and practices which have come to constitute the responses, on personal, social and professional levels, to the epidemic.

The self psychological theory examined concerned the elaboration of selfobject phantasies, within an intersubjective context. In this inquiry a self psychological conceptualisation of mourning was examined. The view of the psychodynamic consequences of having HIV or AIDS as involving a disruption of a person's selfobject bonds was broadened to include the idea that a person with HIV/AIDS would elaborate particular selfobject phantasies as a manner of coping with the threat to self cohesion represented by HIV/AIDS. A central theme in the analysis was thus that through the elaboration of particular selfobject phantasies (as a strong stoic man, and as a father-with-family), Phillip was able to disavow fragmenting aspects (about the loss of his wife, children and his own mortality). His sense of self was bolstered in this elaboration, and was thus able to elicit needed selfobject experiences. A key theoretical position was that the elaboration of selfobject phantasies occurs in an intersubjective context. This concept was extended to include the notion that the disavowals and the elaboration of the phantasies allow the counsellor and client to develop an illusion of attunement. This became a central theme of the analysis, that it was through the intersubjectively enacted disavowals that I was able to mirror Phillip and the way that he felt attuned to me.

The selfobject phantasy theory was criticised for omissions in regard to theorising the content of the selfobject phantasies that are elaborated, particularly in terms of their gendered content or form. As the analysis found that Phillip's selfobject phantasies were gendered, this is an important omission. While other theory was considered to address these gaps, it is clear that self psychology needs to consider issues of gender in more depth. The examination of theory aimed at addressing these gaps began with an examination of the dynamics around stigma, drawing on Levett's (1995) work. Particularly, Gilman's (1988) theorisation of an intrapsychic

need to project anxieties evoked by illness into socially marginal scapegoats was examined. Gilman's work was found to be useful, and several of the forms of representation he discusses recurred in the session. Phillip was represented, by himself and by me, as other and contagious and this representation affected the intersubjective exchange and our senses of self in the session. This issue of stigma was important in the study. Gilman's work was however found to be troubled by a universalism and reductionism that left it unable to theorise contradiction and the ways in which new meanings are produced. Recent theorising on gendered development (Benjamin, 1995) was discussed, suggesting the dynamics that Gilman evokes as explanations leave gender and contradictions in forms of representation unaccounted for. Hollway's (1984) discussion of the investment in particular subject positions as producing particular forms of relating was introduced. This theory was developed in order to examine how Phillip's and my subjectivity was re-produced in the (inter)subjective exchange of the session, how our subject positionings affected and delimited the ways in which we coped with 'AIDS' and how our subject positionings affected the unfolding of counselling work.

The analytic reading thus focused on an understanding of the session as (inter)subjective, as produced by the interaction of two variously positioned subjectivities. For this reason an analysis of my countertransference in the session formed a central dimension of the reading. The session involved a process of a representation of Phillip as other (by both of us). Our attempts to manage this experience were effected through disavowals, of the knowing of Phillip's concerns as about HIV (and hence of his otherness), in the elaboration of images of him as strong and stoic. In this elaboration and disavowal I was, paradoxically, able to be cohesed and was able to mirror Phillip. Through this process Phillip was able to feel attuned to me and in this the session served a sustaining selfobject function for him.

Implications of viewing counselling as an (inter)subjective process were examined for psychologists working as consultants, supervisors and trainers to persons doing counselling work. The implications concerned the consulting or supervisory relationship as well as processes that counsellors and clients might experience. The implications turned largely on the psychologist being aware of the (inter)subjective contexts of the consulting or supervision relationship, for example in the relations of power and knowledge in which the relationship occurs.

The analysis and the discussion of the implications are open ended, part of an ongoing discussion of HIV/AIDS related psychological work in South Africa. This unfinished quality reflects the unfolding process of becoming a counsellor, developing a consulting or supervisory relationship, and the multiple meanings around the area of HIV/AIDS. The issues imbricated in HIV/AIDS, including gender, sexuality, stigma, and death, are complex and evocative. In this work, where there are few solutions and few simple certainties, these issues need to be debated thoroughly. Understanding counselling work as (inter)subjective provides a theoretical position from which to engage with this complexity, on the level of one's experience. This complexity is what makes the work difficult, painful and rich. This fluid contradiction behoves the psychologist to attempt to find ways of articulating and holding, in themselves as much as in their clients, the sometimes unsayable experiences of living the history of AIDS.

