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--*-*-*
LABORATOIRE DU DEVELOPPEMENT ET DU MAL-DEVELOPPEMENT
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HIV AIDS EXPERIENCE AND IDENTITY CONSTRUCTION IN HIV POSITIVE ADOLESCENTS.

Masters thesis written in view of obtaining a masters degree diploma

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Presented by

NGEH DAVID NKARNYU

Bachelor's degree in clinical psychology and psychopathology

Under the supervision of

Pr. MAYI MARC Bruno

University professor

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To

My mother, JATO Theresia NDOBE

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LIST OF ACRONYMES

ACCRR	:	Agent Chargé Du Remplissage des Registres
AIDS	:	Acquired Immunodeficiency Syndrome
APS	:	Assistant Psycho Social
ARV	:	Antiretroviral/Antiretroviral
CAMPHIA	:	Cameroon population-based HIV Assessment
CBO	:	Community Based Organization
CD4	:	Type 4 differentiated cell
CDT	:	Centre for the Diagnosis and Treatment of Tuberculosis
CNLS	:	National AIDS Control Committee
CTA	:	Centre de Traitement Agrée (approved treatment center)
HIV	:	Human Immunodeficiency Virus
IOMs	:	Internal Operating Models
MINSANTE	:	Ministry of Public Health
OVCA	:	Orphans, Vulnerable Children and Adolescents
PCR	:	Polymerase Chain Reaction
PLHIV	:	People Living with HIV
R/CTG	:	Regional or Central Technical Group
STI	:	Sexually Transmitted Infection
UNAIDS	:	United Nations Program on HIV/AIDS
VL	:	Viral load
WHO	:	World Health Organization

ABSTRACT

In this study we are looking at the experience of HIV AIDS and identity construction of HIV positive adolescents undergoing treatment with antiretroviral drugs. Coming to look at an African cultural context, the existence of the significance and interpretation given to HIV has contributed a lot to the developments of beliefs around it which makes the life and experience of those living with the disease to be very difficult. In this present study we are interested in the contributions and participation of the HIV AIDS experience in the process of identity construction of an HIV positive adolescent. The main focus will be looking at the part that the experience of HIV AIDS play in the process of the normal identity construction and how this contributes to the process of individuation. To get to this, a number of criteria was followed and put in place for the selection of our participants permitted us to get five participants under anti-retroviral drugs at the Centre hospitaliere universitaire (CHU) Yaoundé. The collection of data was done through the use of a semi directive interview which helped us to collect data in the form of a discursive interview from our five selected participants. From here we used a transversal content analysis method in order to analyze our data. From the data that we interpreted and analyzed, it informed us on the fact that being an HIV positive adolescent or carrying the status of an HIV positive adolescent greatly contributes to the process of identity construction through factors such as the influence of peers, culture, family behavior and personality influence. These factors affect them both positively as well as negatively in the way they get to interpret the world around them through ideologies and cultural influences inculcated in them and the representations that they make of themselves as a result of it which appear to be more negative than positive making them live in isolation and in shame of a situation which at the origin was not even their fault. These results were discussed based on the functionalist, cognitive and psychodynamic approach.

Key words: adolescent, identity, identity construction, HIV, experience, adolescence, representations.

RESUME

Dans cette étude, nous examinons l'expérience du VIH/SIDA et la construction de l'identité des adolescents séropositifs qui suivent un traitement antirétroviral. Dans le contexte culturel africain, l'existence de la signification et de l'interprétation données au VIH a beaucoup contribué au développement des croyances qui l'entourent, ce qui rend la vie et l'expérience des personnes vivant avec la maladie très difficiles. Dans cette étude, nous nous intéressons aux contributions et à la participation de l'expérience du VIH/SIDA dans le processus de construction de l'identité d'un adolescent séropositif. L'accent sera mis sur le rôle que l'expérience du VIH/SIDA joue dans le processus de construction de l'identité normale et sur la façon dont cela contribue au processus d'individuation. Pour y parvenir, un certain nombre de critères ont été suivis et mis en place pour la sélection de nos participants nous a permis d'obtenir cinq participants sous antirétroviraux au Centre hospitalier universitaire (CHU) de Yaoundé. La collecte des données s'est faite par l'utilisation d'un entretien semi-directif qui nous a permis de recueillir des données sous forme d'entretien discursif auprès de nos cinq participants sélectionnés. A partir de là, nous avons utilisé une méthode d'analyse de contenu transversale afin d'analyser nos données. Les données que nous avons interprétées et analysées nous ont appris que le fait d'être un adolescent séropositif ou de porter le statut d'un adolescent séropositif contribue grandement au processus de construction de l'identité à travers des facteurs tels que l'influence des pairs, de la culture, du comportement familial et de la personnalité. Ces facteurs les affectent aussi bien positivement que négativement dans la manière dont ils interprètent le monde qui les entoure à travers les idéologies et les influences culturelles qui leur sont inculquées et les représentations qu'ils se font d'eux-mêmes en conséquence, qui semblent être plus négatives que positives, les faisant vivre dans l'isolement et la honte d'une situation qui, à l'origine, n'était même pas de leur faute. Ces résultats ont été discutés à partir de l'approche fonctionnaliste, cognitive et psychodynamique.

Mots clés : adolescent, identité, construction identitaire, VIH, expérience, adolescence, représentations.

GENERAL INTRODUCTION

The concept of identity is a notion that is one that is not new to man neither to the body of science and almost everyone has at some point in time asked themselves the existential question of who they are. A lot of research has been done on the concept of identity and on the processes it takes to be built in an individual. Some of the authors having worked on this topic is Erik Erikson, James Marcia, Jeffery Arnett and has also been found in various approaches to psychology such as the cognitivist approach, the behaviorists and the psychoanalysts who developed a rather keen interest in this subject matter and how it is being built in every adolescent. Identity is defined as the pattern of perception, assumption and action an individual manifest while interacting with others and certainly not how one feels from moment to moment. (J Peterson 2022). Identity construction then is the process of building these various individuations.

Chronic disease on the other hand is defined as that which affects humans permanently throughout their lives. For Timmreck (1982), it is characterized by permanence, irreversibility and residual disability. According to the WHO (2005), these diseases are characterized by the extent of their impact on daily life not only for the patients but also for their entourage. The chronic disease disrupts everything in an individual's life, from health to quality of life, friendships and family relationships, leisure time and working life. The presence of a chronic disease requires specific education and long-term comprehensive bio-psycho-social care. There are several diseases that fall into the category of chronic diseases that have been threatening the existence of humanity for a long time. These include cancers, diabetes, high blood pressure, hepatitis and HIV/AIDS. In the context of this research, these chronic diseases are of particular concern to us, especially HIV/AIDS. It is one of the most devastating chronic diseases on the planet. The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have been among the most talked-about topics in the news for about half a century. Following its discovery in the United States in 1983, this infection, which for a long time remained one of the biggest killers in the history of diseases on the planet, has attracted a great deal of medical and psychosocial scientific interest. For a long time represented as an incurable killer disease, progress in the field of medicine led to the discovery of antiretroviral drugs that prevent the multiplication of the virus in the cells. This discovery brought AIDS into the category of chronic diseases. People living with AIDS have become more aware of their

illnesses and have seen their health improve and their life expectancy increase with the use of these drugs. But the chronicity of this disease makes life difficult for those affected, as they are forced to adapt to a new way of life.

Also, several psychological studies have already been conducted on HIV. Duclos (2000), conducted research that showed the traumatic impact of the announcement of an HIV positive status on therapeutic compliance. Bourdet-Loubère and Mazoyer (2012), also conducted a study which aimed to identify resilience factors in women with HIV undergoing medically assisted reproduction. Kwendahoua's (2012) study highlighted the different themes of the death drive among people living with HIV. Finally, Mvondo (2018) worked on the psychic structure and depression among PLHIV and it emerged from this study that the psychic structure was a determining factor of depression among PLHIV. For Desclaux et al. (2014), Self-stigma was the major form of stigma. It was estimated in their study to be 46% compared to stigma in interpersonal relationships which was estimated at 40% and stigma in health services which was 11%. In addition, in 2006, the Swiss AIDS Service (ASS) and the Swiss Federal Office of Public Health (SFOPH) published an article entitled "HIV and guilt". And many works mentioned below amongst others.

Looking into them we realize that there is little or no attention that has been or is being paid to the nature in which these people especially at the adolescent stage view and identify themselves. And they hardly come to consider themselves as being a full and integral part of the societies they live in mostly resulting from the

Our work is structured around two main parts, each with three chapters. The first part is entitled the theoretical framework. It includes the problematic, the literature review and the explanatory theories. The second part is entitled the methodological and operational framework. It includes the methodology, the presentation and analysis of the results, and the interpretation and discussion of the results.

Part I:

PROBLEMATIC AND LITERATURE REVIEW

CHAPTER 1

RESEARCH PROBLEMATIC

1.1. Context and justification of the study

In this first section of our problematic, we will be presenting the data and status reports relating to the prevalence of the HIV / AIDS epidemic both globally and at the continental level, with an emphasis on Sub-Saharan Africa and particularly Cameroon. From there we then go to the specificity of the target population which are adolescents.

- **Statistics**

The phenomenon of HIV / AIDS has been among the most publicized topics of the day for about half a century. Following its discovery in the United States in 1983, the care of patients infected with HIV presents a real public health issue in the world. According to UNAIDS compared to global HIV statistics in 2017, an estimated 36.9 million people are living with HIV globally (UNAIDS, 2018). In antiretroviral therapy, approximately 21.7 million people had access to it in that same year. In this context, mainly in the gender approach 65% were adult women aged 15 and over and 53% were adult men aged 15 and over. Among newly infected people, there are around 1.8 million. According to the same report sheet, since the start of the epidemic, around 35.4 million people have died from AIDS-related illnesses and in 2017, around 940,000 deaths are estimated to be linked to this infection. In addition, according to global statistics, out of 36.9 million living with HIV in 2017, around 35.1 million were adults and around 1.8 million were children under the age of 15. This number of infected young adults is the reason we chose to conduct this study on HIV + adolescents. In addition, viral load screening coverage remains low in many parts of the world with only 47.4% of people having a suppressed viral load. These gaps in the HIV testing and treatment cascade mean that more than half (52.6%) of people living with HIV globally do not benefit from viral load suppression, increasing the risk of drug abuse. -HIV resistance and jeopardize efforts to achieve the impact goals of the 2030 Agenda for Sustainable Development (UNAIDS, 2018). This could also be explained by the lack of psychological care for HIV patients.

Regionally, in Western and Central Europe and North America, an estimated 2.2 million people were living with HIV with 70,000 new infections recorded in 2017. That same year, an estimated 13,000 deaths were estimated. Moreover, in these parts of the world 1.7 million have had access to treatment. Similarly, in Eastern Europe and Central Asia, UNAIDS reports that in 2017, 1.4 million people were living with HIV; with nearly 130,000 new infections recorded that same year. As a result, 520,000 people access treatment, and around 34,000 AIDS-related deaths are estimated.

The situation remains worrying in East and South Africa, the worst-affected part of the world, with an estimated 19.6 million people living with HIV, and 800,000 new infections recorded. More than 12.9 million people accessed treatment in 2017. In addition, West and Central Africa has nearly 6.1 million people living with HIV and 370,000 new infections recorded in 2017. An estimated 2.4 million people have accessed treatment and 280,000 people have died from AIDS. In reaching the 90-90-90 goals, the levels of viral load testing, treatment and suppression in this region are significantly behind schedule. Only Rwanda has achieved the second goal.

Particularly in Cameroon, from 2004 to the present day, the prevalence of the epidemic has experienced a remarkable decrease from 5.5% in 2004; 4.3 in 2011 to 3.9 in 2016. According to the results of a household survey conducted by Cameroon Population-based HIV Impact Assessment [CAMPHIA] for the assessment of the impact of the pandemic (CAMPHIA, 2018) , the prevalence rate fell from 3.9% in 2016 to 3.4% in 2017. According to this study, launched in the ten regions of the country with 14,000 households, or around 33,000 people aged 0 to 64 years selected. randomly, 400,000 new cases of HIV were diagnosed among 16 to 64 year olds. According to the gender approach, women aged 16 to 49 are the most infected. The situation is worrying in the South, East, Center and North-West regions which come respectively with 6.3; 5.9; 5.8 and 5.1 (CAMPHIA, 2018).

In addition, according to UNAIDS (2018), after the results of the survey carried out in 2017-2018 by CAMPHIA, viral load suppression in Cameroon is less than 50% due to low treatment coverage. The rate of PLWHIV / AIDS placed on ARVs is 71% with 49% of people living with HIV knowing their HIV status (UNAIDS, 2018). UNAIDS estimates that with this figure Cameroon is far from reaching the 90-90-90 target, i.e. 90% of PLHIV who know their serological status, 90% of PLHIV put on antiretroviral treatment and 90% of PLHIV with an undetectable viral load.

- **Consequences of the phenomenon**

HIV / AIDS, like many chronic diseases such as cancer, diabetes and high blood pressure, has had terrible and devastating socio-economic, socio-demographic and health consequences since the emergence of the first cases in 1985. This is a pandemic whose impact remains considerable in our society today. As a socio-demographic consequence, millions of children find themselves orphans, we are witnessing an increase in orphans. Additionally, HIV / AIDS affects adults in their most sexually active years which coincide with their most productive years (Chrystelle, 2009).

Regarding the socio-economic consequences, the economy of developed countries and those in the process of development becomes paralyzed and collapses because of the enormous sums spent to face this pandemic in terms of its prevention that its handling. charged. One of the effects of HIV / AIDS, according to the WHO (2004) health report, is the devastating financial hardship it causes, which in turn have tragic consequences.

According to the International Labor Office (ILO, 2003), Beyond the suffering it imposes on individuals and their families, the epidemic deeply affects the social and economic fabric of societies. HIV / AIDS has become a terrible threat to the world (Nzié, 2010). Public and private institutions find themselves in need of their qualified employees who are sometimes paralyzed or even dead. Indeed, HIV / AIDS affects development through the workforce.

With regard to the health consequences, HIV / AIDS progressively degrades the health of the individual in its entirety, that is to say in the social, psychological and physiological domain. The population's life expectancy is reduced, communities are wiped out, health services are overwhelmed (Nzié, 2010). This pandemic contributes to the occurrence of opportunistic diseases like tuberculosis. HIV / AIDS is portrayed as a fatal incurable disease (Megnemendong, 2016). But with the discovery of antiretrovirals, many people living with HIV have seen their health improve and the death rate has decreased (Michel, 2018). Antiretrovirals work on viruses by preventing them from multiplying in the body. However, do antiretrovirals guarantee the overall well-being of PLHIV? Although antiretrovirals have caused a dramatic decrease in the "morbidity and mortality" associated with HIV infection, 19.4 million people - more than half of them - still have an unsuppressed viral load (UNAIDS, 2018).

However, new concerns have emerged, in particular, the introduction of very long-term treatment for the disease, which has led to short, medium and long-term complications from

antiretroviral treatment (Viard, Leclercq, & Roudière, 2004). We can cite the toxic effects of these molecules such as: hypersensitivity reactions, mitochondrial toxicity, effects on cell differentiation, disorders of glucidolipid metabolism and the indirect effects of combinations of antiretroviral drugs such as restoration syndromes immune system, lipodystrophic syndrome, vascular accidents linked to metabolic disorders (Viard, Leclercq, & Roudière, 2004).

We therefore see that this disease has terrible effects on the somatic, behavioral and also psychic level in PLWHIV / AIDS, thus making their experience quite difficult and worrying, hence the importance of carrying out this study. Among the factors that may prevent detection and suppression of burden in PLHIV, UNAIDS (2018) cites discrimination, violence and stigma. We will focus on the psychological factors related to the individual himself that are likely to affect his psychological experience. According to the World Health Organization (2008) "the prevalence of mental disorders in people infected with HIV is considerably higher than in the general population".

Indeed, HIV / AIDS has exposed a set of ancient socio-cultural irritants held back by the claims to the omnipotence of modern myths (Lemieux, 2011). In an African cultural context and particularly in Cameroon, the representation of HIV is a common, collective thought that equates it with death, slow poison, bad luck, a mystical illness (Kwendahoua, 2012). In this context, AIDS represents in the minds of individuals the imminent potentiality of finitude. According to Kwendahoua (2012), the representation of AIDS has three main axes: mental, social, and cultural.

• On the mental level, AIDS is synonymous with death, the announcement breaks, breaks and causes a real collapse of the subject, whose only random hope is a miraculous cure;

• On the social level, AIDS is a sex disease resulting from a life of debauchery, it is a punishment from God, and pushes PLWHIV to live in shame, withdrawal, guilt and many others;

• Culturally, AIDS is a slow poison, a curse, a mystical disease, or the revenge of a family member who has already passed away (Kwendahoua, 2012).

To this end, the psychological and even psychopathological consequences of HIV / AIDS are serious and emerge as soon as the diagnosis is announced, both in the patient and his family circle. The announcement of the diagnosis of HIV / AIDS is a traumatic situation. Patients

suffer as much as those around them. So getting diagnosed with HIV / AIDS is often not an easy thing. It is a disease that scares everyone only through its name (Megnemendong, 2016). The diagnosis of AIDS therefore has a traumatic effect not only for the patient, but also for those around him. From this perspective, whether it is the announcement of serology, the acceptance and sharing of one's status, the daily intake of drugs ... the risks of denial, depression and trauma are high (Tchassep Nono & Tengpe Wabette, 2016). Thus the announcement of HIV seropositivity triggers many subjective reactions that are directly related to the idea of death. This disease generates a lot of anguish and fear. Often the emotion is so strong at the first announcement that the patient and their family hear only a small part of what is said. The patient often experiences this trauma throughout his life as a patient. The introduction of antiretroviral therapy put this epidemic on the register of chronic diseases. However, some patients had their viral load suppressed or undetectable and others not. This situation remains worrying for many States and also for the organizations responsible for the care of PLWHIV who would like to achieve the last objective in the 90-90-90 objectives by 2020.

- **Measures taken against those consequences**

Since the start of this infection, the united nations, nations, non-governmental organizations and associations have implemented multiple strategies that can help deal with this scourge. Globally we have UNAIDS and many other United Nations organizations. Faced with this pandemic, many African States have mobilized, each at their own pace and in their own way, to fight against what appears more and more clearly as a mortgage on the future of the continent (Gruénais, 1999 cited by Tsala Tsala, 2004). The political challenges of the fight against AIDS in Cameroon are real (Tsala Tsala, 2004). In Cameroon, the government set up a year after the effective start of this pandemic, i.e. in 1986 the National Committee for the Fight against AIDS (CNLS) which is placed under the supervision of the Ministry of Public Health... This committee is responsible for overseeing the application of government policies for the prevention and care of HIV / AIDS. It was from the year 2000 that he began to develop national strategic plans for the fight against HIV, AIDS and STIs which set out targets to be achieved within a specific period. Encouraging progress has been observed, such as the significant increase in the number of approved treatment centers, HIV / AIDS treatment units in the various district hospitals and FOSAs, and free ARVs since 2007. The latest strategic plan was developed in 2017 and runs from 2018 to 2022. All of the above shows that there is international and possibly national mobilization to block the way to this burden. Without forgetting the various laws put in place to fight against discrimination, stigmatization and

violence which are the factors which slow down the screening and suppression of the viral load. Despite all these efforts for PLWHIV placed on ARVs, their experiences are still worrying. This is the reason why this research is carried out with a view to capturing or apprehending the participation of early cognitive patterns unsuited to the onset of feelings of guilt in PLWHIV.

Several studies have been done on the psychological experience of PLWHIV / AIDS. In his study, Mvondo (2018) showed that psychic structure is a factor in the onset of depression in PLWHIV. According to Kwendahoua (2012), the announcement of the diagnosis is a traumatic situation, an impact of the strong emotional power linked to the proximity to death. For her, AIDS is a violent event that shakes one's identity, provokes intense psychic work on the infected subject who seeks to abandon everything, to want to destroy himself. In addition, she adds that as soon as the announcement is made, the subject suffers as a whole, with his physique and his psyche. In addition, a study carried out in Burkina Faso on the analysis of the forms of stigmatization of PLWHIV in Africa shows that self-stigmatization is the major form of stigma because it is estimated in this study at 46% compared to the stigma in interpersonal relationships assessed at 40% and stigma in health services which is 11% (Ky-Zerbo, et al., 2014). This shows that PLWHA have this attitude of stigmatizing themselves and of feeling different from others. Another study conducted at the University of Geneva on the benefits of psychological support for PLWHIV shows that in addition to the link between stigma, disclosure of HIV status and mental disorders, the state of health is also affected according to the experienced by patients by knowing that they are affected. The most common mental disorders are stress reactions, anxiety disorders, adjustment disorders, mood, and substance abuse. According to this study, current empirical data reveal an increase in the prevalence of mental disorders in PLWHIV compared to an uninfected population.

1.2. Position and formulation of the problem

According to (Tchassep Nono & Tengpe Wabette, 2016) National and international policies for the fight against HIV / AIDS promote comprehensive management of this infection. Right up to date, a good number of people who are living with the HIV disease and are on anti-retroviral drugs still have viral charges loitering around in their systems which have not been completely suppressed. A situation such as this one makes us ponder on the sources of such a fault be it the scientific organizations or the world bodies in charge of these domains. It might even be right down to the local governments not giving accessibility to improved ones. That notwithstanding, this can equally be as an absence or lack of proper psychological follow up.

This would mean that in terms of care for PLHIV, the needs are not limited solely to access to antiretroviral drugs. PLHIV also need psychological care, strictly speaking, which contributes to better social integration and also to psychological balance. In addition, according to a global study, ARVs have had a 33% failure rate and non-compliance is the main cause (Chongwang, 2018). This study shows that simply distributing ARVs is not enough, national treatment programs must improve to enable the achievement of the 90-90-90 objectives. Among the factors that hinder sustained viral load suppression, UNAIDS (2018) cites discrimination, stigma and violence. She argues that HIV-related stigma and discrimination disempower people living with HIV and those at risk of HIV infection, as some people living with HIV in some countries may drop out of treatment to avoid HIV infection, the dishonor that the disclosure of their serology could cause. This very study makes us understand that gender wise women are more vulnerable to physical abuse with their intimate partners and will not have anywhere to run to as a result of this load that they carry on themselves. In fact, faced with the need to take psychological suffering into account in the supply of care, the public authorities and certain non-governmental organizations have associated caregivers with psychosocial counsellors, community outreach workers, associations and a few social workers who provide psychological care. On the other hand, this way of operating can have the following drawbacks: the absence of solid training for these psychosocial agents in psychological support, the absence of supervision of the various stakeholders and the non-respect of the ethical and deontological rules of the helping relationship (Tchassep Nono & Tengpe Wabette, 2016).

1.2.1. State of the question studied

According to the WHO (2008), the presence of HIV/AIDS increases the risk of developing mental disorders. According to this organization, HIV/AIDS is a heavy psychological burden. Sufferers frequently suffer from depression and anxiety as they struggle to cope with the consequences of being diagnosed with the infection and face the challenges of living with a life-threatening chronic disease, including the shorter life expectancy, complicated treatment regimens, stigma and loss of social support, family or friends. Integrating mental health into HIV/AIDS initiatives and programs in countries offers an opportunity to improve the health of people with HIV/AIDS (WHO, 2008). A series of modules and training materials for integrating mental health interventions into antiretroviral therapy programs have been published by WHO. In addition, the main factors that have influenced the death of PLHIV/AIDS are: the CD4 count, the clinical stage of the disease and the psychological state

(Onohol & Sanou, 2017). Regardless all of this, an aspect not well looked into is that of the holding up of adolescents born in an HIV experience. The importance of this is the critical nature of this stage termed adolescence which is that stage where the identity of an individual is being formed and is seen on the three dimensional axis of the child themselves, the parental or guardian's view and finally the impact of peers and society on the individual directly or indirectly.

1.2.2. Empirical observation

The first time this concept came to view was when I was back in my village in Nkambe where we had a neighbor who was sort of known to be somehow promiscuous and this single mother had four children. Unfortunately, she had her fourth child when she was already a carrier of the virus and not a healthy carrier at that. From the view of it, the first three children to this woman had what we considered at that time as a normal growth and development which was simply because they distinguished themselves from the fourth who just happened to be very different from the other siblings from character to moods and the way he interacted with other children around him all this because he was a carrier. At this time it did not mean much to me because I knew little or nothing about the condition that he lived in and did not get to explore more about the subject matter but always had that situation in mind which was then reignited later in life when I came into contact with the second situation where I observed something similar. this time around already in the field of psychology, which then moved me to start posing certain questions as a means to grasp an understanding of what this situation meant or what was the source of it.

The second situation evoked above came up in the course of our academic program, it was required of us to carry out academic internships. It was in the course of this internship that I got the chance to meet a group of youngsters at the society for women and AIDS in Africa (SWAA) and what they had in common was that they were or had someone who was HIV positive and in a good majority were in the age range of adolescents though some of them were much younger than that some of them above the major age in Cameroon of 21. Coming to exchange with them, the note taken was that these persons had rather a difficult time inserting themselves in the various spheres of life be it school or work for those who left school earlier to get into odd jobs to make ends meet. Given that these were mostly adolescents. In a scientific scheme of work, these young people were mostly in the adolescent age range. The greatest difficulty they faced were that of finding a place among their peers or inserting themselves in

social spheres. This made it rather complicated for them to stand out in their various identifications as they were not properly integrated almost everywhere they found themselves. Now coming to contrast this situation observed to what the developmental theory of Erik Erikson stipulates in the fourth stage of his socio-emotional development theory which is that of identity versus role confusion, it makes us understand that one of the determining factors that establishes that an individual has basked to the positive side of this dilemma which is that of an identity is the fact that they are able to situate themselves in a specific group and were able to integrate themselves better in any organization. This is seen through the three main components of Integrity, continuity and interactivity.

1.2.3. Theoretical observation

Identity construction as at the moment of this research has showed up to not be a new topic but something that people have explored over the years such as Erik Erikson, James Marcia and Jeffery Arnett amongst others. Classical theories of identity such as the social identity theory, identity theory, narrative-as-identity, and identity work suggest several different mechanisms through which individuals construct positive identities. "mechanism" here refer to "a process that explains an observed relationship … how and/or why one thing leads to another" (Anderson et al., 2006; see also Hedstrom & Swedberg, 1998). In this section, we discuss some of these classical theories, identifying the different mechanisms for positive identity construction that the theory proposes. Here, they do not attempt to provide an exhaustive list of possible mechanisms for positive identity construction, but rather aim to offer a broad, illustrative sampling of mechanisms that are grounded in various theoretical traditions within identity scholarship. Throughout this section, we also revisit the typology proposed by Dutton et al. (2010) in order to establish clearer linkages among past and current perspectives on positive identity, in hopes of developing a more comprehensive theory of positive identity that highlights the sources of positivity each theory explains how to enhance. We chose to focus on these four theoretical perspectives because they offer varied accounts of the nature, origin, and influences of identity, yet they hold in common the core assumption that individuals possess a certain degree of agency in defining themselves in "positive" ways. Given their primary interest is on how individuals co-construct positive identities at work, the review does not feature theoretical perspectives that view identity as essentially rigid, structurally bound, narrowly defined, and/or exploitative. However, the account of positive identity construction does feature explanatory mechanisms for coping with devaluation, stigmatization, and oppression,

as well as those mechanisms for cultivating more positive identities that are not catalyzed by identity threat. And even coming to look at it, the types of identity threats they posed here does not really cover the scope of the situation of a chronic illness especially that of a sick child which more so carries a lot of not so positive tags to them talk less of informing us as to how these processes take place.

Again, before the 17th century we do not really find a philosopher or psychologist who takes personal identity as its object. John Locke passingly did so in his Essay on Human Understanding. But it is not still not of the existential dimension. It is about the relationship between consciousness and thought, of the connection between the self and thought; of the "sameness" of consciousness and thought or even that of the thinking being who, in time, recognize; it is treated there of the conscience which perceives itself in the past by remembering the actions and thoughts that been associated. It was only in the twentieth century that the term identity begins to designate symbolic experiences, and this is largely at the psychology of Erik Erikson that we owe this connotation. Erikson develops a developmental psychology whose stages are tension between two poles. One of these steps is that of conflict between, on the one hand, identity and, on the other hand, confusion of role. This stage arises between the ages of twelve and eighteen or twenty years. The body transforming, the person is brought to question itself in terms of aesthetics, sexuality and skills. The relationship with parent's changes at the same time that friendships are revealed and that a quest manifests itself of independence. Between the childhood from which she emerges and the future which opens in front of her, there is a whole space for the roles to be confused; it is only, in Erikson's gaze, by discovering his identity that the person will be able to fulfill himself adequately and fully State of the question of who exactly they are or rather still who they perceive themselves to be. They come up with their various angles to the explanation of how identities are being formed in individuals.

In this section, we are going to be examining some of the theories that are laid by some of these authors in an attempt to give an explanation to the notion of identity construction.

- **First explanative theory on the phenomenon observed and its limits.**

The psychoanalytic approach

Psychoanalytical conceptions have particularly contributed to characterizing adolescence by temporary disturbances and maladjustments. These disturbances, which are part of the subject's history, would be necessary for the smooth running of this period. It would be their absence

that would constitute an unfavorable prognosis as to the balance of the future adult. Inserting a discontinuity into previous homeostasis, puberty leads to a set of psychic reasoning's reaching the pulse level but also the instantiable level. Adolescence is then described as a period of tumults characterized by an exacerbated autonomy search and sudden and changing events.

Before the adolescents get to this stage, there are three main stages that helps the individual define the state in which they find themselves namely the phallic, the latent and the genital. It is from this first stage here termed phallic that the idea of identification begins to set in in the child where they begin to determine the differences in the sexes that they carry with the primary focus of the libido being on the genital. This is where Freud comes with the concept of the Oedipus and Electra complexes in boys and girls respectively. At this point, the kids get sexually attracted to the parent of the opposite sex and at the end of the day will identify with the parent of the same sex in order to be able to win the love of the opposite sex parent. Another stage where the concept of identity shows up again is in that of the genital stage which runs from puberty to death and in this stage we see the libido which was first deadened in the latent stage gets reactivated again but this time around with the presence of the forged superego, it does not just express itself but finds a compromise between the id and the superego.

For Gutton (1991), it is then necessary to distinguish puberty and its psychic equivalent, pubertal, adolescents (in other words, adolescence) in this way, rise in drive channeling, mourning work, defensive renovations and the quest for identity becomes the principal tasks pursued by the adolescents with the main preoccupations being the body transformations that shakes up the representation of the body image that the youngster has, first representations of sexual and aggressive drives and the body becomes the first instrument of reference for the adolescent with relation to his environment and how to better handle them. The only loophole we see in this theory or approach is that it does not present to us a variable which shows up to be rather important which is that of a sick child especially those that are in the state of a terminal or chronic disease such as sickle cell or even our disease of interest here which is that of HIV AIDS. This will definitely have some sort of alteration to the smooth passage of an adolescent through this stage given this theory expresses to us the importance of the body image to the growth process of the adolescent and that of mastering his environment there by building himself and on the other hand we see a situation where the illness might actually bring in some alterations on the physical body and consequently the perception of the body image and this pushes us to ask ourselves how exactly the adolescent's identity builds itself around these new circumstances.

- **Second explanative theory on the phenomenon observed and its limits.**

Classical theories of identity

Classical theories of identity such as the social identity theory, identity theory, narrative-as-identity, and identity work suggest several different mechanisms through which individuals construct positive identities. “mechanism” here refer to “a process that explains an observed relationship … how and/or why one thing leads to another” (Anderson et al., 2006; see also Hedstrom & Swedberg, 1998). In this section, we discuss some of these classical theories, identifying the different mechanisms for positive identity construction that the theory proposes. Here, they do not attempt to provide an exhaustive list of possible mechanisms for positive identity construction, but rather aim to offer a broad, illustrative sampling of mechanisms that are grounded in various theoretical traditions within identity scholarship. Throughout this section, we also revisit the typology proposed by Dutton et al. (2010) in order to establish clearer linkages among past and current perspectives on positive identity, in hopes of developing a more comprehensive theory of positive identity that highlights the sources of positivity each theory explains how to enhance. We chose to focus on these four theoretical perspectives because they offer varied accounts of the nature, origin, and influences of identity, yet they hold in common the core assumption that individuals possess a certain degree of agency in defining themselves in “positive” ways. Given their primary interest is on how individuals co-construct positive identities at work, the review does not feature theoretical perspectives that view identity as essentially rigid, structurally bound, narrowly defined, and/or exploitative. However, the account of positive identity construction does feature explanatory mechanisms for coping with devaluation, stigmatization, and oppression, as well as those mechanisms for cultivating more positive identities that are not catalyzed by identity threat. And even coming to look at it, the types of identity threats they posed here does not really cover the scope of the situation of a chronic illness especially that of a sick child which more so carries a lot of not so positive tags to them talk less of informing us as to how these processes take place.

Again, James Marcia devised a structured interview to categorize teenagers into one of four identification states. The statuses are used to explain and pinpoint how an adolescent's identity building process is progressing. According to Marcia's idea, identity is operationally defined as whether a person has considered numerous options and established firm commitments to a profession, religion, sexual orientation, or set of political values. However, Marcia does not

mention what becomes of the options considered when sets in the variable of a chronic illness given that from a biological plan and even right up to socially, it hinders the smooth flow of the decision making as it will hinder certain career choices as a result of the status…

- **Third explanative theory.**

Erik Erikson's socio-emotional development theory

According to Erik Erikson who is one of the main authors we will interest ourselves in is his theory of socio-emotional development. This theory holds that an individual in the course of growing up goes through 8 stages of development and the stage at which individuation starts to set in is that which he calls "identity vs role confusion" at this stage the child begins to ask themselves the essential question of who they are and what they will become with the triangular axis that determines their environment at that moment which is that of the introspection directives within themselves , the guidelines laid to them by their parents on the kind of person they should be and become in the nearest future and finally the pressure from peer groups and their various orientations in life's explorations. The author makes us understand that it is as a result of a proper resolution of each stage that an individual successfully crosses to the next stage and for this particular stage it is when the quest for a proper identity is obtained that its nemesis of role confusion is avoided and a demonstration of this achievement of identity is seen in the individual's ability to evaluate personal goals and values and being able to accept what they deem fit and reject what they do not consider. It is the achievement of this that helps them cross to the next stage. However, the triangularity of this theory does not show us or make room for the situation of a fourth variable which is that of a chronic illness where the child from their moment of awareness of their status changes a lot of factors in them and alters the "normal process" of identity formation as stated by Erikson and that happens to be our point of interest here. moreover, he describes adolescence to be an active period of identity construction through dialectical interaction between two main concepts of identity which he calls personal identity and social identity. Personal identity is the organized set of feelings, representations, experiences and plans for the future relating to oneself; it is a feeling of unity, continuity and similarity to oneself in time and space. Social identity on the other hand largely results from interactions with others, belonging to different categories. Some are based on physiological characteristics such as gender or age; the others correspond to classes and social groups, such as profession, religion or nationality, categories whose content is not neutral, but associated with representations of roles and standards of conduct (Coslin, 1999).

Erikson (1968) calls the sense of inner identity the integration that must be achieved in adolescence. To feel integrated and unified, the young person must feel a gradual continuity between what they have become in childhood and what they think they will become in the future; between what he thinks he is and what he knows others perceive and expect of him. Identity includes and prolongs all previous identifications. These identifications refer to the time when the child assimilated to a model by imitation and internalization of attitudes and behaviors. Identity is then an accumulation of innumerable past identifications. From these identifications then, what happens to the presence of an unforeseen variable which in itself is a life threatening factor such as HIV. How does this intervene as part of the factors that determine the identifiers that the child looks to in order to build for themselves an identity. For Erikson, recalled by Cloutier (1996), identity in adolescence therefore faces a crisis that can only be resolved through new identifications with peers and models outside the family. Identity development then depends on the evolution of three components in the adolescent:

- the emergence of a feeling of inner unity that integrates action into a coherent whole,

- the acquisition of a sense of temporal continuity linking past, present and individual future, leading the adolescent to become aware of following a life trajectory that has meaning and direction,

- interaction with important people in the environment that guides choices.

Integrity, continuity and interactivity are therefore the three components of identity from Erikson's perspective.

But this adolescent crisis cannot be isolated from the crises encountered previously. Erikson's theory therefore offers a complete perspective of life in which adolescence holds a crucial place in that it has the role of preparing the adult by defining his identity. This leaves us in the dark as to how the process takes place with the variable of a chronic disease that has the possibility of intruding into the equation of individuation which has not been evaluated to see how it contributes to the process of this identity construction, or better still how their own identity is being constructed with the presence of the variable of a terminal disease.

1.2.4. Other works touching this problem

Freud in his New Lectures on Psychoanalysis (1933) explains that if we drop a block of crystal on the ground, it breaks but not in any way; the breaks, although invisible on the outside until

then, are already determined in an original and immutable way by the mode of prior structure of the crystal. It would be the same for the psychic structure. Gradually, from birth (and no doubt before), depending on heredity but above all on the way of relating to parents from the very first moments of life, frustrations, traumas and conflicts encountered, in function also of defense mechanisms, the individual psyche is organized, crystallizes, just like the mineral crystal, with lines of cleavage that can no longer vary thereafter. We would thus end up with a real stable structure whose two models are represented by the neurotic structure and the psychotic structure. This goes a long way to solidify the theory of chaos which is originally a mathematical theory but regardless in a cross disciplinary state indicates to us in support that in a situation of chaos with the example of shattered glass making us understand that even at the break, it shatters in a specific patterns and the underlying patterns remain and can still be put back together in the patterns in which it was broken. Regardless that, the observation made is that of the inability for these HIV positive individuals to construct themselves a proper identity after the realization of the situation of crisis which is that of the chronic illness and better fit into their society. The trouble this creates for the adolescent is a problem of identity crisis.

According to Tejiokem. 2012, we are made to understand the overall data collected in these studies concerning the follow up of infants living in sub-Saharan countries with intermediate prevalence of HIV has enabled us to focus on certain aspects that could help in improving early care and follow-up in HIV-exposed infants. These include the structural and functional organization of health structures, the effective implementation of current recommendations, and the active coordination of their wellbeing. data were collected from two surveys: the current ANRS-PEDIACAM cohort which started in 2007, in three urban hospitals located in Cameroon, and the ACIP-EPIPEV cross sectional study Our results strongly suggested that both early HIV diagnosis and initiation of ART in infants were feasible and well accepted in "real life" pediatric urban settings. Among HIV-exposed infants enrolled in the PEDIACAM study, 89.7% were tested for HIV at a median age of 1.5 months and 83.9% completed the process by returning for their results before 7 months of age. Incomplete process was associated to factors related to the quality of antenatal care and obstetrical emergency than environmental. Among HIV-infected infants, 83.5% started ART before 7 months of age. However, ART initiation was considered as suboptimal in approximately one third of them. However, this study does not indicate to us the population in which we are interested in and as such does not answer our preoccupation of identity construction given the population is not indicated.

Furthermore, Yi-Hui Lee and al. 2008 in their article presenting to us HIV AIDS preventive self-efficacy, depressive symptoms and risky sexual behaviors I adolescents giving us a cross-sectional questionnaire survey tell us of the high rates of HIV/AIDS infections among young highlight the importance of focusing on reducing risky sexual activity, which is a key factor to the spread of HIV/AIDS. Few studies have looked at the link between HIV/AIDS prevention self-efficacy, depressive symptoms, and adolescent hazardous sexual behavior. Nurses' ability to administer effective programs for lowering teenagers' risky sexual behaviors is limited by their lack of awareness. regardless, in a case where they are already infected, these authors lay emphasis more on the prevention of further spread without really taking into consideration the aspect of their new mode of operation which is that of better coping with the new situation on the axis of self building. The main aim of their study was to investigate the relationships among HIV/AIDS preventive self-efficacy, depressive symptoms, and risky sexual behavior among Taiwanese adolescents which is the appropriate population for our work.

1.3. Enunciation of research problem

From the information gathered above, our research problem will consist of finding out the lapse between what the literary observation says and what the empirical observation shows which in this case, our main theory of focus will be the theory of socio emotional development of Erikson which gives us the various factors that an individual at the level of identity construction will need in other to have a proper identity and individuation such as identity diffusion, foreclosure, moratorium and achievement which is a process that ultimately creates self-awareness and a strong sense of self, a sense of continuation, clear choices and commitments as to aspects such as career, religious and sexual orientations as well as interactions in peer groups, the most primary of them being friends, family, schoolmates, other social groups, societal trends and pop culture as a result of this achievement. whereas from what we observe, there are a group of individuals that don’t get to follow the same pattern and don’t show out the same results as the others considered normal. for those who show different results here, they all have one thing in common which is that they are HIV positive. At this point where they are, the problem of difference introduces itself as there is a clear difference as to what the theories stipulate which focuses only on the child considered normal and what the observations show us which is that of discontinuity in orientations, life choices based solely or very much influenced by the situation that they live in which is that of HIV. this brings about a situation of identity foreclosure and no room for free expression resulting from the social tag that is

labeled on their situation/status. this keeps us in the dark as to the processes that are put in place or the step by step nature of the construction of identity when it comes to the situation of the child that is in the situation of a terminal chronic illness. and how this condition of theirs actually has an impact or contribute in their process of individuation.

1.4. Research question.

To begin with, our study which has as population the people and specifically adolescents that are living with HIV AIDS come from our preoccupation which is that of the identity construction in young adults and its alterations from the standard process as a result of their serology status. Talking of serological status, our interest will be carried on how exactly it participates or its contribution to their identity construction. To get to this preoccupation properly, it brings us to the question posed as follows.: *"**how does being HIV positive contribute in the identity construction of an HIV positive adolescent?**"* or better still, "**how is identity being constructed in adolescents who are facing a life threatening disease such as HIV AIDS?**"

1.5. Hypothesis.

As a provisionary answer to this problem raised, we can say that *the experiences that are lived by the adolescent who is HIV positive participates in the identity construction of the HIV positive adolescent*

1.6. Objectives of this research

We learn from (Kwendahoua 2012) that long-term illnesses profoundly disturb individual psychology and keep the subject in a state of psychic dismantling. This makes us understand that the person suffering is not suffering just from the biological aspect of the illness, but equally from the external view on it which is the stigma put on the disease and this goes a long way to damage the mental health and state of the patient. A bodily injury can be the source of several concerns in the lives of those affected. In psychoanalysis, the HIV/AIDS patient presents a feeling of abandonment, loss, despair, trauma, psychic unbinding (Kwendahoua, 2012).

As a result, our study here which is based on the identity construction in HIV positive adolescents will be to apprehend the contributions of various psychological as well as social factors both internal and external to the construction of the identity of HIV positive adolescents regardless their undergoing treatment.

1.7. Interest of the study

This research is of scientific, social and medical interest. From a scientific point of view, this study could provide knowledge in psychopathology and clinical psychology. In the context of psychopathology, the study sheds light on the question of the influence of individual antecedents on the experience of PLHIV/AIDS placed on ARVs. On the clinical level, it contributes to the understanding of the various factors predisposing PLHIV and the way their identities are built and the various aspects of it.

Throughout this chapter, we have presented salient elements related to the problem of this research. In the next chapter, we will discuss the literature review while defining the key concepts of our study.

- **Scientific**

On a scientific level, the interest that this work carries will be in enhancing more knowledge and shedding more light to the subject matter there by bringing a contribution to the already massive body of scientific knowledge.

- **Social**

At a social level, this study will bring more enlightenment to the society especially those living with these individuals that are carriers and will give them alternative suggestions on how to treat and better live with such adolescents and make life with them much better and convenient.

- **personal**

At a personal level, this research work will help me bring more clarity to a situation that I earlier on observed in the early years of my life and again in the course of my academic program and after having put in place the elements that will help me find clarity, this research with help me get that closure and equally help others around me.

1.8. The goal/aim carried behind this research

The aim of this research is to bring a contribution to the study of the psychopathological factors intervening in the experience of PLHIV/AIDS especially adolescents.

1.9. Delimitation of the research study

We delimit our study on three dimensions: thematic, social, and spatio-temporal. Thematically, the central theme addressed in this study is HIV experience and identity construction in HIV positive adolescents. SPIs are unconscious and/or conscious representations that an individual has about himself, others and his environment.

In relation to social delimitation, this research addresses a social phenomenon (HIV/AIDS) that challenges everyone. It focuses in particular on the insertion of people living with HIV/AIDS placed on antiretroviral. These are PLHIV who belong to the African cultural era.

In the spatial-temporal delimitation, this study addresses the identity construction of PLHIV having SPI placed on antiretroviral living in Cameroon and being on antiretroviral in one of the antiretroviral supply centers.

1.10. Definition of key words

In this section we will be ending here with the clarification of the terms that we have here in our topic and the terms we will be interested in here are HIV AIDS, Experience, identity, identity construction, adolescent.

1.10.1. HIV AIDS

The acronym HIV stands for the Human Immunodeficiency Virus, AIDS on the other hand stands for Acquired Immune Deficiency Syndrome. this virus is an infection that attacks the body's immune system, specifically the white blood cells called CD4 cells. According to the World Health Organization (WHO) HIV destroys these CD4 cells, weakening the person's immunity against opportunistic infections such as tuberculosis and fungal infections, severe bacterial infections and even some cancer.

1.10.2. Experience

The English oxford dictionary defines experience as the practical contact a person has with an observation of facts or events, that is an event or occurrence that leaves an impression on someone. For example, a company experiencing difficulties or learning a lesson through a very painful experience. For the American Psychological Association, it is an event that is actually lived through, as opposed to the one that is just thought about there by presenting contents of consciousness. The experiential theory proposed by Kolb 2015 takes a more holistic approach and emphasizes how experiences, including cognition, environmental factors and emotions influence the learning process. According to John Dewey on the other hand, his concept of experience allows a holistic approach to education, in the sense that it is based on the interaction between the human being and the world. It takes all sides of human existence, its being in the world, as the methodological point of departure. According to Panes (2008), lived experience refers to all the events that will the life of the individual concerned by a study on a phenomenon that includes him. From this angle we can point out experience being all the practical encounters that an individual has that leave an impression on them on the cognitive, emotional and sociocultural spheres of their lives.

1.10.3. Identity

The merriam webster dictionary defines identity as the distinguishing character or personality of an individual. The American psychological association defines identity as an individual's sense of self defined by a set of physical, psychological and interpersonal characteristics that is not wholly shared with any other person and a range of affiliations and social roles.

The fundamental hypothesis of psychoanalysis is, in this respect, that the representations we have of ourselves representations we have of ourselves and our bodies are not only the product of the product of a conscious cognitive process; they are also the result of affective They are also the result of affective movements and in particular of impulsive investments, which the theory of narcissism has tried to account for. These representations are marked in a fundamental way by the first interactions. These representations are marked in a fundamental way by the first interactions that the infant has with its family environment (Edmund Marc 2005). According to (J. Peterson 2022), Identity is the pattern of perception, assumption and action an individual manifests while interacting with others and certainly not how one feels from moment to moment.

1.10.4. Identity construction

also called identity formation or identity development is the process through which humans develop a clear and unique view of themselves and their identity. Erikson (1968) defines identity as a "fundamental organizing principal which develops constantly throughout the lifespan." Identity involves the experiences, relationships, beliefs, values, and memories that make up a person's subjective sense of self. Here we find aspects such as self-concept, personality development and values which are closely related to identity formation.

1.10.5. Adolescent

This is an individual that is in a developmental period termed adolescence. Adolescence is one of those terms that differ much from person to person and also from culture to culture. Adolescence is defined by the English oxford dictionary as the period following the onset of puberty during which a young person develops from a child into an adult. An adolescent on the other hand is a young person in the process of developing from a child into an adult. According to the American psychological association, adolescence is the period of human development that starts with puberty (10-12 years of age) and ends with physiological maturity at approximately 19years of age although the exact age span varies across individuals. During this period, major changes occur at varying rates in physical characteristics, sexual characteristics, and sexual interest, resulting in significant effects on body image, self-concept, and self-esteem. Major cognitive and social developments take place as well: Most young people acquire enhanced abilities to think abstractly, evaluate reality hypothetically, reconsider prior experiences from altered points of view, assess data from multiple dimensions, reflect inwardly, create complex models of understanding, and project complicated future scenarios. Adolescents also increase their peer focus and involvement in peer-related activities, place greater emphasis on social acceptance, and seek more independence and autonomy from parents.

CHAPTER 2
DEFINITION AND BACKGROUND KNOWLEDGE ON THE HIV DISEASE

A chronic disease is defined as that which affects humans permanently throughout their life. For Timmreck (1982); it is characterized by permanence, irreversibility and residual handicaps. According to the WHO (2005), these diseases are characterized by the extent of their impact on daily life not only for patients but also for those around them. Chronic disease disrupts everything in an individual, from their state of health to the quality of life, their friendships and family, their hobbies and their professional life. The presence of a chronic disease requires specific education, comprehensive long-term bio-psycho-social care. There are several diseases that fall under the category of chronic diseases that have threatened the existence of mankind for a long time. These include, among others, cancers, diabetes, high blood pressure, hepatitis, HIV / AIDS.

In the context of this research, the chronic diseases that is of particular concern to us is the case of HIV / AIDS. It is one of the most devastating chronic diseases on the planet. Human Immunodeficiency Virus (HIV) is the virus that causes the Acquired Immunodeficiency Syndrome (AIDS) and has been among the most high-profile topics of the day for about half a century. Following its discovery in the United States in 1983, this infection has long been regarded as one of the biggest killer diseases in the history of diseases on the planet, and has generated great scientific interest in both medical and psychosocial terms. Long portrayed as an incurable killer disease, advances in medicine have led to the discovery of antiretroviral drugs that prevent viruses from multiplying in cells. This discovery brought AIDS into the category of chronic disease. Because with these drugs, they perceived an improvement in their health and an increase in their life expectancy. But the chronicity of this disease makes it difficult for those who are affected because they are forced to adapt to a new way of life.

Several psychological studies have already been carried out on HIV. Duclos (2000), conducted research that showed the traumatic impact of reporting HIV status on medication adherence. Bourdet-Loubère and Mazoyer (2012), also carried out a study aimed at identifying the factors of resilience in women affected by HIV in medically assisted reproduction. The study by Kwendahoua (2012) highlighted the different themes of the death drive in people living with HIV. And finally, Mvondo (2018), for her part, worked on the psychic structure and depression

in people living with HIV (PLWHIV) and it emerges from this study that the psychic structure was a determining factor of depression in PLWHIV. On the other hand, several studies have been carried out on the factors that intervene in the experience of PLWHIV. These include works by Ky-Zerbo, Desclaux et al. (2014) who have highlighted the feeling of guilt by highlighting stigma as the main determinant. They also showed that self-stigma was the major form of stigma. It is estimated in their study at 46% compared to stigma in interpersonal relationships evaluated at 40% and stigma in health services which is 11%. In addition, in 2006, the Swiss Aid against AIDS (SAA) and the National Office of Public Health (NOPH) published an article entitled "HIV and guilt". In this article, the authors indicate that the HIV diagnosis since its inception has been stigmatized. For them, stigma breeds discrimination in society and generates suffering for people living with HIV and their families. In the same article, Dietiker argues that guilt in PLWHIV results from moral judgment. And this judgment then triggers various feelings such as shame, annoyance, anger, sadness or anguish (Dietiker, 2013). In examining this work, we perceive that these researchers have emphasized stigma, discrimination and the look of others as a determinant of the vulnerability, the feeling of guilt among PLWHIV. However, several laws have been put in place to fight against stigma and discrimination against PLWHIV.

2.1. Origin and epidemiology

In this part, we will present the data and status reports relating to the prevalence of the HIV / AIDS epidemic both globally and at the continental level, with an emphasis on Sub-Saharan Africa and particularly Cameroon.

The phenomenon of HIV / AIDS has been one of the most publicized hot topics for about half a century. Following its discovery in the United States in 1983, the care of patients infected with HIV presents a real public health issue in the world. According to UNAIDS compared to global HIV statistics in 2017, an estimated 36.9 million people are living with HIV globally (UNAIDS, 2018). In antiretroviral therapy, there are approximately 21.7 million people who had access to it in that same year. In this context, mainly in the gender approach 65% were adult women aged 15 and over and 53% were adult men aged 15 and over. Among newly infected people, there are around 1.8 million. According to the same report sheet, since the start of the epidemic, around 35.4 million people have died from AIDS-related illnesses and in 2017, around 940,000 deaths are estimated to be linked to this infection. In addition, according to global statistics, out of 36.9 million living with HIV in 2017, approximately 35.1 million were

adults and approximately 1.8 million were children under the age of 15. This number of infected adults is the reason we chose to conduct this study on HIV + adults. In addition, coverage of viral load testing remains low in many parts of the world with only 47.4% of people having a suppressed viral load. These gaps in the HIV testing and treatment cascade mean that more than half (52.6%) of people living with HIV globally do not benefit from viral load suppression, increasing the risk of drug abuse. -HIV resistance and jeopardize efforts to achieve the impact goals of the 2030 Agenda for Sustainable Development (UNAIDS, 2018). This could also be explained by the lack of psychological care for HIV patients.

Regionally, in Western and Central Europe and North America, an estimated 2.2 million people were living with HIV with 70,000 new infections recorded in 2017. That same year, an estimated 13,000 deaths were estimated. Moreover, in these parts of the world 1.7 million have had access to treatment. Similarly, in Eastern Europe and Central Asia, UNAIDS reports that in 2017, 1.4 million people were living with HIV; with nearly 130,000 new infections recorded that same year. As a result, 520,000 people access treatment, and around 34,000 AIDS-related deaths are estimated.

The situation remains worrying in East and South Africa, the worst-affected part of the world, with an estimated 19.6 million people living with HIV, and 800,000 new infections recorded. More than 12.9 million people accessed treatment in 2017. In addition, West and Central Africa has nearly 6.1 million people living with HIV and 370,000 new infections recorded in 2017. An estimated 2.4 million people have accessed treatment and 280,000 people have died from AIDS. In reaching the 90-90-90 goals, the levels of viral load testing, treatment and suppression in this region are significantly behind schedule. Only Rwanda has achieved the second goal.

Particularly in Cameroon, from 2004 to the present day, the prevalence of the epidemic has experienced a remarkable decrease from 5.5% in 2004; 4.3 in 2011 to 3.9 in 2016. According to the results of a household survey conducted by Cameroon Population-based HIV Impact Assessment [CAMPHIA] for the assessment of the impact of the pandemic (CAMPHIA, 2018), the prevalence rate fell from 3.9% in 2016 to 3.4% in 2017. According to this study, launched in the ten regions of the country with 14,000 households, or around 33,000 people aged 0 to 64 years selected. randomly, 400,000 new cases of HIV were diagnosed among 16 to 64 year olds. According to the gender approach, women aged 16 to 49 are the most infected. The situation is worrying in the South, East, Center and North-West regions which come respectively with 6.3; 5.9; 5.8 and 5.1 (CAMPHIA, 2018).