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APPENDIX

Figure 1 (Gilman, 1981)



43. A broadside "On the Pox Called Malafrantzosa," 1500, from *Archiv für die Geschichte der Medizin* 1 (1907).



Figure 2 (Gilman, 1988)

51. The individual living with AIDS as black, male, and homosexual (*Newsweek*, 21 July 1986).

Figure 3 (Gilman, 1988)

With the introduction caused by the virus, HTLV-III, HTLV-III, LAV, or ARV are a variety of names for the same virus. They tend to cripple the immune system. They can invade the brain, and have with resisted treatment. Out of a total of 3,000 patients diagnosed in the U.S. so far, 15,000, nearly 50% of them in the well defined risk groups, will have died by the end of the year of a disease that was identified only five years ago. In 1991 the death toll is expected to reach between 149,000 and 201,000 but these figures pale beside those of cancer, which can strike anyone, in or out of so-called risk groups, and will kill in estimated 472,000 Americans this year alone. Moreover, unlike influenza and some other viral diseases, AIDS isn't easy to contract. It isn't spread through casual exposure. Nor does infection by the virus necessarily lead to the disease called AIDS, which is the end stage of the whole spectrum of HTLV-III-caused diseases. The Centers for Disease Control, or CDC, has estimated that in the U.S. between one million and one and a half million people are infected with the virus, as indicated by the presence of antibodies in their systems, but only 20 to 30 per cent are likely to get AIDS.

For the disease to be transmitted, it's believed that the virus must be present in the donor's blood or semen. It must be alive and stable. And the victim's immune system must be unable to resist the onslaught of the virus, so that it can successfully invade certain white blood cells that serve as master controls of the immune system. In the U.S., the most likely candidates for infection are 1) male homosexuals and bisexuals who are the recipients during anal intercourse with an infected partner, a



practice that can damage the fragile, blood vessel-lined tissue of the rectum; 2) drug addicts who share contaminated needles; 3) homosexuals and bisexuals of either sex who are also IV drug users; and 4) recipients of frequent blood transfusions, like hemophiliacs.

The CDC's projections for 1991 don't significantly alter the risk picture. By that time 270,000 people will have been diagnosed as having AIDS. More than 70 per cent of them will be homosexual and bisexual males, and 25 per cent IV drug users (about eight per cent of them homosexuals). Of the new cases in 1991, about ten per cent—some 7,000—will be classified as heterosexuals, some of them also IV drug users. (The corresponding number this year is 1,100.) The projected total seems high, but it represents an increase of only three per cent of heterosexual cases. This category includes people who've acknowledged contact with either an infected person or with a member of a risk group. Moreover, the CDC doesn't define what it means by heterosexual transmission, or heterosexual contact, nor can it say whether the cases will be spread through vaginal sex, anal sex, or sharing contaminated needles. In spite of the authoritative ring of these figures, the U.S. Public Health Service (PHS) said in June "Current information is insufficient to predict the future incidence of HTLV-III/LAV in the heterosexual population."

The spread of AIDS almost equally among men and women in Africa, reportedly through conventional male-female sexual relations, is often cited as a reason to expect widespread heterosexual transmission of the disease in the U.S. But the African experience with AIDS may not be applicable to Americans. As

49. The person living with AIDS as melancholic (*Discover*, September 1986).

## TRANSCRIPT

P: My eenigste probleem, I have 2, now about 3 months ago my wife passed away. She passed away, my family, her family, took my children away from me. I had 2 children with her. I was married before, six or seven years. My family took my children away from me. Now the council says if I'm alone I cant stay in the house.

R: The council says that if you live alone, they won't rent you a house?

P: Ya

R: Um, what sort of house is it, a council house?

P: Ya, a council house.

R: And before, your your children lived with you?

P: Everyone, we were all together.

R: Mmm

P: My daughter, she's 4 years old, she has the same sickness. I dont have any contact with them, any. I haven't even heard from them over the phone. The're in Retreat.

R: Who are they staying with?

P: My wife's sister, she's looking after them. I went to soc worker in X, she said the hospital can help me with a grant, so I came here.

R: Tell me, the social worker, who is she?

P: Mrs E.