Moreover, according to UNAIDS (2018), after the results of the survey carried out in 2017-2018 by CAMPHIA, the suppression of the viral load in Cameroon is less than 50% due to the low treatment coverage. The rate of PLWHIV / AIDS placed on ARVs is 71% with 49% of people living with HIV knowing their HIV status (UNAIDS, 2018). UNAIDS estimates that with this figure Cameroon is far from reaching the 90-90-90 target, i.e. 90% of PLHIV who know their serological status, 90% of PLHIV put on antiretroviral treatment and 90% of PLHIV with an undetectable viral load.

HIV / AIDS, like many chronic diseases such as cancer, diabetes and high blood pressure, has had terrible and devastating socio-economic, socio-demographic and health consequences since the emergence of the first cases in 1985. This is a pandemic whose impact remains considerable in our society today. As a socio-demographic consequence, millions of children find themselves orphans, we are witnessing an increase in orphans. Additionally, HIV / AIDS affects adults in their most sexually active years which coincide with their most productive years (Chrystelle, 2009).

Regarding the socio-economic consequences, the economy of both developed and developing countries is becoming paralyzed and collapsing due to the huge sums spent to deal with this pandemic in terms of its prevention as well as its handling. charge. One of the effects of HIV / AIDS, according to the WHO (2004) health report, is the devastating financial hardship it causes, which in turn have tragic consequences.

According to the International Labor Office (ILO, 2003), Beyond the suffering it imposes on individuals and their families, the epidemic deeply affects the social and economic fabric of societies. HIV / AIDS has become a terrible threat to the world (Nzié, 2010). Public and private institutions find themselves in need of their qualified employees who are sometimes paralyzed or even dead. Indeed, HIV / AIDS affects development through the workforce.

With regard to the health consequences, HIV / AIDS progressively degrades the health of the individual in its entirety, that is to say in the social, psychological and physiological domain. The life expectancy of the population is reduced, communities are destroyed, health services are overwhelmed (Nzié, 2010). This pandemic contributes to the occurrence of opportunistic diseases like tuberculosis. HIV / AIDS is portrayed as a fatal, incurable disease (Megnemendong, 2016). But with the discovery of antiretrovirals, many people living with HIV have seen their health improve and the death rate has decreased (Michel, 2018). Antiretrovirals work on viruses by preventing them from multiplying in the body. However,

do antiretrovirals guarantee the overall well-being of PLHIV? Although antiretrovirals have led to a dramatic decrease in the "morbidity and mortality" associated with HIV infection, 19.4 million people - more than half of them - still have an unsuppressed viral load (UNAIDS, 2018).

However, new concerns have emerged, in particular, the introduction of very long-term treatment for the disease, which has caused short, medium and long-term complications from antiretroviral treatment (Viard, Leclercq, & Roudière, 2004).

We can cite the toxic effects of these molecules such as: hypersensitivity reactions, mitochondrial toxicity, effects on cell differentiation, disorders of glucidolipid metabolism and the indirect effects of combinations of antiretroviral drugs such as restoration syndromes immune system, lipodystrophy syndrome, vascular accidents linked to metabolic disorders (Viard, Leclercq, & Roudière, 2004).

We therefore see that this disease generates terrible effects in people living with HIV / AIDS at the somatic, behavioral and also psychological levels, thus making their experience quite difficult and worrying, hence the importance of carrying out this study. Among the factors that may prevent detection and suppression of burden in PLHIV, UNAIDS (2018) cites discrimination, violence and stigma. We will focus on the psychological factors related to the individual himself that are likely to affect his psychological experience. According to the World Health Organization (2008) "the prevalence of mental disorders in people infected with HIV is considerably higher than in the general population".

Indeed, HIV / AIDS has exposed a set of ancient socio-cultural irritants held back by the claims to the omnipotence of modern myths (Lemieux, 2011). In an African cultural context and particularly in Cameroon, the representation of HIV is a common, collective thought that equates it with death, slow poison, bad luck, a mystical illness (Kwendahoua, 2012). In this context, AIDS represents in the minds of individuals the imminent potentiality of finitude. According to Kwendahoua (2012), the representation of AIDS has three main axes: mental, social, and cultural.

• On the mental level, AIDS is synonymous with death, the announcement breaks, breaks and causes a real collapse of the subject, whose only random hope is a miraculous cure;

• On the social level, AIDS is a sex disease resulting from a life of debauchery, it is a punishment from God, and pushes PLWHA to live in shame, withdrawal, guilt and many others;

• Culturally, AIDS is a slow poison, a curse, a mystical disease, or the revenge of a family member who has already passed away (Kwendahoua, 2012).

To this end, the psychological and even psychopathological consequences of HIV / AIDS are serious and emerge as soon as the diagnosis is announced, both in the patient and his family circle. The announcement of the diagnosis of HIV / AIDS is a traumatic situation. Patients suffer as much as those around them. So getting diagnosed with HIV / AIDS is often not an easy thing. It is a disease that scares everyone only through its name (Megnemendong, 2016). The diagnosis of AIDS therefore has a traumatic effect not only for the patient, but also for those around him. From this perspective, whether it is the announcement of serology, the acceptance and sharing of one's status, the daily intake of medication ... the risks of denial, depression and trauma are high (Tchassep Nono & Tengpe Wabette, 2016). Thus the announcement of HIV seropositivity triggers many subjective reactions that are directly related to the idea of death. This disease generates a lot of anguish and fear. Often the emotion is so strong at the first announcement that the patient and his family hear only a small part of what is said. The patient often experiences this trauma throughout his life as a patient. The introduction of antiretroviral therapy put this epidemic in the register of chronic diseases. However, some patients had their viral load suppressed or undetectable and others not. This situation remains worrying for many States and also for the organizations responsible for the care of PLWHIV who would like to achieve the last objective in the 90-90-90 objectives by 2020.

Since the start of this infection, the United Nations, nations, non-governmental organizations and associations have implemented multiple strategies that can help deal with this scourge. Globally we have UNAIDS and many other United Nations organizations. Faced with this pandemic, many African states have mobilized, each at their own pace and in their own way, to fight against what appears more and more clearly as a mortgage on the future of the continent (Gruénais, 1999 cited by Tsala Tsala, 2004). The political challenges of the fight against AIDS in Cameroon are real (Tsala Tsala, 2004). In Cameroon, the government set up a year after the effective start of this pandemic, i.e. in 1986 the National Committee for the Fight against AIDS (CNLS) which is placed under the supervision of the Ministry of Public Health. . This

committee is responsible for overseeing the application of government policies for the prevention and care of HIV / AIDS. It was from the year 2000 that he began to develop national strategic plans for the fight against HIV, AIDS and STIs which set out objectives to be achieved within a specific period. Encouraging progress has been observed, such as the significant increase in the number of approved treatment centers, HIV / AIDS care units in the various district hospitals and FOSAs, and free ARVs since 2007. The latest strategic plan was developed in 2017 and runs from 2018 to 2022. All of the above shows that there is international and possibly national mobilization to block the way to this burden. Without forgetting the various laws put in place to fight against discrimination, stigmatization and violence which are the factors that slow down the screening and suppression of the viral load. Despite all these efforts for PLWHIV placed on ARVs, their experiences are still worrying. This is the reason why this research is conducted with a view to capturing or apprehending the participation of early cognitive patterns unsuited to the onset of feelings of guilt in PLWHIV.

2.2. Some psychological aspects of HIV

2.2.1. HIV and morals

In the ANRS-VESPA (anhedonia, anxiety and depression) survey, HIV-positive patients suffer from difficulty in experiencing pleasure (anhedonia) comparable to that seen in patients hospitalized for depressive or schizophrenic disorders. In addition, a patient in four have anxiety disorders and one in ten suffer from depressive disorders. This prevalence was obtained by setting a conservative threshold based on HAD scores: they thus isolate people who have certain disorders, by not taking into account patients with less marked symptoms of anxiety or depression. The relationships between anxiety-depressive disorders and anhedonia (defined as the inability to experience pleasure) can take different forms: the latter can be understood as a symptom of depression or be considered as a predisposing factor to depressive and anxiety disorders, and constitute then a ground of vulnerability to the onset of mood disorders. The factors associated with these disorders are indicative of strong social inequalities health issues that cross the HIV positive population, as well as the disabilities that seem to promote anhedonia, anxiety and depression tend to stack up. Thus, it is the patients who have poor housing conditions, no jobs to find better accommodation, no diploma to find a job, no friends or primary partner to support them, who most often have difficulty experiencing pleasure as well as symptoms of anxiety and depression. In addition to these socio-demographic factors

common to the three types of disorders, it also appears that anhedonia increases from the age of 50, while HIV positive women are more prone to anxiety disorders. Finally, the progression of the disease (measured by viral load and CD4 count) and, above all, the side effects of the treatments and the discomfort they cause are associated with anxiety and depressive disorders.

2.2.2. Seropositives: Hostages of The Virus and of Society

In addition to people with AIDS, our society has the psychological responsibility for the growing cohort of people living with HIV. When a human group - at the scale of France - has a contingent of 150,000 to 250,000 subjects in 1989 (certain forecasts pessimists bring this number to over a million and a half at the end of 1993)? carrying the virus of a fatal disease for which it there is no truly effective medication, this human group does not cannot ignore the massive psychological impact of contamination in the following aspects: anxiety at the announcement of HIV seropositivity; the anguish continues over the days to be hostage to the virus. “ It appears to me that this qualification of hostage is the one which, in our clinical experience, most accurately characterizes conscious experience HIV positive: he is the prisoner of an enemy who has not yet declared belligerent, a clandestine enemy ready at any moment to launch his attack, devious warrior, unpredictable, using caches, camouflages, masks so as not to be flushed out. This is certainly the case for all foreign bodies (viruses, bacteria, parasites) against which the body normally defends all the time. But this precise retrovirus has yet to find a opponent capable of facing it. The testimonies of the hostages in the usual sense of the term - and of specialists in victimology, describe the deleterious effect on the psyche of this traumatic experience, during the period of isolation and continued threat, but also its long-term effect after release and confirm the need for appropriate, specific psychotherapy. We cannot stress enough this condition of passive hostages by report to the virus.

Those infected also express a second way to experience their HIV status as hostages: many of them feel hostages of the healthy society, the medical profession, politicians who could, under the weight of an opinion influence, deciding to 'unplug' (as we say in intensive care unit), that is to say to no longer treat under the pretext too high cost of expenses. of health or of too relative therapeutic effectiveness.

2.2.3. Psycho-Ethical Aspects of HIV-AIDS

Psychology, in the face of the AIDS scourge, cannot ignore ethical aspects of its function. There is no psychology without "soul", without underlying ethics, except to be a cold

technology. Likewise, there is no such thing as an ethics which is not based on a psychology, that is to say on an idea of man and his psychic functioning in his natural state, of culture or in its spiritual quest. However, the prevention of the AIDS epidemic requires, beyond technical protectionism (preservation), a system of psychological / moral values: respect for others not to be contaminated, understanding of the suffering of those affected, "self-love" opposed to narcissistic hatred, to self-hatred, to the death instinct. Among the structural instances of the human being, besides the Ego, representative of the social personality, and the id, which constitutes the base (resulting from the biological instincts) of the libidinal and aggressive impulses, exist as constitutive of the human psyche the Superego and the ideal of the ego.

The Superego is the heir of the Oedipus complex, the unconscious interiorization of parental and social prohibitions. It is the unconscious part of what in every human being will manifest itself in the form of a moral conscience.

The ego ideal is an instance which provides the individual with an identifying model, intended to satisfy both personal narcissism and social demands. It is the ideal aiming aspect of the Superego.

Our society has tended, for half a century, to consider these two last unconscious structures as obsolete, or as simple product of an outdated bourgeois morality. Gold personality cannot be built if it is not based on a system of prohibitions and ideals. All psychology is founded on an ethics, even if it wants the to ignore. The “benevolent neutrality” (S. Freud) of the psychoanalyst was defined by D. Lagache as “an exterior and interior attitude of non-aggression” towards the patient undergoing treatment, that is to say –say a respect for the other self-healing through personal re-creation. Since 1920 the psychoanalytic conceptualization “distinguishes two great orders of impulses: those which are animated by Eros, the impulses of love, and those which are governed by Thanatos, the impulses of death. Regarding the Eros drives, they manifest themselves in two forms: the narcissistic libido which corresponds to the love and care of the Self, and the object libido which is invested in the other and in particular the desired being love.

F. Pasche (1964), considered it necessary to introduce into the psychoanalytic corpus, in addition to these two libidinal destinies, a third tendency which he calls anti-narcissism and which pushes the subject to detach himself from himself, to deprive oneself of one's own substance for profit on the other, a pure gratuitous outpouring of the I. These basic psychoanalytic notions are essential for understanding, on a sociological scale, the aggression

felt by the presence prevalence of the virus, and the temptations of rejection, exclusion by the group social, as well as human internal resources to compensate for it psychically. Ethics is not a slice of psychology nor is psychology an aspect of ethics. Rather than confuse or oppose, psychology of the depths and ethics are at stake, to the extent where they tend to identify what philosophers call nature human.

Clinical psychology is a science that has its methodology clean, based essentially on the control of what is referred to in psychoanalysis under the name of countertransference, that is to say the part a priori of the observer, the therapist, the caregiver in general in the therapeutic action that he conducts and observes. Ethics, as we hear it today at the level of adults social groups or the human species, emanates from an organism group of reflection on the action, on the experience and on the project. Her function would it not be assimilated to the analysis of the countertransference of the therapist at the level of individual care ”? The HIV-AIDS phenomenon places us beyond concrete morals individual, in constant psycho-socio-ethical research in the face of problems to be solved urgently, which may arise under form of dilemmas:

_ How to preserve individual freedom and collective service everything at once?

- Can we make a necessary change in sexual behavior without changing mentalities, that is to say without reintroducing the traditional morality or inject a neo-morality, and then on which bases?

- How to protect adolescence particularly exposed to the epidemic without transmitting certain affective rules traditionally considered as values, in particular concerning love? The youth runs an obvious danger of psychological manipulation which calls for our vigilance (T. Anatrella).

Finally, if there is a problem that relates to both ethics and psychology is the problem of death. But the current problem caused by AIDS is the near-fatal course of the disease. Our clinical experience confronts us with this difficult face-to-face with death, if necessary to give it a meaning at all costs, in the individual or social life process. The psychotherapist - in his somatic life support initiative and psychic - always reaches that limit of death. Form to understand and interpret life processes, it leads to the psychological uninterpretable of the death to be assumed. It's only ethics that can give meaning to death. This thirst for meaning - spiritual, religious or humanitarian - must be heard by the psychotherapist “? Going against the sentence of La Rochefoucauld "The sun and death cannot be stared at”, a patient hung up to life - to death -

by quoting me the word of G. Bernanos, this familiar of death: "W do not die each for himself, but some for others, or even one for the other, who knows? "

2.2.4. Neurological Damage ‘Associated with HIV Infection

The HIV pandemic has grown extremely rapidly. In 1981, the first cases of AIDS were reported in the United States. Seven years later millions of people are infected across continents. Central neurological damage is observed in 40% of cases or peripheral in patients with pre-AIDS (ARC) or AIDS proven. This figure includes tables specific to the retrovirus and all opportunistic conditions observed in the nervous system.

To date, no scientific data allows a formal prediction of the risk of AIDS in a person who is simply HIV positive. 30% of the asymptomatic infected population is at risk of developing ARC or AIDS over a period of 5 years. HIV infection is the leading cause of encephalitis in infected individuals and is at high risk of reaching number one in the general population in the short term.

2.2.4.1. Virological Aspects

The nervous system is a prime target for infectious diseases. Advances in medicine, the emergence of antibiotics and Anti-parasitic drugs have made it possible to control non-parasitic attacks brain viruses from the second half of the twentieth century. However, it took another 30 years for anti-viral treatment to improve or even cure viral encephalitis. Currently, only herpetic meningoencephalitis benefits from definitive and evaluated therapy. The delay and insufficiency of antiviral treatments give a particular acuity to HIV infection. As early as 1982, neurological damage specific to HIV was described in some patients with AIDS. The virus was isolated in 1983 in lymphocytes by the respective teams of Montagnier and Gallo, in the cerebral parenchyma by Shaw in 1985 Virological taxonomy makes it possible to classify this retrovirus in the Lentivirus subfamily.

These viruses are well known to veterinarians and are associated with various encephalitis in the animal world. HIV is structurally very similar to the Visna virus and genomics. The latter is the etiological agent of a paralyzing epidemic encephalitis which decimated sheep farms in Iceland during the 1930s to 1950s. It constitutes an animal model allowing a physio-pathological study of human encephalitis associated with AIDS. AIDS is characterized by major immunosuppression, the reflection of which more or less faithful biological is

represented by the decrease in helper lymphocytes and their functional impairment. These are the main target of the virus. In addition to this lymphocyte tropism, HIV behaves like a neurotropic virus and colonizes the nervous system very early. The expression of neurological signs is random and differed by relative to the time of infection, except for meningitis acute characteristic of the primary invasion. The neurological attack of AIDS remains to this day one of the most more complex of this disease. Its mechanism is not unambiguous. Opportunistic infections and tumors reflect direct from immunosuppression.

2.2.5. Neurological Diseases Specific to HIV

2.2.5.1. Aseptic meningitis

The acute form is the most frequent [10, 18], it corresponds to the primary HIV infection and precedes or accompanies seroconversion. It is part of a flu syndrome reminiscent of mononucleosis infectious (fever, polyadenopathy, splenomegaly, arthralgia, acute pha ryngitis, maculopapular rash). Its clinical frequency is between 5 and 10%. Meningitis biological is often more frequent if it is systematically sought. The table includes headache, photophobia, syndrome meningeal which is not always complete, this in a feverish context. Transient paralysis of the cranial nerves (V, VII, VIII) or regressive encephalitic impairment may have been associated with it. The appearance of CSF is that of acute lymphocytic meningitis (pleocytosis ranging from 20 to 300 cells / mm * with proteinorachia of 0.5 at 1 g / l). Isolation of the virus from CSF is characteristic of this meningitis and intrathecal anti-HIV antibody synthesis was in evidence. The evolution is usually towards a spontaneous regression of signs.

2.2.5.2. Subacute encephalitis

Its frequency remains poorly evaluated (65% for Navia) over a series of 70 AIDS patients, 22% in the Levy series on all the neurological manifestations associated with AIDS the onset is insidious and gradual, frequently revealed on a psychiatric fashion; it is difficult to differentiate a depressive syndrome, which is very common in this population, from early encephalitis. Early signs concerning certain cognitive functions memory problems, loss of intellectual concentration,

- transient confusion, intellectual stickiness.

These disorders are perceived by patients or detected by neuropsychological sensitive tests. These signs of onset can be associated in 50% of cases with a motor impairment with balance

disorders, abnormal fatigability at the walking, writing disorders. Behavioral disorders are reported in 40% of cases. A real picture of acute psychosis with delirium and hallucination, sometimes represents the inaugural manifestation of the disease. More often, it is apathy, disinterest or loss of relationship with its social environment. Headaches or seizures have been described among the early signs. At this stage the clinical examination assisted by neuropsychological tests is often more sensitive than imaging or EEG. The X-ray scanner is usually normal, only MRI is able to show suggestive signs in the form of a hyper signal in T2 at the level of the white matter, periventricular, localized preferentially at the frontal and temporal level [18, 21]. The study of the CSF is poor: the pressure is normal; it allows to eliminate an infection associated with the negativity of the various microbiological examinations. The most frequent anomaly is shown by a discretely increased proteinorachia (0.45 to 1 g / l) associated or not to a moderate pleocytosis (10 to 50 elements / mm).

HIV can be isolated and there is intrathecal synthesis of specific antibodies in the majority of cases. The development of this currently fatal leukoencephalitis is rapid; it can be accelerated in inter-current opportunistic infections. In children with a congenital infection, leukoencephalitis has has been reported in 75% of cases [24, 25]. The clinical picture is quite close to that of the adult. The prognosis is pejorative. The evolution is done in a less progressive way, when walking up a staircase, and associates Microcephaly and psychomotor retardation.

2.2.5.3. Vacuolar Myelopathy

It has been particularly well described by Petito and Navia to be associated in 90% of cases with subacute encephalitis and the elective role of HIV as an etiological agent is now recognized.

The clinical picture is frequently entangled with cerebral damage or peripheral neuropathy, and it is mainly the data pathological pathologies that made it possible to isolate this neurological entity. The clinic finds walking disorders, with Para paresis spasticity, ataxia and pyramidal syndrome, more or less marked depending on the presence or absence of peripheral neuropathy. Urinary incontinence is found in 6 out of 10 cases. Faced with this painting evoking slow spinal cord compression, the CSF study did not find any hydraulic blockage. Myelography is usually normal, MRI in some cases can suggest the diagnosis. Only the anatomo-pathological data are specific, showing a very suggestive vacuolar degeneration with involvement of the white matter of the posterior and lateral spinal cords. In addition to these lesions, there is macrophage lipid overload. This myelopathy has a preferential dorsal topography. It is not a deficiency

myelopathy, comparable to combined sclerosis of the spinal cord because the vitamin dosages are normal in these patients. The appearances are characteristic and differ from the lesions observed in other infectious myelitis described in AIDS (Herpes virus Type I or II, Cytomegalovirus).

2.2.6. Clinical Aspect and Management

Faced with the neurological involvement of HIV infection, the doctor is faced with a complex diagnostic problem. The semiology is misleading and nonspecific, the investigations in imaging, or even brain biopsy, are not always definitive and the etiological catalog of the various pathologies seems limitless. The diagnostic process must also take into account in its aggressiveness of the patient's short-term prognosis, of the possible treatment, and of course of the respective frequency of the main etiologies encountered.

2.2.6.1.HIV and Quality of Life

What quality of life with HIV? The chronicization of HIV infection involves taking into account the quality of patients' lives, and no longer just their viral load and CD4 count, knowing that antiretroviral treatments that improve the immune-virological status of HIV-positive patients are likely to have a negative impact on their quality of life. Measuring this quality of life requires attention to the impact infection and treatment in all aspects of daily life, including taking into account, for example, the difficulty of carrying out certain tasks, certain usually harmless actions (going upstairs, getting dressed, shopping, etc.), or their impact on mood, professional activity, relationships with the entourage and most of all interaction with peers when it concerns children who are already conscious of their state of being. The international MOS SF-36 (medical outcome study short form-36) scale allows a synthetic approach to quality of life, reduced to two physical and psychological dimensions, by comparing the HIV positive population and the general French population. This approach first illustrates the strong impact of HIV infection and its treatments on the quality of life of patients. In fact, half of the patients questioned have a physical quality of life that is strongly degraded, and similarly half of these patients have a quality of life that is equally strongly degraded psychologically. Turning to the factors associated with these indicators, it appears that the material difficulties (financial insecurity, poor housing conditions) have a strong impact on the quality of life, and in particular the physical quality of life. From other social factors considered, experiences of discrimination by relatives seem to participate in a significant degradation of the mental quality

of life. Finally, the quality of life undoubtedly maintains complex relations with the revelation or, on the contrary, the concealment of the positive results from relatives (for example, a degraded quality of life can force revelation). With regard to medical factors, after taking into account the close relationship between anxious and depressive affects and quality of life, they have a very clear impact on the physical component of the latter, but less on its psychic component. Specifically, a high viral load and having already reached the AIDS stage are associated with a poorer quality of physical life. Above all, the risk of deterioration in physical quality of life is very important among patients who perceive bothersome side effects of their treatment

2.2.7. Alexithymia in HIV Patients

This difficulty in managing affects, in psychically containing the painful emotions, to experience and communicate them has been described in the United States by Sifneos under the name of alexithymia, term which derives from the Greek: has for lack, lexis for word and thymos for emotion, so it is literally the lack of words for emotions. Let us quote Sifnéos !! in the presentation of this concept: "A poor fanatic life resulting in a form of utilitarian thought, a tendency to use action to avoid conflicts and situations stressful, marked restriction in the experience of emotions and particularly a difficulty in finding the words to describe their feelings, have been spotted by a number of researchers in all of Europe and the United States as characteristics of a large number of patients with psychosomatic disorders". In alexithymia the differentiation and verbalization of affects do not exist or are disturbed and they remain in the form of emotions. The subject fills His internal void with external details, which may be particularly well observed in language.

According to Joyce MacDougall, "what is targeted is the maintenance of an inner death state so that the emotional experience felt to be threatening to the integrity of the subject is definitively discarded". This feature of mental functioning can be more or less pronounced, it may depend on socio-cultural factors. André Haynal has noticed that the percentage of suicides is higher when culture limits the expression of affects, which confirms the fact that putting emotions into words limits the risk of their putting them into action.

Alexithymia can be transient in each of us and react to an overflow of the psychic apparatus by an influx of painful excitement. Michaël Von Rad citing the studies of Krystal and Shipko, under the line that one can become quite alexithymic, following extreme stresses like those experienced in concentration camps or in the Vietnam War. But alexithymia can also be a

permanent feature of mental functioning. It would be frequently observed in patients with psychosomatic illnesses, in subjects subjected to toxic substances, in antisocial personalities tending to violent acts and also in subjects who resort to compulsive sexual behavior, subjects of which the sexuality, whether homo or heterosexual, is an "addiction" allowing the appeasement of painful internal tension. These subjects would have an above-average capacity to eject from their psyche threatening affects. A particularly demonstrative example of this operation permanent mind is given to us by Fritz Zorn whose “feelings” would always have been "atrophied and sick". "For thirty years I have therefore existed for the body but during the same time, I was dead for the soul ". We find here the caesura body / psyche incriminated by psycho-socialists. Imagining the type of woman he could have married he gives a voucher for.

Example of the presentation of alexithymics and their relational mode adapted to avoid narcissistic wounds: "she would be just as apathetic and boring as me and just like me, would everything so that neither of us was hurt or only touched by the other ". The defensive function of alexithymia is well understood by Fritz Zorn. It is above all a matter of protecting oneself against the eruption of unimaginable catastrophic emotional states: "I denied that there could be any problems for me because I vaguely felt that if there were any they would collapse on me in a way so appalling that I couldn't even imagine it ".

2.2.8. Emotions That Overflow in The Body

We intuitively know that overflowing emotions are capable alter the functioning of the body, which psychic pain can be the cause of somatic illnesses; this commonly accepted knowledge supposes the existence of links between the central nervous system, seat of emotions and the immune system involved in the onset of many diseases. Popular intuition has been supported by arguments scientific matters; the results of numerous epidemiological studies carried out in the United States argue in favor of this influence emotions on the immune system, I will name just one, published in 1977 and which seems to me particularly apt to stimulate our reflection: twenty-six subjects who recently lost their spouse have were compared to a control group, in the tests performed, the only noticeable difference was a functional deficit of T lymphocytes. Experiments with animals confirm what the results of these studies allow to presume, that is to say that information emitted by the central nervous system, supporting psychic functioning, can influence the functioning of the system immune.

The conditioning experiences ?! have amazing effects: we got thirsty rats to absorb saccharine water they hate and this absorption is associated with the injection of cyclophosphamide, potent

immunosuppressive substance. When the immune-suppressor effect thus obtained has disappeared, the absorption maneuver is repeated of saccharine water, but this time without combining it with the injection of cyclophosphamide. We are surprised to obtain powerful immune effects despite the absence, therefore, of an immunosuppressive substance. It was thus possible by conditioning to influence the development of diseases. A conditional stimulus may have been substituted for an immunosuppressive therapy in the case of experiential lupus erythematosus. The immune system therefore receives information from the system. nervous system and anatomical and functional links were evidence between the two systems. The existence of nerve endings has been identified in the lymphoid cells of the thymus, lymph nodes, spleen, bone marrow. But it is mainly through the blood that information circulate, thanks to messenger mediators, hormones and neuro peptides. In vitro experiments have shown that neuropeptides could strongly suppress the production of antibodies or prevent the migration of killer T cells to places where their presence was necessary. There is evidence that the central nervous system and the immune system can communicate directly and immediately but also by recalling a nervous memory and an immunological memory.

2.2.9. Mortifier Silence and Isolation

Finally, the difficulty in putting emotions into words, which would be particularly marked in AIDS in a situation where the patient is silent, is almost ashamed, is silent as this is one of the characteristics of this disease which could be a factor of poor prognosis in the disease stage proven if we refer to the study published in (Jama in October 1979) and quoted by Dr Saltel in the doctor's daily journal. This study which deals with advanced forms of breast cancer, does not show significant differences in the fate of thirty-five patients, according to the scores obtained at different scales of psychological items, otherwise a better prognosis for more sthenic patients, more claimants expressing better their emotions and their concern.

Among the affects and representations that can be mobilized by the diagnosis of HIV positive, fear of illness, the prospect of a bodily deterioration, the anguish of premature death can be particularly unbearable and therefore foreclosed from the psyche but the anxieties of abandonment, exclusion and relational isolation can also be difficult to contain psychologically by certain subjects who have a vital need for external objects to fill an internal lack.

In a situation of relational desertification, the reaction of an alexithymic would be favored and would tend to be prolonged. Through interviews with HIV-positive people, this reaction appears influenced by the quality of the emotional environment, a presence affectionate

seeming capable of strengthening the vital tone and a brake on mental and somatic disorganization whereas, on the other hand, the attitude of a departing entourage can amplify the distress of the seropositive; for fear of exclusion, the pain will remain unspeakable, the subject will stifle his suffering and silence the diagnosis because:

- "saying it" exposes the HIV-positive to being rejected as a follower of marginal sexual practices;

- "to say it" in your workplace is to take the risk of losing one's job;

- "telling" the sexual partners often causes them to flee be it as a result of fear for themselves or just a means of preserving reputation as a result of the stigma attached to it;

- "telling" parents is difficult because they often ignored the peculiarities of their child's sexuality and the fear of hurting them and to see them move away often retains the confidence.

Emmanuel Hirsch 1986 said "The problem is that we dare not say that we are HIV positive, that we are sick for fear of being rejected. I am homosexual and in this environment we don't talk about it, but because AIDS is scary, because it doesn't happen to us but to others, it is something dramatic, which prevents relationships keeping everything in oneself is too much to bear. We cannot talk about it with HIV-negative people, because it creates a real barrier as if a mask were placed in front of the mouth to avoid possible contagion".

The anxiety of the thought of being abandoned and not the actual abandonment itself can equally be a great trigger in the notions of suicidal attempts. S.G. Consoli and I. Ferrand reported the results of an investigation carried out in the United States in 1985 with caregivers in a psychiatric ward welcoming patients suffering from AIDS. This survey reveals that: "64% of caregivers feared they were contaminated and 36% experienced major anxiety when they had to take care of the patients ". Healthy information could reduce panic movements of a population that no longer lives the virus carrier as a bearer of death, leading him to wall himself into a silence that favors denial and evacuation from the psyche of experienced people all the more terrifying as they are unspeakable. Overwhelmed by the media with alarmist information in which the fear that they inspire, fear that they can read in the attitudes and gaze of the social and even medical entourage, some virus carriers undergo a highly traumatic situation, where they see an inevitable death approaching in isolation. If the patient often cannot say anything, on the other hand everything is told bluntly, he can imagine himself condemned by an "honorable" disease to a death the pangs of which are detailed in the newspapers, supporting

photos; such crudity in the information accessible to the patient is fortunately quite exceptional, the patient with AIDS, often young patient, can read: "death occurs in 100% of cases", "there is no currently effective therapy for this", without any mediator being near him to mitigate the brutality of the information received.

"Without being able to talk about their condition, the HIV-positive and the sick manage their problems in a silence that is rarely broken and with an extremely small number of familiars"? Condemned to the unspeakable, the HIV-positive is exposed to the unthinkable. "The patient leads an individual fight against the disease and less than 10% of those affected resort to associations or psychological support" but they don't necessarily want to find a psychological support, judging by some of the reactions of the patients listened to.

In conclusion we can then say that When they become seropositive the vulnerable subject, terrified by a diagnosis carrying nameless pains and terrors, stuck in a trying situation of contagious pariah, can have recourse to various methods of defense the objective of which is to put it out of reach of catastrophic emotions. Among these defenses some are likely to increase its fragility in the face of the AIDS virus: this is the case with denial which does not allow the subject to protect oneself from the danger of "risky behavior" and the case of foreclosure of affects whether obtained by somatopsychic inertia of the essential depression type or by physical hyperactivity with operative life.

Finally, relational isolation by prolonging the effects over time pathogens of untold emotions could promote the passage of the stages of seropositivity at the AIDS stage. So it belongs to each of us not to accentuate the deleterious pains of people who are often young and vulnerable through panic reactions and an attitude of rejection.

a. Stigma isolation and attempted suicides

Stigma, isolation and attempted suicides. In the ANRS-VESPA survey, 22% of HIV-positive patients questioned have already had a suicide attempt during their lifetime: 27% of women and 20% of men. This prevalence is clearly higher than those observed in the general population at any age and for both sexes, relative to the general population, the proportion of people with HIV who have attempted suicide is three to five times superior. These data do not make it possible to determine whether these attempts are before or after the diagnosis of seropositivity, but there is every reason to believe that the daily test of HIV is "suicidal". Medical information, in particular that relating to the progression of the disease, does not have a significant influence on suicide attempts, other than having been infected through homosexual intercourse or

injecting drug use, or to report a change in physical appearance due to treatment, knowing that these influences certainly refer to the social ordeal of HIV: homosexuality and drug injection remain behaviors that are still largely stigmatized, and lipodystrophy, in addition to being able to reveal seropositivity and therefore exposed to discrimination, degrades both the image that the individual has of his body and the one he wants to show to others. Some factors associated with suicide attempts are independent of the infection to HIV: this is the case with homosexuality, material insecurity, social isolation, and in the opposite direction of foreign origin (which plays a role of protective factor). Rather, other factors are specific to HIV infection and its treatment: in addition to changes in physical appearance, experiences of discrimination due to infection from family members, friends, sexual partners or co-workers. Thus, among patients who report more often such experiences, the prevalence of suicide attempts reaches almost 50% there by establishing a huge problem both to the individuals and their surroundings.

For a very long time since its appearance, many people as well as scientists were convinced that when talking of the sexually transmitted HIV it only has to do with homosexual intercourse, but it is no longer the disease of homosexuals. The infection claims even the lives of heterosexuals as they are more and more victims of HIV.

Together with intravenous drug users, they constitute now one of the new groups most at risk. On the 40 million HIV positive people expected by the year 2000, 80% will have it been heterosexual, that is, sexual intercourse between men and women. In 1992, there was a 62% increase in heterosexual group i.e. 71% for men and 54% for women. At this rate 280,000 new cases will be appeared in heterosexuals by the year 2002. No one is immune. Therefore, whether one is a man or woman and if we have had, even in the past, sexual relations with several partners, it is necessary to pass the AIDS test. Even a person with only one partner is exposed if the latter displays risky behavior.

2.2.10. AIDS, an illness also psychological.

The very first clinical psychology Laboratory to get interested in the study of the psychological aspects of AIDS was that of the university of Grenoble in their faculty of social sciences in 1983 where they had their first alert on the psychological aspects and implications of the illness rather than just the physiological and biological aspects of it. This new keen interest was not triggered by the fact there were too many peoples infected by this disease, but rather by the fact that they had to sensitize the medical staff, the administrative department and the psychologists

on the psychological and psychosomatic aspects of this illness which was something that was rather greatly ignored. Secondly, those who were tested positive especially those who were already sexually active were very little or not at all informed on the kind if lifestyle they were to adopt with their loved ones being family or love relationships wise and a proper orientation on the safety measures of sexuality needed to be adopted so as not to cut them off completely from the circles of their social lives extending from the inner circle of the family right down to the society where they lived. It is in this context of deployment of research and reflection that surprised us in 1981 by the idea of AIDS, in 1983 its biological and medical reality, in 1985 its psychological and socio-ethical importance, that is to say, its impact on the level of deep unconscious mentalities and collective behaviors.

The AIDS phenomenon, occurring on a planetary scale, cannot be treat or study psycho-sociologically unrelated to the countries those most affected by the epidemic; so we spent many research and training agreements with various foreign countries, especially in Africa. AIDS (Acquired Immunodeficiency Syndrome) and HIV (Human Immunodeficiency Virus) seropositivity require

many titles for the interest and research of psychologists, as well as the reflection of what I will call socio-ethicists, attentive to distant causes and long-term consequences of changes in mentality and mores. A first remark is necessary concerning these two areas, psychological on the one hand, socio-ethical on the other hand: ethicists were equally very early alarmed by the AIDS phenomenon because:

a) because of its strong media coverage: "AIDS is a medically transmissible disease" (M. Hannoun).

b) due to the rapid spread of the epidemic, which has forced the urgent production and implementation of information programs and prevention involving "moral" behavior: protection of oneself, of course, but also the protection of others;

c) and because of the political recovery that could be made through at the expense of the people or groups most affected by the disease or infection. In short, it went without saying that the moralists were involved very early in the AIDS debate.

2.2.11. HIV and the silence of psychologists

It could have been the same with regard to the place of the psychology in the approach - understanding - individual and group of this new disease. It has not happened. On the contrary, we have noted the strange silence of psychologists in France in particular, since 1981, in scientific publications or in the media outburst (especially from 1986) around the AIDS problem? Be careful? Step back? Overflow by a psychological fact new (major epidemics are distant in time or in space)? Feeling helpless in the face of a disease whose transmission and effects confront us with the "rock of the biological"? Side by side with the problem of death, still little cleared on the map unconscious? Lack of organization, of communication between medical services and psychological laboratories? Passive waiting an effective medication or a protective vaccine? We must recognize this singularity: psychology has not still found its place in AIDS research. I will take as proof the fact that psychological research were not the subject until the end of 1988 * of tenders from the share of large national scientific organizations (C.N.R.S. or I.N.S.E.R.M.) or health or environmental supervisory bodies. Only biological, medical, epidemiological research and relatively material, social or moral mutual aid actions are considered by the public authorities to be promoted. We must therefore note that AIDS and HIV seropositivity are which have remained in the domain of biologists, physicians and essentially voluntary aid groups for the "plague-stricken" of our time. We can observe that the medical profession - the non-psychologists -, to through scientific texts or press articles, underlines the urgent need for individual and family psychological help felt by AIDS patients at different stages of their disease, and by HIV-positive people gripped by the anxiety of the "unknown": the unknown of the incubation time, the silence of the virus. That's what also notice, during their consultations, the psychotherapists private, increasingly sought after by these patients and their families, and by HIV-positive people and their couples. And we know through these consultations how many are those of their companions in misfortune who, often out of guilt, out of despair, out of simple fear of rejection (as happened to them at the dentist sometimes) do not dare yet ask for that specific help or don't even know it exists.

2.2.12. Psychological suffering of aids patients; facing death.

It is first and foremost the psychological suffering of people affected by the disease or affected by the first symptoms pre-AIDS which mobilizes the psychologist. We know from many testimonies - J.P. Aron ‘, A.E. Dreuilhe * for example, other less personalized statements at television, radio and the press - internal conflict at work in the patient knowing, in 1989, that

the outcome of his struggle would probably be fatal despite all the hope he put on AZT and in any case recent study on human experimentation with the CD4 molecule. This face-to-face with death, as for condemned cancer patients®, requires intensive psychotherapeutic support, all the more important that the family environment is often failing, always unconsciously ambivalent, so pervasive, underlying but well enduring, the condemnation, sometimes clearly expressed, of drug addiction or sexual addiction: "He (she) looked for it". I will come back to this family impact of the disease later. The nursing teams are currently very insufficient for the views of psychotherapists trained to assume this function. listening to renouncing the future, to life, listening to guilt, the search for spiritual, moral, social, or philosophical values that can give meaning to this limited future and to death herself. It is evident that the personnel who treat the body (doctors, nurses) is overwhelmed by this new task: new by the rapid and inevitable evolution of the disease, by the youth of the affected population, by the expressed guilt, and especially by the association of sex or drugs? and death.

N. Horassius-Jarrie et al. (February 1987) describe the medical distress in the face of this new disease to be treated, or in the face of the infection to be announced. They note two extreme attitudes observed: the medical solution objectifying underestimating the psychiatric risk in favor of the somatic risk, or subjectifying absolutism, "respecting" the subject to the point to refrain from any action, including disclosure of HIV infection. A third attitude, spontaneity, would consist for some to be guided by "urgency and common sense". Now what is the emergency in the case of seropositivity (apart from advice on superinfection and contagion) and what is "common sense" facing a risk of death? The authors' conclusion is that carriers of the virus or AIDS must be "accompanied by psychiatrists and nursing teams (who will have to take care of their) countertransference attitudes in such a context of death that psychiatry is not used to dealing with frequently "

CHAPTER 3

THEORETICAL PERSPECTIVE OF THE RESEARCH

3.1. Crisis rupture and overtaking

In the first edition of this book, the impressions given by this work is from the propositions that the lectors of the first edition brought up which was a question not too well explored. This consisted of articulating the space of the psyche reality of the subject to that of the intersubjective group they proceed and contribute in their constitution. On the other hand, the perspective sought to be introduced here is that of the previous works done by these authors.

In the first section of this chapter, the author introduces to us the notion of transitional analysis. They start by bringing in the notion of crisis which is one of the core subjects in this work making us understand that it is usually at the end of the incident that induced the crisis that we often realize their presence and the struggles that come with them, it is from there that we begin to make sense of the significance of what they have on us and how to reconstruct and give a place to the part that they will now have in us. This work of memorization definitely awakens the fractures and the schisms that came without our knowledge in the internal world of our childhood, desires and their objects. Crises is then defined here as the successive traces of events often produced by a unique and decisive separation that we experienced in our body, in our affections, in our ties and in our knowledge. These crises assuredly have their determinisms proper to them, their modes of resolution and their significance in the structuration of the human psyche.

When an object, an organization of objects having psyche activities are placed in a favorable position, they function as a meta-psychic guarantee, a para-critic, para-recitative envelope, an environment of significance that words convert to sense. Neo-divinities, the resurgences of ideological formations, totalitarianisms and sectarian groups, paradoxical idealization of death.

In the next phase which is that of making the transition between rupture and suture, the primary condition for it is a trial at hope. It is possible that we do not find a way out towards life but we are always obliged to look for it. Through this global experience of crisis through which we only perceive partial components is where we perceive the true figure of man, the being of

crisis, the subject in crisis in its genesis and structure, the critical agent of intersubjective games. It is then through this crisis that man is being made man and that their story transitions between crisis and resolution, between rupture and suture. Between this limit is created a space of possible creation, exceeding and games. This is what D.W. Winicott calls the transitional space. The importance that are of the environment and the frame is always manifested by their default which does not stop production and is necessary for growth. It is this default that puts a human being in crisis.

The next question is how this crisis is being overcome, the author makes us understand that through the regulation activated by the psyche activities of the mother who equally receives the group of intersubjective delegations which she represents and mediatizes. The psychic activities of the mother sustained by the primary group is the first psyche container, the condition for the shoring of instinctual drives and the id on the manifestation of pleasure and displeasure. This way the crisis comes unceasingly to continue in the unending cycle of crisis and its irresolution. This original and founding prevalence of the group, in the psychic consistency that it possesses and that the mother and maternal function present and represent, founds the ability therapy of groups in the elaboration of crisis experiences.

All the crises of subsequent growth: the oedipal crisis, that of adolescence, the crisis of middle of life, the seizure of entering old age, most seizures structural changes in the psyche of onset of old age, most seizures structures of the psyche can only be worked out and overcome by conjunction of the subject's own resources and those of the intersubjective environment. That the crisis is experienced as a killing marks the always threatening connotation of the disturbances that arise in a living system. The crisis of the systems built to ensure the security, continuity, capacity, conservation and resource is always experienced as an exposure to death, this is what prompted O. Fenichel to write in 1945 that "the structures of the individual created by institutions contribute to keep these same institutions". This makes us understand that the crisis of one is the threat of the other. This research on the crisis was born, like all research, as well as the writing of Freud, on "the urgency of life". Emergency that masks the crisis, too long since the time has come to treat the emergency as a symptom to be deciphered.

The specificity of the transitional space is to make it coexist, without crisis or conflict the already there and the not yet happened. This space is first made up through the mediation that the mother establishes between the bodily and psychological needs of the child and the physical and social environment that surrounds it; cultural experience is an extension of the idea of

transitional phenomena and play. Transitional analysis offers a practical perspective psychoanalytic centered on the elaboration of the experience of crisis, so that a transitional area is reestablished between the intra-psychic space, the intersubjective space and the space of culture. Transitional analysis is therefore a method of investigation, treatment and elaboration of the psychic effects of experiences of rupture and discontinuity in the individual and group psyche. He describes, in fact, the demand for psychic work imposed on the psyche its necessary and vital connection with the bodily (the drive) and with inter-subjectivity (identifications, the ego). they didn't think they had to reject outside the field of research a non-psychoanalytic approach, also distant or opposed to the psychoanalytic perspective that analysis from a systemic approach.

3.2. Benchmarks for the conception of crisis.

It is in fact through the crisis that the need to seek support, find a reinforcement and a comfort: by the disorder also comes that, dynamic, to create new regulations and find pleasure in them. This then brings us to the concept of multiple shoring and the group structuration of the psyche. The idea of multiple underpinning is rooted in the thinking of Freud. Furthermore, Freud's creative life strongly suggests a quadruple shoring which I suppose is fundamental; shoring on the body, on the mother, on the group and on the Self (self-support). The accidental failure of one of these supports always mobilized in Freud a movement of depression and the use, or return, to a more solid shoring, from which he can take support and model to create.

The Freudian model of choice of object by scaffolding suggests a representation of the process of multiple shoring, that is to say: the recovery transformer of the propped by the prop in an intermediate space shoring that we can imagine as a communication airlock or isolation, between two heterogeneous spaces. The fundamental character of any support is not only to belong to a support network, but also to be in "mutual support" Note that the pleasure of finding a support "in mutual support" it is important to precise that the pleasure in finding mutual support is just as much that of complementarity as that of antagonism (support on the antagonist). An example of a scaffolding contract is that of the relationship between the leader and his group. The narcissistic aspects of this contract are easily spotted. This takes us to the nature of the system in which the subject will now live in considering the nature of the crisis. Thinking of a man as living in crisis is thinking of him as being in a permanent state of organization, disorganization and reorganization. A crisis is being defined here as a sudden and decisive change during a process or an illness, for example the violence manifested accredits

the worry of a more severe evolution and gear towards the terminal nature of an illness. This threat is then often seen as a means to mobilize new survival regulatory behavior and actions. Erikson (1968) distinguishes two causes of crisis, the external causes which are from the surrounding environment and has a direct impact on the subject and the internal causes on the other hand which Erikson refers to as developmental crisis which stems from within the subject and its manifestation is greatly felt outside or externally in aspects such as the physical presentation of the patient its particularity being that it appears throughout the growth process of the patient. The solutions applied to resolve these crises usually vary depending on the nature of the crisis.

The crisology of E. Morin is a perspective based on the general theory of systems. The concept of system here being the idea of antagonism, the cybernetic system being attributed to regulatory retroactions, the maintenance of constancy and stability in the system. With all this settled, we can then carry our attention on the manner in which the crisis is being elaborated and subjectively used.in the organization and usage of ideals, defense mechanisms and the coherence of their personal way of thinking, feeling and doing thereby participating in the growth of many dimensions that constitutes the growth of the rupture and how they all participate in the crisis.

3.3. Union and separation; the transitional aspects in crisis.

In this section, we have to understand that there can only be a notion of crisis where there was stability and a notion of separation were there was union. This therefore brings us to the very first separation which is that of the mother and the child at birth and nature of it which starts by the cutting of the placenta and umbilical chords. The notion of transitional analysis here is that of establishing the logic of no one without the order, no a without b which makes the separation from them complex. Coming back to the place of birth which is the first point of crisis is where the child and the mother who were first in some sort of perfect symbiosis start to find ways in which they can re-harmonize this separation. It is equally through the separation of these ties that there is the notion of existence and where the child can be called an individual.

The baby coming to the world initiates a double point of the separation crisis from the point of leaving the mother and joining a new world and that of the mother’s end where she loses what used to be an integral part of her for all the pregnancy period. Overcoming this stage is way easier for the mother as she already begins to prepare herself for the day of expulsion (child

birth) on like the child who just goes out without permission. In overcoming this which has also been seen as a means of overcoming post-partum depression is the process of the mother physically making new ties with the baby externally and assuring the baby's needs and the baby on the other end by the baby going towards the mother in time of need and later on separating when the time is due. This separation usually creates the personalization of the individual and equally determines the way they are going to interact with each other in the psychosocial milieu. This teaches the child to be able to better apprehend situations of crisis in later life and always come back to its resolution as was or is done with the mother after the birth of the baby. This is what E Jacques describes as the crisis of life milieu. This brings us to the conclusion that rupture, illusion, paradox and transitional spaces are never just concepts in a vacuum but rather a well arranged space for its manifestation. From a psychological point of view, the mother is never pregnant alone, the parents are and also the immediate family. In an African context in particular, the genealogy extends right down to the grandparents and in some cases even includes neighbors attesting that the joy, the anxiety and the crisis when it comes end up being collective and in a well-defined system. Now in the context of a cultural heritage and separation where it counts out immigrants, it tells us more about continuity assured by cultural heritage which is the extension of the potential space between the individual and their environment which can be contributed by the social group for their very own benefit where what is found can be kept (Winnicott 1975). Now the experience of rupture is that which puts individuals especially adolescents in knowledge that cultural heritage alone is no longer able to ensure the continuity of existence as is the case where there in the urbanization of the adolescent where they have to meet new standards of training and the in-between

The hypothesis drawn here can be that the first feeling of rupture and crisis experienced by the child and how they process it during this period of crisis. It is being rooted in the way they handle it. They may handle it by coming back to the initial object of separation or establishing new ties with an object judged to be somewhat equal to the initial object lost.

The main work concerned here is that if a loss which goes both ways i.e. the object that is disappearing and the one that is being abandoned. One of the major traits that develops in the one abandoned is that of hostility and rage which according to Freud is a form of mourning the loss of the object of affection. These feelings simply consist of love or hate directed towards others, the self or the objects. This concept of breach in the environments code also gives way to a breach in the aptitudes of organizing conducts and regulating instinctual elaborations by assigning them a goal and an object.

Not only is the in-between culture no longer able to provide conditions for adaptation given that the old situation is no longer the ideal neither is the new one already acquired but there is still that doubt of the potential space where is sought to establish the feeling of security based on maximal experience. From there we can place the hypothesis that a situation of maximum dependence has to be established in order an atmosphere of confidence and that feeling that assures protection against the return of the trauma can only be omnipotent. In a more socio-cultural setting on the concept of separation especially in Africa, The growth as the state of vital dependence is said here to be favorable in creating a situation of crisis and the complexification of the solutions to reduce the crisis. what the clinic also reveals is that the development of the crisis highlights contribution representation systems resulting from work psychosocial metallization. The use of certain systems of representation is to be understood from the perspective of the defense of the integrity of the threatened global system or the attack of systems antagonists. The ideological mentality fulfills this double function of defense and attack. I have proposed, in this perspective, the analysis of the utopian mentality as an attempt to establish the paradox of a change that would take place without change. The analyzes proposed by ethnologists and social psychiatrists in about the transformation of traditional societies illustrate quite closely these words and shed light on the relations between individual and group in a situation of crisis, especially when social crisis and individual crisis are in phase, and the role that representational systems play in it.

So illness is one of the few possible solutions. So the puff delusional, so frequent in Africa, expresses and reflects the degradation of the place threatened, consequence of social change. "The delirious puff," writes H. Collomb (1965), is a struggle against loneliness and isolation. They are in search of contact: quest for the other through a new facade, attempt to join by identifying with him through the mediation of systems of representation" (p. 233). So delusional illness, psychotic state transitory, is an issue found by the subject when group assistance is destroyed or insufficient. It often allows, thanks to hospitalization, that is to say with the assistance of a new cadre and a transitional group, a readjustment of the personality to the new conditions of existence.

The question raised here will be that of knowing if this whole mentality of suture after rupture is ideal and can be established or is it merely a utopia. As earlier mentioned, when someone is displaced towards a group of attraction, affiliation or reception, the transitional is no longer disposed. The transitional people no longer have as we said, the use of any code. Whereas what happens is that the receiving groups react defensively faced with any motion likely to endanger

the balance of their own coded system that already works well for them. We will then witness capture mechanisms, or encasement, rejection, or even transformation of the transitional so that it becomes admissible (training, enculturation). On the other hand, the members of the group of departure (extraction) tend to experience the exodus of one of them as a loss of substance or energy, and often as an attack from the starter against his home group.

Of these modes of organization of transition by organizations and groups common and well known to the subject and his social environment are deduced from concepts of ideological position and mythopoetic position. The mythopoetic position admits the open, the transformation and the changes in assignments. She accepts polysemy, reduced in the ideological position: thus does the myth encode different orders of reality; it generates interpretation as loss, rediscovery and creation of meaning. Mythos is the word that arises as creation because it is in the tradition of the already said, which is not repetition but reference: a continuity that does not impose itself as a limit to Poesies. The object exists as such, which both resists destruction and insists on recognize. This supposes an adjustment of the depressive anxiety towards repair and creation. And it is worth nothing that these two positions are coextensive in the group.

3.3.1. Dilemmas and the situational paradoxes of crisis

In this section, we are pointing out the aspect of human nature as being the only animal that distinguishes itself through logic, training, forms and reforms and sometimes in the perilous act of creation. This equally brings up the aspect of a crisis where by in order to form there has to be the process of deformation and then reformation and this human formation is considered to be a dimension of transition. This is the result of the common construction of individuals and their components and it is these components of group training that makes the group training an apt situation for development and resolutions of paradox tensions.

The very first type of crisis evoked in this section is that of training. This is because the process of formation will mean that one will first of all have to deform the preexisting systems in place in order to be able to accommodate the new ones. All this is being done at the same time with the quest to not wreck the ideal self that the training system is coming to meet. Now figuring a way out to better train self without tempering with the self-narcissism which actually there to defend the ego from deception and destructive attacks. Now in the situation of this type of dilemma, the subject is confronted with two choices, either to renounce being further deformed by the new ideologies and keep the faulty self, thereby avoiding the deformation that comes

with it, or they continuous to adhere to the new ideology and then inevitably encounter attack. In both cases, the instincts of death will have a higher chance of triumphing in direct relation with the narcissist idealization.

In the second type of crisis is sociocultural in nature and is in the form of the changes in groups and the real dilemma here is the transitional period from one group to the other and this is manifested in the form of the conflict of weather the subject will be accepted in the new group or will even be able to leave out their old codes in order to adhere to the new one and secondly in a case where adhering to this new group is perceived by the members of this group and intrusive and a danger, how well will the subject be able to convince them otherwise or better still if they were to go back to their initial group, how will the new nature and code of the group welcome them or even in a case where they might have left out the code of the old group they belonged to, how do they manage to readapt to it. But before we get to the modes of resolutions of these dilemmas, it is important to note out the paradoxal components of the crisis.

A paradox here then is considered by Watzlawick to be the turbulence at the level of the logical systems present and at the heart of change. He talks of two types of changes here with the first one being that which happens in the group and the second one which happens outside of the changes done within the group and this second one is more radical than the first. This type of perspective situates a paradox in the process of transition. As such, the terms dilemma and logical trainings in paradoxal productions is proven by games and tolerance tests to the tension of the crisis not in a realistic manner given that the frame is in the meta i.ie at a level logically implicating an exit of the crisis system that the training process can go on. Maintaining the formative situations is making possible the games of new relations to happen.