R: You dont have her number?

P: [Get's up] Ek sal, I'll go and get it for you.

R: Dis okay, ons kan dit later haal, because maybe the social worker there can help with things, the application. She said that you must apply and if you get a grant then you can?

P: My circumstances are that at the moment, I don't see a way of staying on in the house.

R: Is the problem that you dont have any income?

P: Ya. [pause] This month it's a year since my wife was sick. She fell pregnant, she collapsed and so she went for a medical check, she collapsed, that's when we found out about the sickness. Our daughter got this sickness from her, [pause] our son, 8 years old, there's nothing wrong with him, there's

R: How have things been for you?

P: In the beginning I was a bit sad about, probably about the, that I have a sickness that nothing can be done about, but my age shows me that, that's just the way life is. Why be sad, you've lived your whole life.

R: Mmm

P: My closest family is my cousin, in Grabouw. I'm alone in X.

R: And now you're sad because your children are gone.

P: I didn't have a choice. I couldn't ... them, for them to stay. They said that there was no one to look after the children. One of the clinic sisters was planning to come and look after the kids, but then they took them away.

R: Was it the welfare?

P: The welfare man, uh, Mr T., the welfare in X., he gave permission for the children to stay ... but then they decided that they should go to Retreat. [Pause] Now everyday one of the sisters comes round, apparently she's been promised the house by the council.

R: You've got so many problems ...

P: Normally it's ... about two days a week. Most of the time I sit alone in the house. To stay alone in the house, a three bedroomed house is too much.

R: There aren't any friends?

P: Lots, but, but by quarter to seven, seven o'clock, then everyone's at home asleep.

R: So you're left alone

P: Stokseel alleen. The last person that I say good night to is the last person I see till the morning. About a month ago I get some char work, and it gets me a bit of money, en ek stap so rond

R: It seems to me that when you're alone like that you think of your children and your wife?

P: You know, my divorced wife lives nearby and I had 3 children with her. One's just finished school, one's in standard 7, the other's in standard 10. I've at least got for them and I see them every day. I don't want to be apart from from from what's mine. My brother and the rest of my family are staying in Grabouw and I could go stay with them, but to stay with them is too far, I want to be with my kids. I'm 40 years old, I want to see how my children grow up. To be apart from them, it's not right.

R: Is there not a way of contacting them, of being in more regular contact

P: I've got a phone number of of in Retreat. But it's far and it's expensive to travel. I want to have the children for the school, uh, holidays. The school holiday is in July.

R: And that's okay with your wife's sister?

P: Ya she said its fine

R: It looks to me that this is something that youre really looking forward to

P: I havent asked them yet.

R: Oh you havent asked them yet

P: [shakes head] mm

R: But I think it's something that you are looking froward to?

P: I'm missing my daughter, I want to see her

R: She's 4 years old?

P: 4 years ja

R: and the other, he's 8

P: He's 8 ja. I've got 5 kids. My oldest son was born five-seven-seventy-seven, my oldest daughter was born twenty-five-seven-eighty-one, the third was born the eleventh of the tenth sevety-eight. I had no more kids untill the twenty-three, twenty-third of the eighth, eighty eight. My baby was born twenty-two-ninety-two. I can tell you, in six years I lost two wives [long pause]. Haai, if you can think how much hurt, hurts have happened, happened in your life, and it's not easy. [Pause] Now, these days, I don't sleep. I'll anytime, ...come here and try to eat healthy and look after myself and a person gets old and as I get older I see who isn't thrown away. There's a lot of people that our, our case, our sickness, there's alot of people that will [pause] You can't advertise your sickness because people reject you as soon as you are, like a, you know, contageous. They want to keep far away from you. If, if, so I chose to close my life [pause] cause we know her name, her name bwcasue the number

R: [talk about med appt check up, dr to go through tests talk about grant doc will fill in form]

P: See the social worker said to me that appaarently the patients with our disease get preference over others, like TB patients.

R: Explain procedure of DG grant applic that next week dr fill in form at medical check up. It looks to me, that as you talk, that you've got a lot on your mind.