In the work of the death drive and creativity, A. Green recently opposed to transitional time the chronic equivalent empty space, what he calls dead time. Transitional time is a "time out of time, potential time being established at the moment of inaugural separation from the object, transforming the separation into meeting" (Green, 1975, p. 107). Examining what situations mobilize such temporal disinvestment, Green recalls that the experience psychoanalytic shows that it occurs "when different series occur seem to coexist simultaneously in the event, generating the telescoping: the fantasy and the real, no doubt, but also the inside and the outside, the past and the present. This analysis of dead time could shed light on the meaning of utopia, as a negative hallucination of time projected into a space which, again subject to

libidinal flow, could be paradoxical, and precede space potential. Time dead to desire, empty time; time to develop mortified impulses.

3.3.2. Elements of transitional analysis

3.3.2.1. Transitions and the developing of a breakup experience

The transitionality is the development of a breakthrough experience in continuity. It would also be defined by the uncertainty about the recovery continuity, trust and integrity of Self and the environment. Transitionality can be characterized by oscillation or alternation between three production methods: the first concerns the capacity for subject to invent (to find-create), in this intermediate situation, what Winnicott names a potential space, a field of illusion or an area transitional and what Green, more recently (1975), attempted to describe like transitional time, opposed to dead time.

A second mode of elaboration of transitionality is the appearance of an empty space, time of nothing and psychic death, of the telescoping between the past, the future and the present of the annihilation of codes and networks identifiers. A third mode of development is characterized as the emergence of a objectified and reified space, full time, too full, without hole, where sometimes the object, the real and the other occupy all the space to the point of containing it, sometimes the pure delusional subjectivity. This method of development is that of structure and fetishization These three modes of elaboration of transitionality constitute moments articulated at the limits which seeks, deforms and builds the subject: in these successive decentralizations, at the margin. It is worth noting here that “It is not the object that is transitional but the situation” The concept of transitionality makes it possible to identify the conditions that will make possible the ability to reestablish, in the experience of rupture, union symbols. I therefore particularly insist on the relationship between the frame, container, potential space and subjects. Transitionality is a process that includes (or does not understand) certain functions fundamental. The object is not in itself transitional29. Winnicott specifies: "It is not, of course, the object that is transitional. The object represents the transition of the small child who passes from the state of union with the mother to the state where it is in relation with it, as something external and separated” (1971, 1975 edition, p. 26). What was designate as transitionality, possible experience of a potential space, is this passage from a state of union with the environment to the state where the subject is in relation with him, as something external and separate. More precisely again, because the category of the après-coup is essential

here: a separation has taken place which is developing as a break in psychic continuity and social (time, space, relations) and reveals that a previous state of union is replaced by a state experienced as exteriority and separation, in the uncertainty of a new union. We can assume that any rupture, more or less, refers to a other, fundamental, which has already taken place, and whose experience has been marked by the subject by the drama of the Hilflosigkeit, the situation of being helpless and without recourse; drama linked to the specific state of prematurity in humans, that of land and vital dependence on the mother (on the maternal environment). Resumed, accentuated, elaborated during the narcissistic "fall" (A. Missenard, 1975) this drama acquires its social dimension by the fact that the mother herself is caught up in the desire for someone other than herself. To be without recourse and without help is to be thrown out of the other's field of desire. In a study of 1968, J. Oury writes, drawing inspiration from J. Lacan: "to be dependent on the other means not to have assumed the double cut: one which is the separation of the mother's placenta, the other "more institutional", which is the cut of the umbilical cord. We can say that this "between-two-cuts" constitutes the transitional object". This object must fade in order for the real object to appear. But for the object real is significant, the transitional object must be constituted. The central hypothesis which organizes my conception of the individual and group psyche (and which orders, on the basis of multiple supports, the between group formations of the psyche, the group psychic apparatus and the group) led me to grant a decisive place, in the transitionality, to the games of groupality (being in a group, belonging in a group) and of individuality (the unique being, the indivisible being).

3.3.2.2. Transitional analysis and functions.

The proposition that the transitional analysis should be the exercise of the practice of psychoanalysis establishes the necessary conditions for the work of thought in the elaboration of the lived experience of the rupture between two states. These conditions are due to the establishment of a framework (and a device) able to produce the necessary processes, for each subject, for the development critical experience; they also depend on the establishment of functions, dependent on the existence of the framework, adequate for this elaboration. These functions are described in terms of container and potential space. The container function corresponds to the re-establishment of the psychic process thanks to the work of transforming destructive content by a human active container and the ability to make this metabolization possible. the transitional function is the re-establishment of the ability to articulate symbols of

union in a paradoxical space of play, beyond the experience binding of division-separation or union-merger. This is better expanciated as seen below.

a. The executive function

J. Bleger (1966) says of the framework that it is the most primitive organization and the less differentiated in personality30. It is the “me body-world fusional element”, on the immutability of which training depends, existence and differentiation (of the ego, of the object, of the body image, of the body, mind, etc.)”. The setting is a permanent presence without which the ego cannot constitute itself or develop. It is a non-process, that is to say a series of invariants within the bounds from which the process can take place. So it is what remains permanent for change to happen. One of the characteristics of this framework is that it is "silent": we have no conscious perception of it nor conceptualization as long as it is not lacking. Is it in the break or in the threat that it appears. The transfer to the frame and inter-frame interference now comes to be the setting up of the frame of psychoanalytic experience of their own framework that had led the participants to "Psychotize". In this perspective, I was particularly sensitive to the advent recent, in so-called "training" groups and organized according to a psychoanalytic, of several phenomena to which I attribute a certain importance, both for their symptomatic value, and for the questions theoretical-clinical that they arouse: I mean, on the one hand, the frequency and the intensity of transfers to the framework (the "training" institution of psychoanalytic reference, Psychoanalysis as an institution, such Association, School, Society, Psychoanalytic Group); on the other hand and dice then, inter-frame interference phenomena: between the frame institutional, support and container of the psychoanalytic framework and the framework psychoanalytic himself. These two aspects, new it seems, encountered in the practice of. training, therapy and analysis, highlight a central phenomenon.

b. The container function and potential space

While the frame is the still and stable part of the personality, and it receives in deposit the psychotic and symbiotic part of the person, the container represents the active aspect of this support, by which the mother, thanks to what Bion calls his capacity for reverie, is able to modify the painful projections of the baby. The container function allows the use of the frame. The container provides active, transformative support for projections imaginations of the patient (of the child). It is through the container that is established the primordial exchange which, in symbiosis, consists in the mechanism primitive of projective identification. Without a container that receives them, metabolizes and restores or preserves them, depending on the

child's condition and of his needs, there is no psychic life possible. The group situation - provided it is properly handled, that is, recognized in its psychotic basis and in the primitive bond of

projective identifications which ensures the construction of the group psychic apparatus -, constitutes a favorable situation for the invention of a potential or the blocking of each in a space of fetishization.

Transitional analysis is based on the experience that a potential space must be "invented", in which are presented, articulated and recognized psychosocial structures of different levels, which constitutes the status paradoxical of any transitional object and "subject". When, in group psychodrama, we designate in the statement of the rule a play space, we present an element necessary for the exercise of the potential space function: this space cannot be created if it is not found already there. Thus we create, by marking and hyphenation, the space of rupture and of union. It is important that the space and the object are presented.

It is certainly not enough to implement the means to restore the framework, the container function and the transitional space so that the experience of crisis and rupture. The interpretive game depends, in the psychoanalytic work of the cure, just as in that carried out by the means of the group, from the report of the analyst - or analysts - to the manager analytical, to their capacity to exercise the container function, to promote space and to move in it, to work in a system of structures symbolic. In other words, transitional analysis requires the analyst to work on his own transitionality. Which could be expressed as: the participation of the analyst to the analytical process within the framework of the analysis; its possibility to find an analytical container to be able to contain; finally, his work of theorizing, which implies everything at the same time, and not without tensions or conflicts, a frame, a container, a transitional space – empty and full - and a system of symbolic structures. This is the latter set that we would like to review now.

- **Interpretive game and theorizing work**

Theoretical and practical models of change

Transitional analysis and the concept of transitionality lead to develop, or re-develop models of change. In this perspective, some research brings elements of theorization which take into account, in a central way, the articulation between objects or organizations that are different but nevertheless closely correlated and presenting some aspects of similarity. In his work on

Freud and the problem of change, Widlöcher has showed that throughout Freud's work the emphasis is on the resistance to change through successive discoveries, in the framework of treatment, transfer, defense mechanisms, reaction negative therapy.

It is in this perspective that D. Lagache (1967) situated his study on the individual change during the psychoanalytic process. He writes: “During the analytical process, the engagement, the release, the reconversion implies a close union of living and dying. Without rejecting any of these statements, it is important to reconsider them in a perspective where the emphasis is on the fact that a crisis occurs, is developing and is resolved through the relations of which the subject is made and which, if they are undo, undo too. Change is no longer just individual, even if it is not taken into account consideration as the uniqueness of a person. Postulate that change requires a strong hypothesis on the psychosocial structure of the subject, that is to think of the interference of several dimensions: it is to have correlated levels of intervention. But it is first to question the concept – the fantasy first - of an individual.

3.4. Ties and attachment

3.4.1. Ties

The questions posed by the concept of the object relation, in its relation to the model of the drive, give the measure of theoretical pluralism which, in contemporary psychoanalysis, is a state of affairs. According to Brusset (2006), “it is impossible to focus on a notion by artificially isolating it from a more global problematic, nor to stick to a single author, nor even only to the work of Freud. ". On the other hand, he will conclude, it is possible to tear away from the movement and the complexity of clinical data the perspective of a metapsychology of limits and links, of their components and their hazards in the relations of the ego and Objects.

According to Green (2006), “the notion of link has long been part of the theoretical arsenal of psychoanalysis, without this being explicitly stated. It has been brought up to date with the temptation to introduce new designs in order to better understand certain clinical aspects of recent discovery ". However, the notion of link, like some of the new operational concepts of psychoanalysis, does not have an unambiguous definition. Despite the fact that all the authors wish to speak about the same thing, one notes on examination some dissensions in the developments and the explanations given to the concept of link.

3.4.1.1. The problematic and definitional approaches to the concept of ties.

The question of ties between two or more subjects has not left many authors indifferent as a good number of them makes attempts to elaborate on this aspect from their various points of view

Eiguer: For Eiguer (1984), ties suppose an intra and intersubjective dimension, it is the fruit of a behavioral and phantasmal interaction between two psyches which influence each other. He sums this up with a statement in 2008 saying “never me without you” which brightens us more on the importance of these ties for every subject.

Rene Kaës: According to Kaës (2008), “the modern concept of link is recent in the field of theoretical objects and psychoanalytic clinic. It is not without ambiguity or confusion, and it poses complex problems for the clinic, the method and the psychoanalytic theory… ”To sketch a first delimitation of this object which is the link, Kaës recalls that in 1994 , he had proposed to call link "the specific unconscious psychic reality constructed by the meeting of two or more subjects. " Kaës (2008) focuses his approach on the structural psychic organizers of the link and on the specific formations of psychic reality that occur there. For him, complexes are therefore the main organizers of the link, and unconscious alliances are the basis of the psychic reality of the link.

Freud (dreams and linking content): From chapter six of The Interpretation of Dreams, the idea of the link appears during the presentation of Freud's approach.

"We are the only ones to have taken into account something else: for us, between the content of the dream and the results achieved by our study, we must insert new psychic material, the latent content or the thoughts of the dream, which highlight our analysis process. It is from these latent thoughts and not from the manifest content that we seek the solution. Hence, a new job is imposed on us. We need to investigate the relationship between the manifest content of the dream and the latent thoughts and examine the process by which the latter produced the former. "

Ultimately, the underlying linkage can be identified during the analysis of the dream. Its origin would be inferred, upstream, in the associations between latent thoughts, without anything allowing it to be detected at this level. We can therefore see that the dream results from a sort of selective stabilization of latent thoughts. "Whatever dream I break down" says our author, "I always find the same principles: the elements of the dream come from all the mass of

thoughts of the dream and each of them, if we compare it to the thoughts of the dream. dream, is indicated there several times". Thus Freud (1967) informs us that, "among the thoughts which analysis reveals, there are many which are quite distant from the core of the dream and which give us the effect of clever and timely interpolations. One can easily discover why they are there: they represent the connection between the content of the dream and the thoughts of the dream. According to Green (2006), the removal of these tendentious links would deprive the dream of its determination. "A synthesis of Freud's findings" said the latter, "would lead to think that, in the work of the dream, a psychic power manifests itself which, on the one hand, strips some elements of great psychic value of their intensity and, of on the other hand, thanks to over determination, gives a greater value to elements of less magnitude, so that these can penetrate into the dream". Freud will however specify that the dream cannot represent logical relations, because according to him, the representation of the dream does not reflect the concern to be understood.

Bion : From 1957 and 1962, the publications which opened Bion to the formulation of a general theory of the psychic apparatus reflected the influence of Klein (1946), notably of his theories presented in Notes on some schizoid mechanisms. To understand the identification with the projected parts, in 1959, Bion preferred to speak of a link and not of an object relation.

Winnicott: Winnicott has made original and specific contributions to the theme of nexus, which in no way can be dissociated from all of his general views. Of the ideas of Bion, Klein's heir, of certain innate dispositions for destruction, as well as of the conception of object relations existing from the beginning of life, Winnicott will take issue with it. In particular, he will question the alleged innateness of destructiveness, the importance of which he will not diminish, however, by postulating it as the result of a primitive deficiency of the environment; thus approaching the position of Freud than that of Klein.

3.4.1.2. The psychoanalysis of ties

Bion developed in 1959 a theory of the link. By link, he means the subject's relation to a function rather than to the object that promotes him. He distinguishes the intrapsychic link between drive and representation, between different representations, between thought and affect, between the subject and his own capacity to think and the interpersonal link. Pichon-Rivière also developed, in 1971 in Argentina, a link theory. He concludes: "There is no psyche apart from the bond to the other. "For Pichon-Rivière, the link is a" complex structure which includes the subject, the object and their mutual interaction, through communication and

learning processes, in an intersubjective framework ", this in a dialectical relation which allows the internalization of the link structure, which thus acquires an intra-subjective dimension.

3.4.1.3. Sketch of a meta-psychological tie according to Joubert (2011)

According to Joubert (2011), the link first functions in the register of the "native" of Aulagnier (1975) on the topical, dynamic and economic levels.

- **The Originality In The Link**

Ruffiot (1984) cited by Joubert (2011), reminds us of the two purposes of love: the individual and the species. One of the couple's goals is the conservation of the species and therefore the rearing of the young, and the other the satisfaction of the sexual drive in conditions of security, regularity and secrecy. Ruffiot (op.cit.) Speaks, for his part, of “object-couple” in connection with the dyadic topic which fulfills the function of instance: the couple loves each other just as the individual ego invests itself narcissistically, s 'love. The unit-couple, on the dynamic level, has limits, external contours against the intrusion of the environment: the couple hides for intimate contacts and shows themselves in society to better display their boundaries. Conflicts can be resolved in the discovery of the complementarity of the sexes, corresponding to an archaic dream of a bisexual being. Economically, the libidinal energy of the dyad is not just the sum of two energetic quantum. Love would be a kind of narcissistic hemorrhage or one-way transfusion of energy.

- **Operation Of The Link On The Topical Plan**

The pictogram ensures union or rejection, that is to say, fusion or tearing; it is about the states of the bond and the transmission of sensory experiences, of affects. Very often clinically, the affects are frozen. We are below the representation. At the level of the family group, we will therefore observe an undifferentiated relationship. We often meet within the family a confusion between the couple and the parental position. For example, the husband calls his wife mom, and vice versa, so the confused parenting shown by Darchis and Decherf Willy (1975) speaks of collusion.

- **Operation Of The Link On The Dynamic Level**

Sometimes there is a conflictuality due to the lack of differentiation and a great underlying origin violence, made of fundamental violence. Etymologically, the term fundamental violence does not connote any aggressive intention. It is a radical which only intends to mean the desire

to live. According to Bergeret (1995), “violence in itself does not involve any will to harm; we must not confuse natural and universal violence, necessary even for the survival of the individual and present from birth, with the hatred or aggressiveness that appears in human beings later and with a status more complex. "According to the principles of interactional epigenesis, defined by ethologists, the newborn child benefits from a genetic equation carrying various imaginary models of a socio-cultural nature.

- **Functioning Of The Link On The Economic Level**

A large amount of energy will be expended by the subjects in order to fight against differentiations and separations. They often appear drained of their energy, each struggling for survival. Thanatos is at work in collective death fantasies. As in the myth, of Tristan and Yseult, to be finally united, one must die together. Thanatos, death drive, originates according to Freud in the thought that the tendency to repetition is a general property of the drives which push the organism to reproduce, to reestablish a previous state which it had had to give up. The change, the progress would be due to the action of external factors, of disturbing factors which force the organism to come out of this inertia. Thanatos is said to be the drive that tends to pull the body back towards the inorganic, or towards the end. The end towards which all life tends is death.

3.4.1.4. Sketch of a meta-psychological tie according to Brusset (2006)

Criticism of the drive model, particularly the questioning of its origin, according to Brusset (2006), has promoted theories of object relations. According to Luzes and Amaral-Diaz, going beyond the alternative between "naturalism" of the drive and "psychologizing" of the object relation calls for an epistemological mutation

- **Analytical Exchanges and Object Relationship**

According to Brusset (2006), the figurations by symptoms and by objects constructed in analytical exchanges cannot be theorized thanks to the model of the object relation, except as totalization, synthesis, a diagram which is then only a first clinical approximation. This is why the notion of object relation will escape the dilemma of the inside and the outside, of the imaginary and the symbolic, of the fantasy and of the reality, essentially in non-neurotic organizations, only on condition of take into account the plurality of levels, psychic spaces and transformation operations in the metapsychology of links. This is the case in the various modes of psychic functioning in exteriority which do not fall into a univocal nosography category, but

which find illustration in certain forms of borderline functioning. They are in fact dependent on internal psychic reality, but this is most often not clinically accessible. In this sense, according to Brusset (2006), some have called them "new diseases of the soul", "new psychic economy", or even "psychoanalysis of limits".

- **Need for A Third Topic for The Development of the Metapsychology Of ties**

In order to preserve the sacred union behind Freudian psychoanalysis, Brusset (2006) proposes to base his new topic on the openings given by Freud which were mentioned above, as well as the two Freudian topics which only take account of the intrapsychic will take "only more relief and necessity". The third topography would therefore be for the latter "a modeling that is not reducible to interpersonal or intersubjective space and to say the third topography does not imply the reduction of the relevance of Freudian topics to the exclusive domain of neurosis, a danger that the definition of a new paradigm from the theory of limit states. ".

3.4.2. Attachment.

Bowlby (1978) before presenting the mother child ties presents to us four main theories which were: the theory of the secondary tendency or theory of learning or theory of the relations of love of the nourishing object: the baby is interested in and becomes attached to a human figure, especially his mother because the latter satisfies his needs for food and warmth, thus learning that it is a source of gratification, the theory of primary object of sucking; the child has an innate need for the breast to suck it; this breast is part of the mother; thus he establishes a relationship with her. the theory of primary attachment to the object: the child tends to be in contact with a human being and to cling to it; this independently of food. The theory of the primary desire to return to the maternal womb: the child regrets the expulsion from the maternal womb and wishes to return there.

The hypothesis proposed by Bowlby (1978) is different from all of these and is based on the theory of instinctive behavior: “It postulates that the link between the child and its mother is the product of the activity of a certain number of behavioral systems which predictably result in the proximity of the child to its mother”. The attachment system therefore appears as a behavioral motivational system. Bowlby (1978) adopts an approach defined by four characteristics i.e. a prospective method as opposed to retrospective psychoanalytic reconstruction, a focus on a pathogen and its sequelae: separation from the mother can be traumatic, direct observation of young children and the use of animal species data.

He defines behavior as instinctive when it conforms to a pattern which appears similar and predictable in almost all members of a species or all members of the same sex, it is not a simple response to a stimulus but it is a sequence of behavior which usually follows a predictable course, some of its usual consequences are of obvious use since they contribute to the preservation of an individual or the continuity of a species; there are many examples of this even when all the usual learning opportunities are limited or even absent.

His theory calls for a new type of instinct theory: “Instead of the notions of psychic energy and its discharge, the concepts at the center of the model are those of behavioral systems and their regulation (control), 'information, negative feedback and homeostasis in behavioral form' Bowlby (1978). Bowlby drew from cybernetics this central idea of homeostasis, that is, that humans maintain their balance through self-regulation according to their environment. Indeed, the theory of cybernetic systems of regulation shows how a simple diagram can be more and more elaborated, to lead to a complex system adapted to the needs. Thus, the most evolved species in phylogeny are those for which the field of possible modifications of behavioral programs is the greatest.

Bowlby (1978) distinguishes between being dependent on a mother figure and being attached to her. In the first weeks of life, a child is dependent on the care of its mother, although he is not yet attached to her. Addiction has, according to him, a functional reference while attachment is purely descriptive: it is a form of behavior. From four months, the child smiles and vocalizes more easily and follows his mother with his eyes longer than he does for anyone else. Bowlby points out, however, that it is difficult to assert the presence of attachment behavior before the appearance of signs showing that the child recognizes his mother but also that he behaves in a way that maintains proximity to her, for example, crying when her mother leaves the room. Attachment behavior is elicited in early childhood by internal factors: hunger, fatigue, illness, cold, pain, and by external factors signaling increased risk: darkness, noise, sudden movements, threatening forms and loneliness.

Attachment behavior in the first year of life is well documented, and appears to manifest itself in a similar fashion during the second year and most of the third year. The child is, however, increasingly aware of an imminent departure. The third birthday usually marks a change, as the child becomes abler to accept the temporary absence of his mother and to take part in play with other children. Bowlby (1978) states: "For most people, the bond with parents lasts into adulthood and affects behavior in countless ways" During the latency period, attachment

remains a dominant trait. In adolescence, attachment to parents wanes as other adults may take a prominent place and sexual attraction to peers begins. The attachment behavior of a teenager or an adult can be directed towards people outside the family, but also towards groups or schools, work, religious, political ..., most often after initial media coverage by a person who occupies a predominant place within the group. In older subjects, the attachment behavior tends towards younger subjects. According to Bowlby, "To label attachment behavior in adulthood as regressive is to ignore the vital role this behavior plays in a man's life from cradle to grave."

3.5. Phases of attachment.

In 1969 Bowlby points out 4 intervals in development which he calls phases. They include:

First phase: orientation and signals without discrimination of figure. From birth to eight / twelve weeks, babies preferentially orient themselves towards stimuli from human beings and look towards people without distinction.

Second phase: orientation and signals directed towards one or more discriminated figures. From eight weeks to about six months, the child continues to behave towards people in the same friendly manner, but he does so more clearly towards a particular figure, the mother figure. most of the time. He also increasingly takes the initiative in attachment behavior.

Third phase: maintaining proximity to a discriminated figure by means of locomotion as well as signals. It usually starts around six / seven months. The child shows more and more discrimination in the way he treats individuals and his repertoire of responses expands. Some people are chosen as auxiliary attachment figures, while strangers are increasingly treated with caution. This phase persists during the second and third years.

Fourth phase: forming an association rectified as to purpose. The child learns to develop strategies that take into account the assigned goals of the adult and tries to influence them. He gains an understanding of the other's intentions. A complex interaction develops which Bowlby (1969) called partnership.

This brings up the children to get into a phase which Mary Ainsworth calls exploratory behavior. The exploratory behavioral system is subtly entwined with attachment, via the attachment figure which provides the much-needed basis of security, from which exploration becomes possible. Ainsworth (1978) spoke of equilibrium, of dynamic balance between these two antithetical behavioral systems. Thus, when the baby is reassured by the proximity, the

exploratory system is activated and the baby tends to leave the base to go exploring. Conversely, when the fear system is awakened by natural signals of danger such as the unknown, sudden noise or isolation, the child then seeks a source of protection and security.

Bowlby (1978) reserves the term anxiety for the situation in which the fear system is activated at the same time as the absence of the attachment figure is felt. The Care Behavior System is a subset of parenting behaviors, designed to bring comfort to a child in real or potential danger. Bowlby (op.cit.) Considered "caregiving" to be the set of parental behaviors including both physical and emotional care given to the child.

According to Bowlby (1978), there is a dynamic equilibrium in the mother-child couple, since different behavioral components are expressed such as the child's attachment behavior, the exploratory and playful behavior of the child, the mother's caring behavior and the behavior of the mother antithetical to parental care.

The attachment bond is a subset of what is called emotional bonding. Affective ties highlight the relationship between attachment and sexuality. Bowlby (1978) recognizes that these systems are distinct but prone to overlap and mutually influence.

In Bowlby's plurality of attachment, Bowlby (1978) will speak initially about the bond of the child to its mother, then will replace the word mother by that of maternal figure. However, he will remain marked by this first idea of "monotropy". Le Camus (1993), for its part, reminds us of the contribution of Schaffer (1964), who, thanks to the study of sixty babies aged from a few weeks to eighteen months, specifies that the child can maintain several links at the same time.

In addition, Ainsworth, at the end of his stay in Uganda in 1978, proposed the notion of "hierarchy of figures". Later, she will discuss the distinction between main figure, usually the mother, and auxiliary figures usually of other people around; which Bowlby will secondarily ratify.

Mary Ainsworth and the situation termed "strange"

Ainsworth (1978) developed a device to test a child's type of attachment. This experimental device qualitatively assesses the type of attachment of the child at the age of twelve months. During this laboratory test, the child is exposed to very brief separations from his mother and brought into the presence of an unfamiliar person. Seven successive episodes, lasting three

minutes each, are linked in a pre-established order, supposed to activate the attachment system with increasing intensity.

The behaviors of the child in the "strange situation" reflect the quality of a particular relationship, of an interactive pattern more than a characteristic of the child himself. Some children classified in one of the preceding categories did not show a truly organized behavioral pattern. After viewing two hundred recordings of "unclassifiable" children in the "strange situation", Main and Solomon (1986,1990) defined a fourth category of "disorganized-disoriented" attachment. About 15% of children, some of whom were initially wrongly classified in other categories, in the low-risk samples of the middle class, show disorganized attachment behaviors: the infant generally seeks proximity to its mother in strange and disoriented ways. , for example by approaching her and then suddenly freezing or looking away. These children show signs of stress or signs of fear from the attachment figure. Main (1998) suggests that the child's strategies are thwarted since they are unable to approach or detach from their parents. The presence of these behaviors frequently seems to be associated with a problem of abuse, mistreatment or neglect.

3.5.1. The operating modes of attachment

From an early age, children internalize sequences of events in which they have participated and form expectations or models relating to the course of relationships. These models would thus help him to understand and interpret the behavior of those close to him, but would also influence him in his relations with new people. Thus, the child would represent the behaviors and intentions of others in the light of what he has experienced within his family. Bowlby (1978) speaks of models of the internal functioning of the Self and of others, and will be inspired by the term “Internal working model” proposed by Craik, in 1943. The principle of a system of representations underlying attachment allowed for a much more sophisticated understanding of individual differences. However, what concerns the stability of these situations, Various studies according to Waters, cited by Pierre Humbert (2003), have shown that these three categories of behavior remained relatively stable throughout the second year. However, after the initial euphoria, some research would not confirm this conclusion. So:

- Belsky et al. (1969) found in their study that less than 50% of infants tested were classified in the same category three months later;

- Lyons-Ruth et al. (1991) the stability of the “disorganized-disoriented” category appears generally to be higher;

- In general, stability is low in samples of high-risk children from less advantaged backgrounds, where major changes in family functioning are common.

According to Murray and Cooper (1994), cited by Pionnie (20000), the attachment statuses can change, for example under the effect of a well-being in the attachment figure during events of positive life or psychotherapy.

Internal Operating Models (IOM)

The internal operative models have the value of true mental representations, mixed cognitive and emotional, and which, as such, are constructed within the framework of early interactions marked with the seal of parental history. These notions are entirely compatible with current work on developmental psychoanalysis, particularly that of Stern (1989) on representations of generalized interactions ". Bowlby, cited by Miljkovitch (2001), borrowing the terminology of memory systems from Tulving (1987), defends the idea that internal operating models could be located at two different levels of mental functioning.

The views of the authors diverge on the question of the multiplicity of MOIs. Does an adult have a general attachment IOM that guides their relationships in a close way or several IOMs, independent of each other or integrated? For example, the reorganization of an operating internal model could take place in a therapeutic context. A first hypothesis would be the facilitating role of the therapist, when this serves as a reassuring base or as a “container”; which frees the individual and allows him to explore his internal world.

On the other hand, an adapted therapeutic environment could bring the experience of new modes of relationships and therefore the fabrication of new patterns of interactions, contributing to the formation of a coherent IOM of secure attachment relationships, cleared from memories of 'previous negative attachment experiences. Certain relationships, which are not therapeutic, can have the same effect: improvement of a parent-child relationship, new friendship or romantic relationship. Within a relationship of trust, the subject could perceive the contradictions between his attachment strategies

The psychopathology of attachment (paradox narcissistic position and regressive position within a tie: cases of couple and family)

Caillot and Decherf (1989), propose the notion of the psychic apparatus of couple, family, and group by referring to the work of Kaës on the subject of the group psychic apparatus, in 1976. They notice, around the fantasy of self-generation of the couple, which different representations confront each other, because they are paradoxical and ambiguous - the anti-family couple, the anti-couple family, the anti-couple couple. Psychic work then consists in allowing the coexistence of these instances. Caillots and Decherf (1989) are led to propose the concept of paradoxical narcissistic position: a very primitive, archaic position, based on paradoxicality, prior to the schizo-paranoid position of Klein (1927). Within this position, the object relationship is paradoxical, anxieties are vital, catastrophic. According to Winnicott (1965) there is liquefaction, absence of container and primitive agonies; it is a "simultaneous autistic and symbiotic organization". The defense of this position is oscillation; the type of transfer is paradoxical.

Eiguer (2002), based on the couple, suggests three link organizers:

- the first unconscious organizer of the link, the Oedipus, putting the choice of object in the foreground. The choice can be made on someone who looks like or is the opposite of the parent of the opposite sex. Liendo and Satir, in 1974, proposed the following formula: "the man seeks as a sexual object what his mother was not, and the woman what his father was not". But there may also be the choice of a partner resembling the parent of the same sex.

- The second organizer is the conjugal self: the couple will structure the narcissistic links on an organizing body, defined as a representation shared by the partners, of their couple (feeling of belonging, interior habitat, ideal of the joint ego).

- The third organizer is infantasmatization, that is to say family mythopoiesis, a transitional space of exchange, humor, flourishing creativity, stories concerning each person's own history and that of the ancestors.

Lemaire (1984) will develop the importance of the transmission of family myths, which can sometimes take the forms of censorship or secrecy, the unsaid, taboo, crypt.

3.5.2. Attachment Disorders

Zeanah and her colleagues in 1993 drew up a nomenclature for childhood attachment disorders.

-Lack Of Attachment

Children with a lack of attachment do not seem to be interested in establishing a special relationship. There is an emotional detachment reminiscent of the "unloving personality" described by Bowlby about young offenders. They do not display separation anxiety.

-Selective Attachment

This category approximates the uninhibited attachment type of DSM IV. These children tend to become attached to everyone, to show indiscriminate attachments. They may use attachment as a kind of social skill, but they do not really care about these adults, nor do they show separation anxiety towards them. Zeanah et al. (1993) specifies that some of these children exhibit risky behavior and easily put themselves in danger. In this case, exploration behaviors are exaggerated to the detriment of attachment behaviors.

-Inhibited Attachment

In this case, the attachment behaviors are exaggerated compared to exploration. The child clings excessively to a specific attachment figure and shows little interest in his environment. This category is reminiscent of the resilient anxious attachment. There is a strong dependence on the attachment figure and extreme distress when separated. The parent may avoid separation to prevent outbursts of anxiety in the child, but it is also possible that the parent himself is distressed by the separation and uses their child's presence as a source of comfort. Some cases of abuse can manifest as strong emotional vigilance, inhibition and social withdrawal from the child, on the other hand a form of compulsive obedience to maintain closeness to the adult.

-Aggressive Attachment

Children with aggressive attachment styles exhibit behaviors that go beyond the simple ambivalence of resistant anxious attachment. Verbal or physical aggression can be a strategy to get the parent's attention. Sometimes there can be a self-harming component.

-The Reversal of Roles

This category includes the "parentification" of the child, who will seek to protect his attachment figure. This parental control attitude was described by Main in children who had shown a disorganized attachment type during the Strange Situation and were seen at age 6 in a separation situation. The child apparently has some fear for the parent, for example resulting from suicidal threats or threats of separation from the parents.

3.6. Identity Construction/formation in Adolescents.

3.6.1. Origin and concept of identity formation.

Many works on French Ontario have been given identity as its object, directly or indirectly. This is easily understood when we consider to what extent the fact identity is inherent in the existence of a community and when we have in mind the role that self-representation plays in contemporaneity, both for the peoples and for the individuals who are part of it. It is possible, by extension of meaning, to trace the reflection on identity until the pre-Socratics. We can then mention the "know thyself" of Chilon, a precept that will become his own Socrates, but whose purpose is more moral than existential. We can point out that the term exists in Parmenides, although the referent has much more to do with the illusion of change, and therefore with the persistence of being, only with the recognition of self, identity being in fact the identical, and not the identitary.

Adolescence which is most usually that very delicate period in the life of a person situated above childhood and adulthood is a distinguished period in a person's life to sum up his/her past and current experience to arrive at a sense of identity, which in turn will guide such person's future plans. Therefore, adolescence is the period that witnesses the sense of identity and self. Adolescence is the first time in life when a person intensely contemplates the question, "Who am I?" Changes in the adolescent which most often starts in the brain gives them the tools to start building a personal identity. Identity is one's sense of self. Identity construction is also known as individuation. It is the development of separate personality at a particular stage of life in which individual characteristics are possessed by a person or a person is known to others. In psychology, identity is the conception, qualities, beliefs, and expressions that make a person (self-identity) or group (particular social category or social group). Any disturbance in the process of identity formation will lead to many consequences like time confusion, role confusion, choosing a negative identity, tendency to excel in all the situations, generalized doubt, and uncertainty. A couple of authors have stood out to theorize the aspect of identity formation of which we have Erik Erikson and James Marcia.

3.6.2. Theories On Identity Formation.

Many theories of development have aspects of identity formation. Two theories stand out in this regard: Erik Erikson's theory of psychosocial development (specifically the "identity versus role confusion" stage of his theory) and James Marcia's identity status theory.

3.6.2.1. Erik Erikson's theory:

Erikson believed that every person experiences different crises or conflicts throughout his/her lifetime. He divided life into eight stages and argued that every conflict of a particular stage must be resolved successfully before any progression to the next of the eight stages. The particular stage by which every adolescent passes through is called "Identity versus Role Confusion." Erikson reported that this crisis can be resolved with the identity achievement, where an individual has extensively considered various goals and values, accepting some and rejecting others, and understands who they are as a unique person. If the "Identity versus Role Confusion" crisis is not solved, an adolescent probably will face confusion about future plans, particularly their roles and responsibilities in adulthood. If an adolescent fail to form one's own identity, it leads to failure to form a shared identity with others, which finally could lead to instability in many areas as an adult. He then concludes by précising the indispensable nature of this identity building in order to be able to better handle and manage themselves in the near future or when they attain adulthood.

3.6.2.2. James Marcia's Identity Status Theory:

James Marcia (1976) explained that there are four statuses of identity; these are identity achievement, identity moratorium, identity foreclosure, and identity diffusion. These are also called paths to identity.

1. Identity Achievement: this is when an individual has resolved the identity issues by making commitments towards goals, beliefs and values after exploration of different areas, then identity is said to be achieved.

2. Identity Moratorium: This postpones identity achievement by providing temporary shelter. Moratorium refers to active exploration of other possible alternatives. This status provides opportunities for exploration. But individuals are in a state of uncertainty regarding life choices.

3.Identity Foreclosure: This occurs when adolescents accept traditional values and cultural norms, rather than determining their own values. They might also foreclose on a negative identity, the direct opposite of their parent's values or cultural norms. Foreclosure is characterized by strong commitments without much exploration of other possible alternatives.

4.Identity Diffusion (also known as Role Confusion): This is the opposite of identity achievement. In this stage, an individual has not yet resolved their identity crisis, failing to commit to any goals or values and in establishing future plans. Among adolescents, this stage

is characterized by avoidance of issues and action, disorganized thinking and procrastination. Identity diffused individuals seem to drift aimlessly and are carefree.

- **Identity Status and Psychological Well-Being**

According to identity theorists, individuals who move away from foreclosure and diffusion toward moratorium and achievement build a well-structured identity that integrates various domains. A wealth of research supports the conclusion that identity achievement and moratorium are psychologically healthy routes to a mature self-definition, whereas long-term foreclosure and diffusion are maladaptive. Although adolescents in moratorium are often anxious about the challenges they face, they resemble identity-achieved individuals in using an active, information-gathering cognitive style to make personal decisions and solve problems. They seek out relevant information, evaluate it carefully, and critically reflect on and revise their views. A study investigated adolescent identity formation in relation to psychological well-being and parental attitudes (viz., acceptance, concentration, and avoidance). Analyses revealed that among boys, psychological well-being was positively correlated with identity achievement while opposite pattern emerged for diffusion. Avoidant and concentrated parental attitudes have significant positive correlates with lower identity statuses (moratorium, foreclosure, and diffusion in either gender). Also, girls in lower identity statuses experienced more avoidant and concentrated parenting.

- **Identity Formation and Gender**

Research revealed that there were statistically significant differences between adolescents with high and low Ego-identity in their overall score of Ego-identity. Concerning Ideological Ego-Identity, there were statistically significant differences between males and females in both Ego-Identity achievement and Ego Identity moratorium. They were in favor of males. Whereas, no statistically significant differences were detected between males and females in both Ego-Identity foreclosure and Ego-Identity diffusion. In another study, gender difference in the ego identity status of higher secondary students in Cuddlier District of Tamilnadu was investigated. Results indicated that the mean scores of both boys and girls were higher in identity achievement rather than other statuses such as identity moratorium, identity foreclosure and identity diffusion. It further indicated that the overall identity status of girls was higher than the boys. The boys and girls differed significantly only in the identity foreclosure and identity diffusion, they did not differ significantly in other statuses. Further, a study was conducted to investigate the pattern of identity development among adolescents of different categories. From

this study it was concluded that, both boys and girls were equally good at personal identity, more number of girls had high relational identity whereas high percent of boys had high social identity and collective identity too.

- **Self Esteem & Adolescent Identity**

A research study on college students selected from different districts of West Bengal was conducted. The correlation analysis conducted between self-esteem and different types of identity statuses revealed that those having high identity achievement status had high self-esteem, especially in the areas of occupation and ideological belief for religion. On the other hand, adolescents who were in crisis and not made commitment had low self-esteem. The analysis also indicated that ego-identity status of students differed with respect to gender and rural-urban location.

- **Identity Formation & Parental Attitude**

In identity formation, the type of relationship between the adolescents and their parents plays a significant role. For example, when there is a solid and positive relationship between parent and adolescent they are more likely to feel freedom in exploring identity options for themselves. A study found that for both boys and girls, identity formation was positively influenced by parental involvement specifically in the areas of support, social monitoring and school monitoring [13]. In opposite to this, when the relationship is not as close and the adolescent fears rejection from the parent, they are more likely to feel less confident in forming a separate identity from their parent(s).

3.6.3. The adolescent as a being in development

Adolescence is inaugurated by the onset of puberty, a biological event that gives boys and girls the physical capacity to fully realize their sexual desires.

The invested erogenous zones here are above all genital. Conflicts are related to the need and fear of independence. The adolescent must, in order to become an adult, mourn all-powerful infantile objects. Thus, he must de-idealize his parents (he sees them as old, ugly, old-fashioned, etc.) in order to gradually detach himself from them. Relational modes are centered by this conflict of autonomization, painful at the start (oedipal reactivation), more or less loudly expressed later, with the search, among peers, for support from the group. Sex object choice is made and practiced when the adolescent feels confident enough. Body anxieties are often

present because the body of the teenager changes abruptly with puberty, and he sometimes experiences it as strange, even foreign. He remains at the center of his concerns and can be the object of attacks in the event of relational difficulties (endangerment, scarification, non-treatment of physical symptoms, etc.).

The entire process of adolescence is long and difficult: it gives lead to periods of spleen with a depressive valence, to a narcissistic withdrawal, to questions, to identity doubts. Verbalization capacities are often overwhelmed by a prevalent tendency to act (anger, running away, taking action) which can, depending on the behavior of those around you and the more or less good resolution of all the previous stages, get organized gradually in a real pathology of acting out (attempted suicide, delinquency, hetero-aggressiveness). The reassuring role of parents (and the family as a whole) remains essential here. To bear the attacks of their teenager without too much discomfort, the parents must be able to rely on their own narcissism (have sufficient self-esteem), but also take turns (solid couple) and refer to the family more generally (support from their own parents, etc.). They can then set and maintain limits by accepting the aggressiveness that their adolescent needs to transform his ties to them. For the parents, the main thing is to resist, to hold on over time, without being confused with the teenager in a "buddy" relationship that does not position the difference between the generations and keeps the teenager in an unacceptable dependence (he is then obliged to "increase the pressure" to detach himself or to block his adolescence).

Through multiple round trips, the teenager gradually advances towards a new phase of separation individuation which leads him to adult empowerment. When this game of failure/success is not possible (parents too "attached" to past relational modes), the progressive separation is more a matter of uprooting, and many psychiatric pathologies can appear (narcissistic pathologies, anorexia nervosa, etc).

3.7. Place of the disease

3.7.1. The double trauma

Any serious illness of a child causes a double trauma for him and his parents Any illness of the child disrupts his life and that of his parents: "Illness is a shaking of subjectivity." (Leblanc, 2002) Let us recall that Freud defines trauma as "an experience experience that brings in the space of a short time such a strong increase of excitement of excitement to the psychic life, that its liquidation or elaboration by normal by normal and usual means, fails, which cannot fail to

lead to lasting disorders This can only lead to lasting disorders in the energetic functioning. There is trauma when there is non-abreaction of the experience which remains in the psyche like a foreign body" (Freud, 1926). Férenczi (1968) explains this state in terms of the annihilation of the of self, of capacity to act and to think which stuns the self and produces an important anguish, not allowing any more the processes of thought processes to develop normally. In addition, apart from this stupefaction situated hic et nunc, the traumatic event also comes to reactivate past events what Arthur Schnitzler (1988) wrote that "an event casts its shadow into the future its shadow in the future, it is a regular process that we must accept as such; more accept as such; more serious is the event that casts a shadow the past, plunging into a sudden darkness parts of life that were in the light and which were in the light and had long been preserved in their state.

The announcement of a child's illness thus represents a real traumatic crisis :

- by the ruptures that it introduces: brutally, "the world changes It is no longer the world of others, of those who are unaware of the unthinkable risks, the dangers of treatments, the pain, the possibility of death;

- because it inevitably shakes up everyone's points of reference, particularly those of the couple, points of reference established, sometimes at the price of compromises that are difficult to negotiate; it then brings to light all the conflicts (even old ones!), revives the wounds, breaks down the barriers, reveals secrets (identical illness in an ascendant, incest, hidden mental illness, etc.) and causes, in a significant number of cases, the explosion of the family;

- because it places everyone in an insecurity that is particularly detrimental to the establishment and consolidation of parent-child bonds, which can bias the later development of the latter;

- because it intensifies the defensive mechanisms of each one, pushing caricature, notably in the identifications between parents and children child (the rank in the siblings or the sex of the child will have here a particular particular importance when it reactivates very strong identifications with one or with one or both parents).

However, the nature and the quality of the reactions of each of the partners (direct reaction of the child; reaction provoked in him by the behaviors of his parents) are essential to behaviors of his parents) are essential both to the good progress of the treatment, but also to the possibility of not adding a psychological handicap to the one psychological handicap to the one possibly caused by the somatic disease itself. illness itself. These reactions are of course influenced by

culture ("a boy doesn't cry"), but they depend above all on the past, on the type of interweaving of stories, on the founding myths of the family (Miermont, 1993).

- The first trauma is primary, direct, due to the fear of death, pain of death, pain, and handicap. How could it be humanly different. This trauma is managed by the pediatrician who, far from being a "mere to be only a "technician" must accompany his patient and his parents in the parents in the painful path of the fight for healing, a path paved with doubts of doubts, fears, renunciations, disappointments and acceptances of what, until then, was unthinkable (heavy surgery; the vital risk; the fixed handicap, etc.) vital risk; the fixed handicap, etc.). The place of the child psychiatrist in (liaison child psychiatry) can be, here, that of listening to the pediatric team the pediatric team, in its own difficulties (fear of asking too much of a child to ask too much of a child; to live at least badly with a diagnostic doubt; to accept that the the fight is lost, etc.).

- The second trauma is more complex to understand. It occurs after the fact, depends on the transgenerational family history and, in particular, on the presence in the family of mourning or illness of other people. The illness of the child then reactivates past wounds, unhealed wounds and, if one is not careful, attacks not only the body, but the attacks not only the body, but also the child's psyche, which has become a worrying element, disturbing a fragile but previously stable parental balance. In these cases, it is often difficult for the pediatrician to listen to everyone and at all levels: the help of a "professional of identification", of someone who will be able to recognize the place of the body doctor, but to unburden him of a whole too heavy pan of unsaid, more or less unconscious fantasies and links to the past interfering with the present battle, will be welcome. This work in articulation does not mean a total transparency: the child psychiatrist carries out "skimming" which guarantees to the parents and to the child the possibility of access to a neutral space of speech, space where all can be said, without immediate and direct consequence on the therapeutic care. The pediatrician and the child psychiatrist then become actors in the same play, even if they do not always intervene in the same act, or in the same scene, and above all do not use the same tools and do not have the same responsibilities (the pediatrician remains the guarantor of the life of the body; the child psychiatrist, that of the psychic life: he is "invited" in the pediatric unit, a different universe the pediatric unit, a different universe from the one he usually works with where the weight of the "real" is less in the foreground). illness of other people. The child's illness then reactivates past wounds, unhealed wounds and, if one is not careful, attacks not only the body, but the attacks not only the body, but also the child's psyche, which has become a worrying element, disturbing

a fragile but previously stable parental balance. In these cases, it is often difficult for the pediatrician to listen to everyone and at all levels: the help of a "professional of identification", of someone who will be able to recognize the place of the body doctor, but to unload him of a whole too heavy pan of unsaid, more or less.

3.7.2. Aggression of the body image

Some diseases and their treatments lead to an intense aggression of the body image. This is a source of very important secondary difficulties in the child's body investment by himself and/or by his parents, this justifies a child psychiatric approach in connection with pediatric follow-up. It is often around this problem that the child becomes depressed or evolves towards depressed or evolves towards more or less invasive anxiety disorders. The image of the body is this partly unconscious image, carrying personal fantasies of the child and an important part of his narcissism, that is to say narcissism, i.e. the esteem that he has of himself. It comes partly from a good unfolding of the "stage of the mirror" analyzed by Lacan (cf. p. 24-25).

Dolto (1984) opposes in a clear way:

- the body pattern : which is "in principle the same for all the individuals (about the same age, under the same climate) of the human species", remains "a reality of fact", "our carnal living in contact with the physical world contact with the physical world", "refers the actual body in space to the immediate experience" and can be independent of the history of the subject; it remains an "abstraction of an experience of the body in the three dimensions of reality that is structured by learning and experience", depends on the integrity of our organism and on the lesions that it undergoes (its construction can be thus upset by a chronic disease) by a chronic disease); "it is partly unconscious, but also preconscious and conscious". - the image of the body: which is "specific to each one", "related to the subject and specific to a type of libidinal relation" and "eminently unconscious", "living eminently unconscious", "living synthesis of our experiences emotional experiences" in the relations; it is structured "by the communication between the subject and the trace, from day to day memorized, of the joy (accomplished desire) frustrated, repressed or prohibited" and "it is in what it is to refer exclusively to the imaginary, to an imaginary intersubjective marked from the start in the human of the symbolic dimension ". For Dolto, "it is thanks to our image of the body carried by and crossed to - our body diagram that we can enter in communication with others": "it is in the image of the body, support of the narcissism, that the time crosses itself to the space, that the unconscious past resonates in the present relation ". Certain diseases attack the image of the body in a direct way through

deformations, pains, damages of the "envelope", more "physical Some diseases attack the image of the body in a direct way through deformations, pains, damages of the "envelope", more "shameful" when they are visible. The child, powerless, can then live his body as damaged, fragmented, bad, disintegrated (which is close, in certain cases, to a psychotic experience, related to a psychotic experience, linked to a regression to the stage previous to the acquisition of a unitary body image, in reference to the Lacanian "mirror stage of the mirror").

In this sense, pain has a particular status. It represents an It represents an "interior scar" which never fades: it goes away, but one cannot forget the but one cannot forget the suffering of the body. This one remains registered in him like an experience more or less depersonalizing according to its intensity, threatening experience, feared, which sometimes makes one lose confidence in oneself and in others (they are powerless to protect against it). Throughout the child's development, the fight against physical pain should therefore be a primary concern, as its prolonged appearance when the child is when the child is very young can complicate the establishment of crucial points of reference for his future (establishment of self-limits, confidence in his body self; confidence in his body, confidence in the outside world with the desire to discover it to discover it; possibility of relying on the adult, etc.).

3.7.3. Other morbid processes intervening more indirectly.

These may be diets imposed on the child (Vidailhet et al., 1986): they frustrate his or her own orality (beyond the restrictions, some children are forced to children are forced to consume products whose taste is recognized as unpleasant); they also plunge his parents into a certain frustration (they cannot frustration (they cannot fill, relieve and calm by the "good things" that they "good things" that they offer to him). In addition, the "deviations" are sometimes experienced as major dangers by everyone, which guilt, shame and anguish: the child creates a cruel and castrating superego and castrating superego, remains subjected to a relation of close dependence with his parents, which complicates all the processes of autonomization (powerful secondary benefits on both sides), and, sometimes locks himself in real sadomasochistic relations with them.

In other cases, the attack is more clearly iatrogenic (alopecia, weight gain due to treatments, mutilating surgery, etc.), while some certain complementary examinations can make the child experience a feeling of a feeling of real bodily dispossession (impression that his body is an object body is an object manipulated, directed from outside by the doctors, the parents). Sometimes, the child is not at all prepared for the examination that he is going to undergo and

does not understand how it will be carried out (and therefore of course not its results) This usually leads to major anxiety. This makes it difficult, if not impossible, to perform the examination. A number of children's drawings on this subject (Schmit, Danon, 2003) highlight this type of difficulty, which can be reduced by can be reduced by explaining to the child the gestures and maneuvers that will be that will be carried out: for example, one can use a teddy bear or a doll on which one a doll on which one mimes the course of the examination (or surgery), then the child manipulates them himself, which helps him to This helps them to "take ownership" of things and to play them down. He then feels like an actor and not just a helpless spectator of what is going to happen to him.

These situations can reactivate fantasies of intrusion, invasion, or even dispossession or instrumentalization of the subject's psychic life. for example, some children experience the MRI that they have been presented to them as a painless examination that "allows them to see everything in their head" as a possibility for the radiologist to know all their thoughts, to transmit them to their parents, or to take them to make them act (especially since they are spoken to in a microphone during the examination to tell them not to breathe, etc.).

Furthermore, certain images of the real body (radiological, ultrasound, etc.) can represent real traumas for the child who cannot manage to "digest" them, so much so that they introduce a hiatus between his own bodily perception and what is revealed to him by the MRI or CT scan. These "too beautiful images" (the radiologist sometimes speaks of "beautiful disconnected from his internal reality which, far from being beautiful, refer to the pain, anguish and impotence) can be very painful when presented without explanation or when they are presented without explanation or in a too brutal way (without instructions!), stagger the defensive mechanisms of the child, sometimes even those of his parents (it is not however a question of their own body... but all the same that of the "flesh of their flesh").

They cannot then become of true representation of oneself: with the opposite of the image, the representation is built through the thought of itself, and thus becomes a true material to think, since it is composed of various of various elements (returned external reality, fantasies, emotions, etc.) articulated between them. The doctor must therefore (and more and more so with the progress of imaging techniques which could sometimes make one think that the images are truer than life, cf. ultrasound or 3-D scanner!

- to prepare the ground, to overcome one's own trauma: the discovery of cerebral lesions in a baby who seems not to be doing so badly or the images which show that the death is going to

happen when we didn't want to think about it, are all staggering violence that the doctor discovers in live, without filter, alone facing the reality; Then, and only then, will parents, child and doctor, in a true encounter, be able to the future in words, with its share of challenges. pain, mourning and handicaps, a future that remains a possibility, so that the child develops there using all his or her abilities. It is as if everyone could then situate themselves in an expanded space, transitional space (Winnicott, 1969), freed from the only "reality" of the image that can "speak" in the common history, without impoverishing denial, nor arid intellectualization.

PART II

METHODOLOGICAL AND OPERATIONAL FRAME WORK

CHAPTER 4

OPERATIONAL FRAME WORK

4.1. Hypothesis

This is a provisionary answer to a question. The main characteristic of this answer is that its validity is still to be evaluated and tested before validated. From the literature review observed above, one could say that the presence of a chronic illness in an adolescent specifically HIV AIDS, greatly influences the process of identity construction of an individual or the adolescent which changes it from what the normal process of construction is supposed to look like, i.e. The ideal process of identity construction in adolescents.

Hypothesis: *the experience of HIV and aids participates in the individual and the social surrounding of subject there by altering the identity construction in the carrying subject*

4.2. Recall of research problem

Before getting into the hypothesis, there is the need for a brief reminder as to what our research problem is. From our literature we understand as the autopoeisis theory of Maturana and Valera puts to us that with the up rise of a crisis, an organism or a unit has the resources proper to it to be able to reconstruct themselves and find a new and better functioning system. In our own case which is that of adolescents suffering from a chronic disease, our interest is to their identity construction and what we realize is that these adolescents with HIV which is our chronic illness of choice greatly alters the natural pattern or order of this individuation in the young adult. Our main question here then is: what is the cause of this disruption in identity formation in adolescents living with HIV AIDS as opposed to what could be considered as the normal process of identity construction as proposed to us by other authors such as erikson and frued amongst others. In other words, how do HIV positive adolescents tend to have an altered process of identity construction. The testing of a provisionary answer to this question will be our next point of focus in this work.