P: I've got too, uh, much on my mind. Like I say to you, at night I can't sleep. My thoughts, are all over the place, strek wragtig reg oor die Kaap [stretch right over the Cape]. I worry about myself. There's apparently nothing wrong, but then there's other things, like I dont go to church anymore. I've got to look at my life, I've

got to start again, but I can't go to a third wife because I'm rejected now. But a life partner would be good, somebody that could look after me, make food, look after me. I must work but now there's some days then I'm pap.

R: Do you worry that if you get sick that you will not be able to work?

P: About my sickness, no. I've got over worrying about my sickness.

R: It's really that you're alone?

P: I can tell you, honestly, I last had sex exactly a year ago. After my sickness, what's come up is that to be in the the, saamelewing [community] its, its not easy. Lately I've been having dreams like a guy who's fourteen seventeen. But that's just how it is.

R: I see that you are very alone, is there nothing you can do to remain in contact with people, maybe go back to church?

P: I must go back to church. At the moment the church could do alot for me, like uh I would give a third to the church and the church does everything for the funeral. The church people can do alot for you, give alot of help. My neighbours have been good, they bring me food sometimes. I dont want to move out of my house.

xxxxxxx

R: If it happened that you lost your house, is there family that you could stay with, is there family in X.?

P: Ja, the only family I've got here in X. is my ex-wife and our ties are broken, because after me she had another man

R: Your family that are in Grabouw?

P: That's my brother, my aunties, cousins, I was born in Macassar.

R: Could you stay with them if it happened?

P: If it happened I could. See, I don't want to be away from my children.

R: You want to stay near them.

P: I want to stay in X because my kids are near by. As soon as it goes better for me, and I'm in a position that I can provide for myslef, I'll fetch my kids from Retreat, becasue it's just about having a fixed home. Say that I'll have have someone with me who'll look after my kids... I know there's expenses ...

R: At the moment are things ... ?

P: Almal my children live with me when I grew up I was never alone. It makes me sad to be alone. Like in the evenings. My wifes family said I would infect the children but I wasnt even the one who had it first. You know the story, as soon as someone knows your sick they leave.

R: Have you told anyone?

P: There's a few, few people that know but I wont tell many people. If I need to tell someoe. My neighbours dont know. I do some jobs for them, and they give me food.

R: Will you try to get work.

P: I can't, I worked as a mechanic, it's hard work. In the old days X was a good town, but there's been hard times. Since I've been out of work, its difficult, its was, ja, three months ago that the doctor said I should come here, but it costs a lot to travel, about eleven rand just to get here. Thats why I dont see my family, I last saw my brother maybe two years ago, he works at a school, but its far.

R: They couldnt visit you?

P: For them its just as far. I want to stay here. The name Jacobs has been here long time in X. [Pause] Will the doctor give me any pills?

R: Next week, perhaps, after the medical check.

P: It's just that somedays I'm very tired. Its just some days, on somedays I feel to tired to go around. The half of my house, things are just piled up, dis a sight, its a mess, I've just thrown things.

R: Its hard for you to have to carry all this by yourself.

P: When I'm alone, my best friend is a dop. I know its not healthy for me, I know its not good, but when I sit there, at least I feel a bit okay.

R: Then you feel okay.

P: [nods]

R: Do you drink with anyone?

P: I drink with people, but like I say in the evenings I'm alone. The sister said its not dangerous for me to share a bottle. She said that at all times if I cut myself and the blood is there, I must clean it up.

R: You know, the virus itself is not strong, by the time the blood has dried the virus is dead, it doesnt live long outside a persons body. You cant infect someone if you share a bottle. Do your friends know..

P: I can say that about two friends know what's wrong with me, I'm not obliged to tell.

R: Sure

P: mm

R: I dont know if anyone has told you how the HIV virus works?

P: mm

R: When you come back next week, would you like to talk again?

P: I'd like that, we understand each other. It does a peson good to talk. If I go back to church, then I'll talk my heart out, because they understand.

R: That'll be good, and if you dont want to talk about the heavy things, talk about just everyday things, but if you want

P: So next week I come back?

{Arrange time of appt}

P: This morning I went to the wrong side of the hospital, I'll know where to go next time. Tell me, what is your name?

R: My name is Rob

P: Rob

R: My surname is Sandenbergh

P: the last Rob I knew was Rob Louw [laughs]. Rob, do you deal with cases like this a lot?

R: [nods]

P: Do it to your best, because one day anyone can be here.

R:[nods] thank you

P: thank you very much