4.2.1. Outline on the main points of the variables, modalities, indicators and indices of the research problem.

1. **General hypothesis:** *the experience of HIV and aids participates in the individual and the social surrounding of subject there by altering the identity construction in the carrying subject*

1.1 Independent variable: experience of HIV AIDS.

1.1.1 Modality: representations of the disease by the individual and others.

1.1.1.1 indicators: perception of the disease

- Indices
    - Guilt related to an irresponsible sexuality
    - Sexual abuse
    - Drug abuse
    - Risky lifestyle
    - Post diagnostic depression
    - Lack of self-care

1.1.1.2 indicator: significance given to the disease

- Indices
    - Culturally seen as a punishment for the transgression of a divinity.
    - Relating to it as an ancestral curse
    - Resulting from an irresponsible sexuality
    - Resulting from improper health care both facilities and personnel

1.1.2 modality 2: people's attitude towards HIV carriers

1.1.2.1 indicators: behavioral dispositions of others regarding the disease

- indices
    - healthcare personnel attendance to the needs of these patients
    - considering the other person as a curse and deserving of their current case
    - violence both physical and verbal towards PLWHA
    - educational discrimination
    - Discrimination (Behavioral expressions of prejudice directed toward stigmatized people)

1.2 Dependent variable: identity construction in HIV positive adolescents

1.2.1 Modality1: social insertion

1.2.1.1 Indicator: fitting an individual into a social milieu

- Indices.
    - Inclusive education
    - Acceptance to carry out social activities with peers
    - Belonging to formal and informal social groups
    - Physically participating in peer or other group projects
    - Adapting (living in harmony) with others in a professional working environment

1.2.2 Modality2: personality building

1.2.2.1 Indicator: having a sense of self identity and individuation

- Indices.
    - Sense of continuity
    - Sense of affiliation
    - Interpersonal identity building
    - Ability to stand out amongst peers
    - Having an orientation in various aspects of life such as career and hobbies

4.2.2. Research hypothesis

GH: the experience of HIV AIDS greatly participates in the identity construction of an HIV positive adolescent

RH1. The representations of the HIV disease participate in the social insertion of an HIV positive individual

RH2. The representations of the HIV disease participate in the personality building of an HIV positive adolescent

RH3. People's attitude towards HIV carriers participates in the social insertion of the HIV positive adolescent

RH4. People's attitude towards HIV carriers participates in the personality building of the HIV positive adolescent

Research hypothesis: *the experience of HIV and aids participates in the individual and the social surrounding of subject there by altering the identity construction in the carrying subject*							
Independent variable: experience of HIV AIDS				Dependent variable: Identity construction in adolescent			
Modality 1: representations		Modality 2: people's attitude		Modality 1: social insertion		Modality 2: personality building	
Indicator: perception of HIV and AIDS by the individual		Indicator: behavior and disposition of others with regard to HIV		Indicator: fitting of the individual in a social milieu		Indicator: sense of self identity and individuation	
Indices:	guilt related to an irresponsible sexuality	Indices:	healthcare personnel attendance to the needs of these patients	Indices:	inclusive education	Indices:	Sense of continuity
	drug abuse		considering the other person as a curse and deserving of their current case		Acceptance in social activities amongst peers		Sense of affiliation
	sexual abuse		violence both physical and verbal towards PLWHA				Interpersonal identity molding
			educational discrimination				
			Discrimination (Behavioral expressions of prejudice directed toward stigmatized people)				

4.3. Clinical interview

Roughly put, an interview is a situation where there is an exchange, oriented or not with the goal of collecting information. In the case of a clinical interview, the patient is greeted by the clinician, who introduces himself, and there begins the “questioning” through which the clinician seeks to understand why the patient has come, what can be a problem for him? What is the extent of this problem? How does this manifest? How the patient got there, etc.? The questions are multiple and almost endless thinking about it.

One thing worth noting is that the clinical interview is not the hallmark of the psychologist. Doctors, nurses, speech therapists, and so on, also conduct clinical interviews that are oriented and constructed according to each person's specialty. However, the interviews are not independent of each other, they partially overlap and thus make it possible to redirect the patient when the difficulties are outside the scope of our skills.

4.3.1. The different types of clinical interview

There are three main types of interviews namely the directive, non-directive and semi-directive interviews.

4.3.1.1. The directive interview.

Here, the interview is very strongly directed and “controlled” by the clinician, he asks the questions and the patient answers. According to the answers, the clinician directs his questioning and orients it to exactly the way he wants it to go.

4.3.1.2. The non-directive interview.

This type of interview is such that we can end up talking then we forget the questions, almost completely, the patient tells his story, with very little or no interruption. In particular, it's the kind of method that can be found in psychoanalysis. The advantage of this interview is to give free rein to the patient's thoughts. So everything depends on the organization that the patient gives to his story. Also known as unstructured interviews they do not use any set questions, instead, the interviewer asks open-ended questions based on a specific research topic, and will try to let the interview flow like a natural conversation. The interviewer modifies his or her questions to suit the candidate's specific experiences.

Unstructured interviews are sometimes referred to as ‘discovery interviews’ and are more like a ‘guided conservation’ than a strict structured interview. They are sometimes called informal interviews.

- **Strengths**

  1. Unstructured interviews are more flexible as questions can be adapted and changed depending on the respondents’ answers. The interview can deviate from the interview schedule.

  2. Unstructured interviews generate qualitative data through the use of open questions. This allows the respondent to talk in some depth, choosing their own words. This helps the researcher develop a real sense of a person’s understanding of a situation.

  3. They also have increased validity because it gives the interviewer the opportunity to probe for a deeper understanding, ask for clarification & allow the interviewee to steer the direction of the interview etc.

- **Weaknesses**

  1. It can be time-consuming to conduct an unstructured interview and analyze the qualitative data (using methods such as thematic analysis).

  2. Employing and training interviewers is expensive, and not as cheap as collecting data through questionnaires. For example, certain skills may be needed by the interviewer. These include the ability to establish rapport and knowing when to probe.

4.3.1.3.The semi-directive interviews.

This time, the interview is not only directed by the questions of the clinician, but also by the verbalizations produced by the patient. The space is less strict and more open to ramblings, which allow patients to step outside the framework of the questions asked to address elements that seem important to them. It is also possible in a directive interview, but it is still less favorable. This is probably the most used type of maintenance.

According to Blanchet (1987) cited by Fernandez and Catteeuw (2001, p.74), the interview as a research technique has been defined as "an interview between two people, an interviewer and an interviewee conducted and recorded by the interviewer; the latter having the objective of

favoring the production of a linear discourse by the interviewee on a theme defined within the framework of a research" (Fernandez & Michelle, 2001). Although there are different instruments or techniques that can allow us to explore the object of our study, we have opted for the interview. The reason why we chose this technique is that it is a technique for which we have a great experience in terms of theoretical and practical knowledge. We used it during our academic internships in the various health facilities. According to Nkoum (2015), it provides very rich data and brings out the complexity of the phenomenon studied. Thus, the interview "makes it possible to discover information on the experience of emotionally charged themes since the way of answering gives indications on the experience of the phenomenon studied" (Tsala Tsala, 2006. P.113-114). According to Angers (1992, p.141), "we also aim, by this means, not only to establish facts, but to bring informants to give the reason for their behavior. We seek to establish the meanings given by people to the situations they experience. The clinical research interview is characterized by several elements. It is above all a face-to-face technique that favors direct contact. The researcher exchanges directly with his subject, without intermediaries. It allows a qualitative sampling of the material provided by the subject with a view to an in-depth content analysis of this material. However, understanding the experience of PLHIV requires an influx of information or data provided by the subject and also, the experience of PLHIV is a very complex phenomenon. There are three main types of interview depending on whether it is in the context of research or in that of the clinic. We have the directive interview, the semi-directive interview and the non-directive interview. The use of one or other of these interview methods meets the goals pursued by the researcher.

4.3.2. Reasons for choice of semi-directive interview

- we opted in the context of this research for the type of semi-directive interview for well-defined reasons. This choice is justified by this quote from Lefrançois (1991, p. 108): with the semi-directive interview, "the researcher has more latitude, which allows him to adapt to the context (environment, personality of the subject, etc.)".
- Also by virtue of the different elements recognized by our object of study, which is identity construction, we know that with qualitative research, we more rarely resort to the standardized interview of the "question-answer" style (Deslauriers, 1991, p.36). This type of interview will allow participants to express themselves to us about their experiences. Thus, we will have an interview corpus that will allow us to do the analysis.

- Again, it is essential in this research because according to Beck (1976) and Young (2003), "it is necessary to stick to the data provided by the patient, by being satisfied with his own words and that it is from his discourse that must be conceptualized and not based on a theory" (Pascal, 2015.p. 5).
- In addition, it will allow the researcher that we are to collect information from PLHIV placed on antiretroviral and having unsuitable early regimens in accordance with the themes predefined in the interview guide. It is therefore with this in mind that we have designed an interview guide (appendix) presenting the themes to be addressed during the various interviews with PLHIV/AIDS placed on antiretroviral.

4.3.3. The objectives of the clinical interview

At the start of every interview, the questions asked to ourselves appear to be crucial like concretely what do we do? What do we tell our patient? Well, we dig a little into his more or less distant experience to understand what brings him to us. Different spheres are to be investigated and questioned, depending on the specialties. But for the psychologist, the social/family sphere, the affective sphere, the professional sphere, and the cognitive sphere are a minimum (almost exhaustive). Even if not everything is investigated with the same depth, none of these spheres should be neglected. It is through the data collected from touching all these various spheres that lays us a proper ground work as to what we are working on.

All this information must be updated through the clinical interview. But that's not the only purpose of the interview. Sometimes, even often, the question arises of the presence of a mental illness in the individual, it is therefore necessary to understand his mental functioning at different levels, through his interactions with others, through his emotional functioning / emotional, and cognitive functioning. This is why, following the interview, the psychologist uses standardized tools to objectify this mental functioning, so that the symptomatology highlighted during the interview is not limited to a subjective opinion.

4.3.4. History

A key point of the clinical interview is the collection of the anamnesis. It is the history of the disease, or the individual's suffering, in short the whole epic of his symptoms from their beginnings until the consultation, described by the patient, with his words, his emotions. We are not confined to the story as such but also to the way it is experienced. With equal history and diseases, the feelings of the person will never be the same. It is in this that any individual

can experience the feeling of never being able to be fully understood. Which is perfectly legitimate, because no matter how empathetic we can be, we can at best only imagine what our patients are feeling.

4.3.5. Evaluation

To go into a bit of detail, through the clinical interview, the psychologist begins to assess the patient's mental functions, such as social adaptation, language, memory, emotional functions, such as emotion regulation, motivation, self-esteem, cravings, executive functions via the patient's flexibility, organization, and planning skills, judgment, etc.

All these clues are important to understand the spheres affected by the patient's suffering, or conversely what is the impact of these spheres on the patient's suffering. This raises the question of the origin of this suffering: is it environmental, cerebral, genetic, developmental?

4.4. Interview guide

In the context of qualitative research, the researcher must construct an interview guide that he will use during the interview with the study participants. It is in fact a summary list of themes and sub-themes that must be addressed in the context of a qualitative survey. It allows the researcher to know when and how he will introduce these themes during the interview. This guide is available to the researcher to enable him to follow the defined methodology, while observing appropriate behavior during the interview. On the other hand, it is essential to note that the order in which the themes are mentioned, as well as the wording of the questions, may vary during the interview. However, this guide is not built just any old way, it respects a very specific order.

Taken in this sense, it consists of the following elements:

Items	Sub-items
HIV AIDS experience	representations of the disease by the individual and others
	perception of the disease
	Guilt related to an irresponsible sexuality
	Sexual abuse
	Drug abuse
	Risky lifestyle
	Post diagnostic depression
	Lack of self-care
Significance given to the disease	Culturally seen as a punishment for the transgression of a divinity.
	Relating to it as an ancestral curse
	Resulting from an irresponsible sexuality
	Resulting from improper health care both facilities and personnel
	people's attitude towards HIV carriers
behavioral dispositions of others regarding the disease	healthcare personnel attendance to the needs of these patients
	considering the other person as a curse and deserving of their current case
	violence both physical and verbal towards PLWHA
	educational discrimination
	Discrimination (Behavioral expressions of prejudice directed toward stigmatized people)
social insertion	*fitting an individual into a social milieu*
	inclusive education
	Acceptance to carry out social activities with peers
	Belonging to formal and informal social groups
	Physically participating in peer or other group projects
	Adapting (living in harmony) with others in a professional working environment
personality building	sense of self identity and individuation
	Sense of continuity
	Sense of affiliation
	Interpersonal identity building
	Ability to stand out amongst peers
	Having an orientation in various aspects of life such as career and hobbies

4.5. Criteria of compatibility

In order to be able to participate in this study, there are a certain number of criteria that the participants will have to present which we will be looking at here.

4.5.1. Inclusive criteria

- Must be between the ages of 13 to 20 by the time this investigation is taking place. This is because we believe that it is at this age range that the nurturing process of individuation starts and begins to hold grounds.
- Must have been diagnosed and is aware of their status for over a period of at least 8 months, this period permits us to investigate at a time where the situation must have had impact on them.
- Must be under the supervision of a parent or guardian, the idea behind this is that the parents play a vital role in the identity construction of a child and this will permit us better evaluate this concept of identity construction
- Must be on anti-retroviral treatment
- Must agree to ,show interest and give their consent in order to participate in this study.

4.5.2. Exclusive criteria.

- PHAs with opportunistic infections;
- Adults as from 22years of age and above
- Children between the ages of 12 years old and below
- People who dropped out of the interview or refused to give their consent formally.

CHAPTER 5.

DATA INTERPRETATION AND ANALYSIS

In this section, we are going to be looking into the information collected from the field work in its raw form and the various expansions of information that has been seen to be embedded behind them. In the first section of this which will consist of interpretation which consists of the process of assigning meaning to information or data and in the second part we are going to be doing analysis which is going to consist of uncovering patterns and trends in the data that has been interpreted. We will be proceeding in a case by case method in this interpretation and end with a cross reference analysis in order to uncover the patterns that underlie in this data.

5.1. Data interpretation

5.1.1. JOHN

For a start, concerning elements of identification our first participant John appears to be a male, 19 of age and dark in complexion. John, is a catholic Christian from the west region of the country and a high school student in his sixth year. he appears to be at the head of the unit in the focus group of their peers where they come for their medications. He is a young and stern fellow, very vigilant and always careful not to say too much than was absolutely necessary. From the very first question I asked him during our interview at the hospital which was that of knowing how long it has been since he has been aware of his status and his answer was that it has been practically seven years that he was told about his status or rather made aware that he was actually suffering from HIV given he was already on medication before and rather not aware of why he was taking those specific drugs all the time. This is one of the characteristics mostly found in a majority of them whereby they are not informed of their status until a certain period in their lives especially for our participants here. He makes us understand that was 12 years of age at this time as such we see john to be e very inquisitive young man with the mind to personally seek for information at this stage for himself.

5.1.1.1. Stigma on HIV AIDS

A concept that john evokes on his own was that of stigma. This alone informs us on the idea that it is a situation that he has come to live or experience in some way and to make sure we were on the same page of understanding, I asked john what he understood or meant by stigma seeing that he earlier mentioned it. In response to this question, John starts by painting to us a picture of what life is like with him in the house where he lived and not just the nature of the interaction but equally how he felt with regards to the reactions that were made towards him in this situation such as isolation where he does not get to interact with the other sibling in the house where he lives and he called family he expresses this in saying *when I was stigmatized I always wanted to leave the house because they made me feel like they did not want me amongst them and they did not want me to live with them (family members) and I don't even have the right to sit with them where ever they are.* here once more, he makes a call to the coping mechanism of involving a third party to the scene. this time around he rushes rather to an external person who is not a family member indicating the home is no longer a place of trust for him to share his frustrations and feelings any more than outside. This portrays to us a form of emotional instability and dissatisfaction with no room for release. Finding out as to how these emotions are being handled by john, he rather expresses a lot of hurt as he describes not thinking of having a place amongst his family people which actually supposed to be the primary source of care and comfort. This is equally explained by the nature of what the disease had done to him at a physical level that had made him to question why his interactions were not really as expected i.e. not very welcomed amongst peers.

Scouting on the elements that gives information on how john makes a representation of the HIV disease by himself and equally how they are represented by those around him, the very first information I will bring to you is the nature of its arrival. From the interview it comes to notice that one precedes the other which in this case is the way the people around John make the representation of this disease that makes means for the way John puts it to himself. in the case where they represent it to him as a terrible disease with no way out, it becomes exactly the way he puts it to himself. More specifically, interrogating the nature of interactions with his peers John clarifies to us that a majority of his peers that are aware are his family members which are brothers and some extended cousins. With the above aspect investigated, john starts with a brief hesitation and his facial expressions changed and there is where he gets into the first aspect of the story expressing the difficulty with his first accommodative home which were his aunt and her family. The nature of the dynamic of this relationship left a lot to desire

and this put our first participant in a state of emotional lack and want from that nature that the family peers accommodated and interacted with him on a personal level. This is expressed in the way he narrates the nature of his relationship with them and how they made him feel by saying *I was always having a feeling of rejection from them* and he expresses this with a rather long face indicating those emotions were still somehow greatly felt by john at the moment of explanation regardless the effort to dissimulate it by saying *but right now I think it's getting better* this brings us to a point where we see john trying to cover up for flaws in behavior which are not his which happens to be one of the signs of an abusive childhood. Again the level of information flow from him to his friends is greatly limited. Concerning his status, the nature of the communication with his friends excludes this aspect which is considered a great part of his life. When asked about those their relationship with him he describes it as stable adding *"at least for those who do not know because I chose not to tell them".* This equally informs us on the way john perceives his status which is as something that not everyone has to know and he decides or rather prefers to keep them to himself for probably fear of what others are going to think about him carrying around such a status and also from what people also consider of those who carry such a status.

5.1.1.2 Significance given to the disease

This second element here has as objectives to bring to us the qualitative representations that each of our participants make of their situation which is that of living with HIV. As per the significance that they give to their status or what it meant for them. From here, his response informed us on a lot of attempts at reconciliation from the emotions of the latter experiences with a sort of accommodating idea where he expresses his opinion of his situation being just something normal that could have happened to just anyone and this gives him hope to not give up. Up to this point it is certain that what he employs here is just a defense mechanism of avoidance which in this case is that of avoiding to face the realities of his situation. From his choice of words in the description of his illness which he terms "ill luck" there is the portrayal of that superstitious aspect of it which is believing that the cause of the situation is as a result of a misfortune that befalls them. This is explained by the strong presence of a cultural influence over the years right from the parents to the society at large that the younger generation and even the older ones used to live.

5.1.1.3 behavioral dispositions of others regarding the disease

From the information gathered so far pertaining to the behavioral disposition of others, we sought to investigate this at the individual level and how each of our participants lived it and dealt with it. In the first scenario, the is some sort of a demonstration of the relationships that are established with the immediate family. This came during the investigations on defense mechanisms or rather coping strategies when such situations which might appear rather emotionally overwhelming to him start happening. The first one that he makes us see here is that of an outreach for emotional support. This is a form of coping strategy that involves the person in a difficult situation to call out for help from a circle of people they consider as close be it friends or family members that they esteem to be not only reliable but that can equally bring them some sort of comfort to the stressing situation. This seen in John's first response on how he handles the situation by reaching out to his father to intervene in the situation by talking to his aunt with which he lived. At this point we really ask the question of knowing to what extend this form of coping or rather this call for help actually helps better the situation given the feelings of insecurity comes from the cousins he lived with. At the same time that was the only solution john could come up with at the time.

In a bid to establish the changes that have been present before and after the proclamation of the diagnostics to them, john fills us in on the fact that the difference is rather present and not only that but rather took a turn for the worse that strained their relationships. He clearly expresses to us that the bond shared between him and the siblings or rather the ones he lived with was rather on a thin string. From an emotional point of view, such a situation is capable of leaving in a person a sort of void especially at an age where it is interactions with the peers and family that is said to have a determining role in the identity formation of an individual. We are made to understand here by john that it is as a results of his status that the whole process changes where he says "…*But immediately they knew that I was seropositive their behavior just changed and even their manner of living with me just took a turn that even I did not understand…"* at this level might come in place some sort of self guilt treating where an individual in this situation will tend to blame themselves for considering themselves as a sort of source of their misfortune seeing that the topic around their discrimination is their status that they always get to bear and move around with be it their fault or not. Regardless that we saw the necessity of going further to investigate on the resilient capacity of the participant especially on the axis of how they on their own part choose to interact with those around them who are aware of this status of theirs. The response received here was a rather very interesting one in

that it brought to light the actual inconveniences that it causes john at a socio-emotional level. This is at the level of the segregation or rather separation from peers and family at home who are actually supposed to be not only the primary source of care giving but equally the first place where one gets to construct a self before testing it outside the sphere of the home. We learn from Erikson's 4th stage of development that development centers around industry and inferiority. This stage begins at age six and lasts till age 11 and during this stage, your child actually starts becoming aware of their individuality. They see accomplishments in school and sports and seek praise and support from those around them. If teachers, caregivers, and peers offer support and a sense of accomplishment, they feel competent and productive. If they don't receive positive reinforcement for their accomplishments, they may feel inferior or incompetent. here with our participant we experience a near similar situation where john is rather denigrated and not really put forth with peers for fear of what he carries and this makes him pull away from the others around him.

Equally, this builds some sort of strong sense of caution around him that makes him hyper vigilant but in this case geared towards isolating himself from the rest of his surroundings for the fear of guilting himself if anything gets to happen to any of the other sibling and they get infected and he shares with us that being it his fault or not there will be some form of self-blame. And from the nature of his response, we see a form of development that is geared towards the other side of what is to be considered the normal or appropriate side of development according to Erikson's 6th stage in the young adulthood where there are the poles of intimacy versus isolation and here we rather see the behavior of john here opting more towards the isolation side of the pendulum where he makes us understand that he would rather have his things to himself and not want anyone entering his space or getting into that of another for fear of infecting them. He shares with us that "…*personally I take a lot of precautions just so that I don't hear one day in the house that there is a newly infected person there or anywhere around me because even if it is not my fault, my conscience will tell me that I have something to do with it that is why firstly all my materials are personal and I don't accept anyone touching my things anyhow…"* this and the fact that he explains to us that was not the initial situation informs us that at the base John will rather be out going than restrained to himself and isolated but we can never always have what we want, here he goes all out and decides to isolate himself because of his HIV status. The question here is further clarified when john is being asked if he would consider himself as an outgoing person and his response was an outright solid "NO"

when asked to tell us more about it, he says" … *concerning friendships with other people, actually I don't know how to run after people anymore…"*

Drawing towards the end of my exchange with John, I asked him if he has a girlfriend and accepted which then pushed me to question the nature of his relationship with her and its dynamics. Here john makes us understand that even the girlfriend is not aware of his status and he actually intends to keep it that way. At the level where it is, one will expect that being in a relationship for two years there should at least be some level of trust to share such an information but regardless he doesn't inform her. This situation makes him to build some sort of secretive habit where even when asked he still decides to keep it to himself.

5.1.1.4 social insertion

Most the social interactions that these youngsters get at this age of their lives is usually from the school environment, at least for those going to school. So when asked if he was a scholar and with his answer which he said *"yes I do"* this tells us that he is an intellectual and to some degree or extent can be able to not only understand but equally analyze what is going on around him and give a somewhat proper interpretation to it. This equally informs us that he has some sort of social interactions that can be explored on both the intellectual, and socio-emotional level that gives us more information with further explorations as to how it is handled and how it is perceived by john. As for what concerns the nature of his interactions with his peers, we are enlightened on the intellectual sphere of his consciousness in the manner in which he answers to the first question as to the nature of his relationship with his peers. In the investigation of this question he informs us that the nature of the relationship with his classmates and friends are rather stable and favorable and we get the hint of this consciousness where he says *"at least for those who do not know because I chose not to tell them".* Which gives us his selective nature in the disclosure of information pertaining to his status. More to that, he informs us of the fact that there is no major difference that he finds between him and his classmates given they are not aware so this comes up to be a superficial mask as to the difference that he will really get to make or the actual troubles he will face to establish them on basis of their awareness of his status as a result he manages to pulls through his school milieu fairly enough for the time being. Seeing into the fact that most of the peers at school are kept in the dark on purpose about his status, we saw the need to investigate on the ones who might just be aware of his status and as expected, it consisted of mostly family members and extended family.

In another way, we see situations where the choice of other social insertions are directly or indirectly influenced by the status of the patient. In John's case, John approaches this question from a double axis where he starts by letting us know that the only problem he finds with this status of his is the fact that he is constantly conscious of it and the negative emotions and thoughts that come along with always having it in mind. On a second axis which is where he presents a rather optimistic view point on the subject matter where he affirms that given he is just like any other person it will not be much of a problem to him as per what concerns his personal goals. He comes to the final conclusion of this question by unveiling a burden which he carried for a while which is that of an uncertainty in his future regarding the world view of his status. This is seen through his affirmation which says "…*though sometimes I think to myself that in the near future it might become a hindrance to some certain things…"* this informs us of the uncertainty is his mind which might actually be a factor that will keep him from pursuing some certain goals as a consequence of this status. In a further investigation as to what these goals are and how he perceives them, he discloses to us his wishes and dreams which have been somewhat formed or traced out by his current situation and status where he affirms that as soon as he is done with the high school he will tell his father that he will like to continue his studies in a medicine school and become a medical doctor. this notion of this aspiration of his being traced to his status is noticed where he affirms "…*after my BACC that I want to get into that field of medicine so I can help children also because I know it is not easy…"* John demonstrates a form of sympathy here with regards to his situation and what he lives and seeks for a means to help out those who find themselves in such a situation as he did. This paints a picture of life purpose traced out by the situation lived by the subject and the question of if the choices in life, career and other social insertion situation would have been different if the status was not the same.

5.1.1.5 personality building

We see according to Erikson that one of the measurements of obtaining an identity status is where an individual is able to build a personality for themselves the by evaluating the choices in interactions that they make for themselves. In the case of john, as a means to dig further into the mechanisms put in place in order to handle these emotions which are rather not favorable or not perceived favorable to john, he rather applies a sort of defense mechanism which might not be very well indicated for this kind of situation which is that of putting in efforts into emotionally uninvesting from his entourage this is the type of defense mechanism seen in the

psychotic structure which is that of cleavage. This is seen through the act that he explains to us as follows "…*This hurt me so much that I did not even want to play with them again until I came back and saw Dr. Kamdem."* At this point the participant John goes through some sort of a reminiscing and with almost tears in his eyes I had to give him time to come back to himself.

In a bid to establish if there is any sort of remarkable difference that john makes between the situation he experiences now to know if it changes anything about him, he expresses to us that there is no change to the person that he is and the person that he was during or rather before the disclosure of his diagnostics and his status to him. Following our previous analysis we get to establish rather marking differences which concerns his intellectual spheres but most especially the socio-emotional spheres with the nature of his relationship with his siblings and those of his peers living around his residence and his new adaptation of life with regards to them and their now knowledge of his status where he considers as having changed and which changed the way he interacted with them which is more of a response from the way those around him who were aware of his status interacted with him. This actually brings him to the point where he adopts a new lifestyle though sort of isolatory but to his judgement and mostly from his caregivers responds to his situation was considered a rather soothing one as a means of containing his status for what must have been considered by them as the greater good. This situation was rather a remarkable change to John which makes us question if John is actually well aware of the situation and how it is impacting him directly or indirectly. At the same time, we equally can say it might just be his own way of having a positive view to life and not let his situation define him much, but at the same time, hopes do not negate facts.

When further clarified to if there is a difference to the him of now and the him of before, he expresses a form of responsibility and consciousness that the new situation has created in him and how it has actually defined him to the person that he is today

An overall remark about john is that of an initially outgoing kid turned reserved and will rather handle the circumstances around him by himself than turn to the next person for help. All of this can make us actually consider the fact that his situation.

5.1.2. SOPHIE

Elements of identification on our second participant presents to us a female who is 18 years of age, a catholic Christian from the center region of Cameroon and from the Beti ethnicity. She is a student in high school here in Yaoundé. at first presentation one could never have imagined her for her age given she looked more like she was 11 with a petite body. From the very beginning of the interview, she appeared rather nervous but still putting in efforts to present a rather care free and more relaxed façade. The first thing I had to do here was to bring some sort of reassurance to her by making her understand that we were in a safe space and that not only is it ok to feel nervous but it's equally normal. Her response to all of this was just a dep breath followed by an "ok". This tells us that she actually needed the reassurance and a safe space to be able talk.

5.1.2.1. Stigma on HIV AIDS

In this phase, she was asked if she was versed with the notion of stigma and her response was negative as in she did not know what the word meant. Now this is a situation that comes up to be rather very peculiar given an adolescent of 18years old who has been living with HIV AIDS all her life is not familiar with the word stigma. Regardless, this brought us to explain to her what it was all about. After the explanation and clarification, we asked her if she has ever experienced any situation pertaining to stigma. From her response, she emphasizes on that fact the she has no much experience of such a situation with reason being that a good majority of those who surround her and know her who might actually produce that kind of action or verbalizations in that light are rather kept in the dark about her status consciously for reasons I believe to be to avoid that feeling of stigmatization. Regardless this it was to be questioned how well they managed to keep everyone at bay of this information such that she affirms never experiencing this situation of stigma. This leaves us with the questions of if Sophie just does not pay attention to is it really the case that she has not had experiences of this situation.

5.1.2.2. Significance given to the disease

Following the significance that Sophie gives to her situation, the answer was as dry as it could get which was plainly *"...you say significance? Hmm I don't know me oh..."* this response came and elaborated more on her level of comfortability with her ignorance and the fact that she did not seek to know how to go about it just elaborates more on her being comfortable with her situation when brought to light about her ignorance on a subject matter.

5.1.2.3. Behavioral dispositions of others regarding the disease

From here, we went into the nature of the relationship with family members which was on that of both close and extended family. This question was to permit us grasp a better understanding on the family dynamics or at least her perception of the nature of her family dynamics and interactions. From her response she tries to elaborate to us that the nature of the family dynamics with relation or with regards to her are rather a favorable one, she goes ahead to make it more plausible by enlisting some of the aspects of it which leads her to her confirmation of the nature of the relationship being expressed in her own terms as good. Here she brings out aspects as her parent's interest in her education by putting her through school and equally their interest in her good health which she expressed her parents taking her for treatment and buying her drugs. At the end of this response, she made another remark that further reinforced the question of whether she is just being ignorant about certain aspects pertaining to her situation and status or that she was just being hopeful about it which is that of her status as a positive carrier to the HIV virus changing one day and this is seen where she expresses to us that "…*and one day one day it will finish…"* this leads us to believe that it is either one of the above possibilities that are sponsoring this belief or rather another form of denial which is but less plausible.

Furthering the conversation, sophie was asked how she interacts with her peers as a contrast to a previous question which was that of finding out how her peers interacted with her and the nature of her response was that of an adolescent who would very much love to be outgoing and expressive as she says "… *"anh", me I disturb a lot of…"* and when called upon to further explain what she meant by that she makes us understand that she plays a lot with her friends and likes to get carried away in the moment but is rather restrained by her situation and status or more like restrained by people who are her care givers and who think it much more beneficial for her to stay at her residence rather than step outside. This is an aspect that limits them from really getting to form stronger bonds with people in and outside of school and she expresses her frustrations with regards to this situation rather with actions of self harm and risky un-adapted behavior such as skipping on drugs. When asked about the "they" she is referring to she says her father.

5.1.2.4. Social insertion

As per what concerns her social insertion, we can start from a basis that she belongs to an academic institution as The first question we started here with was that of knowing if she was going to school and her answer was affirmative. When asked about her class it informed us that she has spent at least 4years in secondary school where she says she is in "*3eme espagnol"* this makes us understand that she should have a rather better understanding of the series of questions that were going to be posed considering she should be literate enough to understand them. Coupled to hat, we can affirm that she has some sort of interactions with these classmates of hers and to some point has a surrounding to interact with which gives us a basis to interrogate her social insertion and how she fits into the dynamics that she finds and is able adapt regardless of her situation where she probably happens to be the only one with the condition of HIV. When we asked this participant about the moment when they were first aware of their status and with their answer which said 2012 tells us this has been a relatively long time enough to get into the details and in view of this time they must have been through sufficient experiences that we can get to explore more from in order to grasp a better perspective of their point of view as to what concerns the focus of our study another aspect worth noting here is that just as our first participant, when the questions start getting personal, there is that guard that they raise as per the information that they give and a cautiousness not to say more than what they probably consider as necessary. When we start with how our participant perceives life in general with relation to her status. Just as the first participant, there is that sense of being extremely cautious as to what should or should not be said and not answering more than absolutely necessary. At the same time too we get to ask ourselves if it is not just a way of brushing off. This answer was "…*well its going on fine…"* this made us to investigate further by ask in what exactly she meant when she said fine, a question of her throwing more light on her answer and the response she gives makes us understand is that she tries to limit herself to the scope of just being contented with the basic minimum that was given her without seeking any more or less from her primary caregivers. She makes us understand that so long as the most important to her needs are met she is ok with it. These basics being her having a place to stay, what to eat and her school fees being paid. This raise the question of an affective or more of the emotional sort of responsibility that is given by the care givers and the nature of their relationship with Sophie and all she has to say about the way she perceives life with them is "…*everything is just fine…"*

Furthering the investigation as to the nature of her relationship with her peers, we find out that the relationship is a rather very satisfactory one, at least from her point of view. As for those who are aware of her status, she lets us in on the fact that there are a few of her friends who are aware of it and she is the one who told them. This shows us that to some degree there has been

a level of secure attachment or rather bond that has been created well enough for her to be able to give her surrounding a degree of rust that she gets to share an information as sensitive as this one with them. This informs us greatly on the nature of her attachment as per the works of Mario Mikulincer (1990) where in 3 studies, 352 undergraduate Israeli students were classified into secure, avoidant, and ambivalent attachment groups, and their differences in trait-like measures of self-disclosure willingness and flexibility and in disclosure reciprocity and liking of hypothetical or real partners were assessed. Findings indicated that both secure and ambivalent people showed more self-disclosure than avoidant people. Findings also yielded that secure and ambivalent people disclosed more information to, felt better interacting with, and were more attracted to a high discloser partner than a low discloser partner. In contrast, avoidant people's self-disclosure and liking were not affected by the partner's disclosure. Secure people showed more disclosure flexibility and topical reciprocity than ambivalent and avoidant people. Findings are discussed in terms of the interaction goals of attachment groups. So far as at now, we can classify her mode of attachment here to be more tilted towards either a secure or an ambivalent one given she is rather open to the idea of sharing it to the people she feels more comfortable with. This equally raises the question as to if this feeling of trust that is established between them could also be seen as contributed to the fact that for the few she has disclosed this to, the nature of the relationship has been a rather protective one as she informs us to the nature of her relationship with those who are aware by telling us "…*I have friends who know that I have HIV so as they already know, (pause) how will I even say this? Well they take care of me actually. They protect me all the time…"* but as the saying goes that too much of anything can be a disease, she brings up to light the fact that to her it gets rather overwhelming where she continues by telling us that "…*even though sometimes I feel it's too much but I think it's just their way of showing me they care."*

5.1.2.5. Personality building

In the next phase of our questionings, we sought to inquire if Sophie had any personal goals and objectives, her positive answer led us to believe that she has had time enough to go through the aspect of a possible future life and is conscious enough of the importance. From here, trying to find out if this status of hers impacts in any way or changes her objectives, the answer she gives leads us to believe that up to this point she is either still living in denial or not conscious enough about her status and the kind of position it puts her in. to some degree, one might think she is just being positive about her situation, but totally ignoring it is another story. Getting a

more critical look at it, we come to the conclusion of eliminating the fact that she is being unconscious giving her age though from the nature of her expressions which was rather inarticulate from time to time but left us to believe that for her to get this far in her educational follow up she must have some degree of consciousness for it which pushes us further into the hypothesis of denial. for the final section of investigation that was going to bring our interview to an end, she was asked if her present situation changed anything about who she was and from the nature of her response she makes us understand that everything remains the same although she ends with a seemingly sad comment where she says "…*The same me of before is still the same me of right now though I will really like for things to change faster…"* this brings us back to the fact that she is still very hopeful of things changing for her which is principally her status and by extension all the surveillance and the restrictions from parental authorities. Not only that, but we see in this last statement someone who yearns for change as though she says her status does not change anything but somehow wishes it did…

5.1.3. XAVIER

For identificative information, Xavier was our third participant, a young boy of 16 but rather looks like he was 12 from the physical appearance, starting to ask myself if that was actually a characteristic or an effect of the virus on the children or rather just him and Sophie. He presents himself as a Christian and a student in his third year in high school. He appears to be a rather soft spoken and introverted person. As per the first question which is set to find out how long he has been aware of his status, Xavier starts by diverting the question and responding in a way of shifting from himself and directly bringing his parents in the picture by telling us "…*it's my parents that informed me about it…"* this brings up a sort of avoidance from his part and the question had to be redirected for him to tell us it has been from since 2016 that he was made aware of his actual status and condition. In the second part of his first recorded answer, he rather makes us understand that even way before he was actually made aware of his actual condition, he has been greatly facing difficulties with his health and other secondary manifestations of them that appeared to be rather very unpleasant to him and this lets us know that even before his awareness he was actually already facing the weight of a sick child. He expresses to us that "…*I always knew I was sick of something but I never knew what exactly it was before my parents told me that it was HIV…"* this raises a question of if after this awareness it makes it any better of rather worse.

5.1.3.1. Stigma on HIV AIDS

Furthering this investigations, Xavier is questioned as per the people who are aware of this his status and condition. As earlier mentioned, this question was going to permit us find out about his interactions with his immediate surrounding regardless every other critical factor with addition now to a third factor of HIV and the ifs and how it impacts on who he is and how he interacts with the world around him. From his answer, we understand that it has equally been prohibited of him from by parents and care givers from sharing that information with the others for fear of the tag associated to that status but then he reveals to us that there are some of his family members that are aware of the situation and equally some neighbors. Again, here we see a repeated pattern of a situation where the child is under obligation though with good intents from the obligators but with a rather heavy load for the individual to bear as they are unable to share what happens to be a very big part of their life with anyone as a result of what it might actually cost them reputation wise amongst other things.

From here we moved to the next phase of the questioning which was on the way he lives the notion of stigma. From the opening question he admitted to not grasping the concept of stigma, so after explanation of what it was, he was asked if he has had an experience similar to that and his response was affirmative. This leads us to believe that from his stand point he must have had some confrontations with the external world on some of the negative view point that some people have on what concerns HIV and how they react to people who are carriers of the virus. From his explanations on how he has experienced the situation of stigmatization, Xavier points to us his school environment and paints to us the picture of how he perceives the view on them. He tells us that "…*well it is usually when I am taking my drugs. Some of my friends in school will be looking at me a type…"* this equally makes us understand that he is very concerned with the way other view him and even if it's just at sight, it to some degree carries his concern. He further explains to us what he lives as a result of his condition, Xavier has a skin condition that makes him have a lot of rashes and tone imbalance and this conditions seems to bother him as he makes us understand that it must be from the nature of his skin that he is being looked upon in a way he does not perceive as positive. In his own words, he says "…*they just look at my skin and be saying I must have a very bad condition and sometimes they are even afraid to come near me…*" this makes us understand that Xavier has an accentuated emotional intelligence that makes him rather sharp to understand these scenarios and interpret them to know what they mean even without having to be told.

5.1.3.2.Significance given to the disease

Following this, we went forward to the significance that Xavier attaches or gives to his status and his response made us understand that he first did not quite get the question but at the same time also sort of tells us that he is hopeful for a better outcome. From his response he makes us understand that here is some level of adaptation to the condition of his disease and the nature of the situations that his status carries. He expresses this by saying "…*I am already used to it and very soon they will find a vaccine for it that will conquer the illness…"* although we have very little close to no information on the aspect of a cure for this disease, information fed to these youngsters is what fuels the hope in them that sooner than later a remedy for this disease will be found and at the end of it they will be good as new and somewhere deep down in them that is the aspiration that they all hope for but so far all they can do to make the situation sot so unbearable is for them to stick to the antiretroviral drugs that keeps them healthy though they carry the virus.

5.1.3.3.Behavioral dispositions of others regarding the disease

In this phase of our questionings and interaction with Xavier, I asked him if his status changes anything about who he is and if so, how it does. He reiterates through his response one more time the importance of his friends to him which actually makes us understand how great a role they play or rather played in his life. It is but normal that children at this stage be more concerned with the companies that they keep and how the interactions go both ways be it from the friends to them or from them to their friends. Again, we see in him the efforts that he makes to keep the few friends that he has and although the method of approach here might not be considered the best for a healthy relationship with peers which is that of keeping information from each other and the ones that you consider friends, it is not very far from what Xavier does here pertaining to his status. He makes us understand that regardless the primary reasons earlier mentioned above as a reason fro nor not sharing the information of his status with his friends and peers being because he was instructed by his parents to do so and because he was afraid of their reaction which was that of them looking at him with contempt, there was equally that fear of loosing the close friends that he has as it it already something that has happened when a few of them found out and the first reaction was to cut out communications with him and even the interactions they used to have such as playing video games together and them coming over to his house just ended at some point and even those who stayed close steered away. On the other hand, he equally feels it is as a result of his unwillingness to tell those who already suspect it

that makes the situation what it is, he makes us understand that there are a few friends of his that have been seeing him taking his drugs most of the time and they have been questioning him on what the drugs were for and he just has not been telling them anything and from the nature of the drugs, the consistency at which he takes them and the nature of what the illness has done to his skin, it will not really be very difficult for curious adolescents to piece it up together, but rather still he prefers not to tell them and at some point he feels like this is betraying the trust of his friends, but regardless this is an option he will rather chose than have to face the looks that might be given to him or the reactions that will be given to him if he actually reveals it to them which is actually what has been the case already from those who found out about it.

Getting into the specifics of the situation earlier described, we see a situation where he presents to us two types of people who are concerned with the awareness of the situation and how they react to these situations which are the older people (the adults) and the younger ones (including peers and other younger kids). We see a situation where the adults try a bit more to relate regardless playing it safer by creating a sort of interaction with him here and keeping a safe distance. But looking into it, at this age is not exactly the age range or the type of people he gets to interact with most often from what he describes as per what the situation was like before they were aware of his status as his appropriate age group or rather preferred age group for interaction will be his peers and those around his age range but to that effect a system has been put in place where the parents of the other children don't find it very welcoming the idea that their children play around him given his status and to my understanding probably that they cannot be supervised or that the parents cannot vouch for the safety of the activities that they will be doing which might cause harm to a neutral party. Regardless all this and the justifiable nature of how it may be, it still does not change the fact that it directly impacts on the life of Xavier given that another great pole of identity building here is that of the social interactions that a subject holds or has with others especially his age group that he grows with. For Kendra N. McLeish and Robert J. Oxoby, 2011, on the exploration of the effect of identity salience on behavior in a simple social interaction. Specifically, they compared ultimatum bargaining across three treatments: priming subjects with a shared identity, priming subjects with an identity distinct from those with whom they will interact, and priming subjects with no particular identity. It was found that subjects are most cooperative in the identity-priming treatment and least cooperative in the distinctiveness-priming treatment. Similarly, subjects reveal the highest demands in the identity-priming treatment and the lowest demands in the

distinctiveness-priming treatment. These were discussed on the implications of these results with respect to the literature on organizational identity. This leads us to believe that an identity constructed around a well-defined social group tends to do much better or rather better responds to the ideal process of identity building better than that just done in patches and conditions not so well defined. In this situation of ours here, we rather see a case where Xavier is rather kept away or rather his prior friends and mates are made to stay away from him there by leaving him in a type of isolatory state. It gets rather elaborate where he expresses to us that "…*nobody wanted to come beside me again and I don't get to even play or talk with them. It's like they were scared of me or something…"* this causes him to somehow involuntarily withdraw himself from the others and this happens to not be a very good way for someone at the stage or in a situation of identity construction in progress.

5.1.3.4.Social insertion

In the subsequent phase of questioning, we dive into Xavier's view on the kind of goals that he has and if he has any and how he plans to go about them. In response to this, he makes us understand like every kid at this stage, he has aspirations in mind and things that he wants to accomplish. The first thing that came to mind was the nature of his answer where he says "… *I will like to be a person of tomorrow…"* this answer was rather flue and when further questioned as to what he meant by it, he further elaborates that he wants to be a working, working and having a job then he concludes by saying "…, *i want to have a good job like every normal person and be a big businessman. At least that is what my father wants me to do…"* this raises the question of if what he wants to do kind of differs from what he is being asked to do and also the reason behind them. Before getting into these questions, commenting on the situation above it raises the question of if what the father wants for him is just another parental aspiration or if there is a reason behind it that makes him chose that career for him, to be more exact if it is as a result of his status that they won't want or are foreseeing and trying to avoid a situation where there won't be work space conflict. This remain one of the questions that we couldn't get an answer to given the participant himself didn't explain given they never knew why themselves. Regardless, we see a situation here where Xavier gets swallowed up in his father's aspirations for him regardless the fact that he has his own aspirations in mind, but still we don't know for sure if this is directly related to his status.

Regardless all these hopes and aspirations for this situation of his to soon get finish, one will think that it will make things a lot easier with Xavier as to what concerns his interactions with

others and the manner in which h is now going to approach life but there is still that accentuated fear to reveal the present status to peers and people who are not yet aware of the actual status as an HIV virus carrier. Nevertheless, he makes us understand that there are still plans he has to share this information with his peers and sort of relieve himself of the burden of having to keep such a secret to those who are close to him. He tells us that "…*I am waiting for the right time to tell them, right now I don't think I can tell them because I don't know how they are going to take it if I tell them now that I have that illness…"* this informs us again to the fact that this situation of his is a burden he wants to be able to share with his friends but for fear of how they are going to react to it he just rather keeps it to himself for now till he finds what he refers to as a good time to share it. More to this, there is still that fear of sharing in resulting from the reaction of people who are already aware about his illness and how they are reacting to it which is many things but good.

5.1.3.5.personality building

Safe to say with confirmation from the participant that regardless these measures, there are still some of his peers who are aware of his status, and from there we went in on an open end for a description of how the experience of life is with them and from his answer, it was with certainty that a sort of change has emerged from the angles of interactions with them, the way they perceive him and equally with the way t has led him to feel about himself in the whole process. He first elaborates to us that before some of them knew, there was always a feeling and sort of a process of mentalization on what it was going to look like if and when they find out and from every indication these thoughts were met with a lot of fear and a not so positive angle of view. We see this when he says "…*at first i was afraid of the way they will start treating me and behaving around me when they found out…"* he then concludes this sentence by saying "…*And I was right.".* this shows us a sort of confirmation to what has been underlying in his mind. This brings us a hint of the murphy's law which talks of what is to be will be especially the one you fear most. But with uncertainty on the validity of this law, it is still rather proven that when we think a lot on something especially one that has a negative connotation to it, we tend to work on it a lot and end up incorporating it in our system and somehow preparing for its eventual arrival and even if it does not come in the form awaited, the predisposition towards it will still be measureable to the degree of preparedness towards it. In an example, it is like preparing for war on the thought that it might be eminent and catastrophic such that when it actually comes and is not even a big threat, the prepared camp faces it no longer as per the

threat seen on the field but more as the way they had pictured it I their minds. This is much similar to Xavier's case where he rather prepares for the worse from others and even ends up acting in regards to it.

When further asked what he wants to be or has in mind as goals, he informs us that he rather wants to be an engineer. Now looking at the two types of careers presented here, one is that of a situation where one gets to build something of their own and are accountable to themselves and the other where there is a lot of team work and mostly done under supervision as an employee. Now in the one hand we see a parent opting for the safer way or at least what he thinks will be safer for his son and on the other hand what the son will rather prefer doing although the father might not opt for it. These questions are rather somehow elaborated and answered to some degree when the subsequent question followed where he was asked if his status in anyway affected his plans and goals for life and if it did he should tell us how exactly they do. His answer informs us on the fact that he will really love for it to not be the case (not affecting his goals) on a physical level but on the other hand there is his representations of the situations that he makes in his mind that makes us understand that he is still somehow affected by it and by the way he runs it in his mind. From the representations that he makes, we see where he makes a comparison with his prior experience as per the kind of treatment that he receives from his neighbors around him and the others who are aware of his status and he does a kind of projection in to it assimilating the situation to look like what he is going to face if he gets in to a career where he has to work with other people. From what we see here the impressions he has and makes from these neighbors and people who are aware of the situation happens to not be a very positive one so he sort of uses the situation as a basis for which he will stand to see how the future will look like for him if he has to work with other people and this already brings to us or rather reiterates the form of isolation that they implicate with themselves that is Xavier and the above mentioned participants like john which will rather stay away for fear of how they are going to be judged from reference of their status and with the way they will want to insert themselves in the society and with the way they are already being treated with their try and efforts towards that insertion. he poses this worry when he says "…*I ask myself sometimes if people will want to work in the same place as me if they knew I have this disease because even just the people in my quarter already behave somehow…"* he moves further from here and makes us understand that this is probably the reason why his father wants him to get into the career he chose for him.

As earlier passingly mentioned above, another aspect of identity construction is observed in the manner in which an individual from his own comfort zone and with his own initiative chooses to go for an interaction with the people around him and more specifically in the choices of people that he takes and the way he or she decides to relate with them be it on an intellectual, emotional or even social level. Regardless all this, Xavier still makes us understand that he always goes for the option of staying away from peers for fear of them discovering his status and what he carries and also because they were strict instructions from parental authorities. As for how the neighbors discovered, he explains to us a scenario where he says "…*one day I think it was in 2009, I fell very sick and my parents were not around and it was my neighbors that were there and they took me to the hospital and that was where they discovered that I have a very serious illness what the doctors told them that I have that disease. That is when the neighbor that lives beside us calls my father that I am seriously ill. That is when the doctor prescribed me drugs that I have to take every day…"* it was from this day that he made the discovery that even his mother was also a carrier of the virus and this is probably why his parents do not want him telling anyone about the situation given they also have a bit of knowledge from the mother's experience on how it turned out which is rather something they will not want repeating to him. He later on concludes that his mother later on got healed from that disease; by which means, we do not know for sure but this actually happens to be believed as the fueling source of the convictions that Xavier has which is geared towards the illness finishing one day and very soon.

5.1.4. BERTRAND

The very first thing we notice from Bertrand is that he appears to be a much healthier carrier. On like all the other participants who from the very first view you could tell that they were sick children, Bertrand appeared to be much healthier and in good shape both physically and more so mentally. He comes off as a brave young man 20 years of age and with more of an alpha trait among his other friends that were there and was equally very bold in his speech. As for how long he has been aware of his status as an HIV positive person. Instead of maybe giving a date like the others, he rather gave us an age saying "…*it was at the age of 14…"* at age 14, we know there is already that heightened consciousness in individuals that makes them aware of their surrounding environment and to some degree are more able to better process the information that circulates around them for this age range and much clearer as compared to our other participants like Xavier who found out at a very tender age of between 3 and 4 years old

and has had to live with that information for a longer period of time than the others. This led me to believe that this case of his will be explained by one of these two aspects, either he must have gone through a proper mentalisation of his situation or what he is presenting to us just might be denial at its peak. Either ways we are going to find out in the course of our investigation.

5.1.4.1. Stigma on HIV AIDS

Now coming to look critically at this response, it makes us wonder at the veracity of most of his answer where he gets to tell us again that he keeps it from them because he does not want his friends to have a negative opinion of him or as he says in his own words "…*looking at me bizarrely…"* from what he gets to explain here it corresponds directly to the very concept of stigma which he claimed he did not initially know anything about. At the same time, it is possible to know a something and not know what word refers to it. Regardless, we still see in him that consciousness of trying to avoid a strange view from another person on him and he does so by keeping information about his status purely to himself.

5.1.4.2. Significance given to the disease

Concerning the significance he gives to his status, as a result of the fact that it was earlier detected in him and he has been on medication and for the secondary effects have not been weighing much on him throughout his life greatly contributes to the fact that he kind of trivializes the virus and regardless his number of years that he has been aware that he is living with this human immune virus, it has never really gotten to the point where it puts him down and this might explain why he does not really consider it as much of a threat to him. Aside from what he does not consider it to be, what he sees it as being is as he says "…*just a virus and very soon they will find the anti-virus and we will all go back to normal…"* and from where he says everything will be back as normal tells us that the situation he lives in right now is very different from what he will consider as normal.

As per how he would describe life with his peers, the first thing we notice here is that Bertrand gives us a lot of information at a time as if to say he had been preparing for it. Although only answering the question to the best of his understanding of the question, he equally gave as much information and he could. The first answer that came out of his mouth with regards to this question was a lie and not only that but exaggerated. He starts giving some sort of a cover up for his situation such making it seem as if life to his with his situation was all full of bliss

where he says and I quote "…*well life is marvelously well…"* now it is true that it is being advised of them to see the bright side of life, but from every indication he was definitely covering something up. Now coming to think of it, he could only have come to that conclusion with respect to some other situations which he considers to be way more terrible than the actual situation he is living in which might make him to come to that conclusion. As per this, the situation he is making a comparison to is other people's illnesses which he considers to be way worse than his by the way and by saying "…*given the sickness i have is not as terrible as others, some don't even have a cure…"* so we see here a situation where he applies a defense mechanism here looking at his situation to be mild as compared to other people's situation of sicknesses which he considers to be worse than his. Behind all of this, we still see a great level of optimism in him where he still hopes for a better near future and equally coupled to the fact that he is a healthy carrier, he affirms to us that normal day to day life for him does not appear to be as hard as it may want to appear for the others and he gets to do a lot of things that everybody in his shoes are unable to do and he will know this because he is a part of the peer group which is also a focus group where they get to share their experiences with each other and he is able to assess them well enough and know which is which.

5.1.4.3. Behavioral dispositions of others regarding the disease

as for elements gathered on this sub topic which was not much given the nature of the way Bertrand decides to handle the information and coupled to the fact that he is a much healthier carrier, there was very little information on this end. From his own experience, the information as earlier mentioned is limited just to the immediate family and no one else and with the family situation where there is some sort of bonding attachment formed, most if the interactions with them appear to be a rather more stable one there by providing him a much more stable environment instead of the chaos that comes with the non-secure attachment type families.

5.1.4.4. Social insertion

When further questioned as to if his status may in anyway impact his goals and objectives, from the way he approaches the question we first see that he always likes to first of all bring us behind and reiterate on what he first said as he says here that "…*well as I earlier on mentioned, it cannot hinder me from my objectives in any way. I believe that even as we carry this disease it does not stop us from accomplishing what we want…"* this makes us question ourselves if this is actually being optimistic or just being unconscious as to the actual gravity

of the situation. This question arises because we would perfectly understand a situation where the participant fully understands the extent to which the situation is serious and can actually hinder them from a lot of things in life and if he came from the view point of "regardless all this we can still accomplish what we want to do" it would have been much more comprehensible but remaining just at the level of blindly holding to the idea that their status cannot hinder them from doing anything. More so, he continues by including the rest of the group by saying that "…*even as we carry this disease it does not stop us from accomplishing what we want…"* there by meaning he is not speaking only for himself but for the rest of his peers in the support group and by extension the rest of those probably in the same situation as he is where as it is not the case at least from the few that I have come to interact with and have gotten their opinion on the same matter and what they get to say about it regardless them staying hopeful is that it is usually hard for them and they get the fear that it might not be easy for them to integrate the systems of work life as a result of the fear that they carry around with them something that has been tagged very negatively in the society that we live in and there by having it at them any other way but normal as for someone who is not a carrier. This brings us back to his academic progress, we see a student who is age 20 and is still in his 6^{th} class in secondary school, this goes a long way to say he must have had a lot of slow breaks on his academic path making us question his level of consciousness on his choice of career given we have already seen a case where a career is being chosen for another by his parents probably as a result of this very status that they carry.

On the next segment of our interactions, we went into the question of stigma, and once more here we see the question of keeping the knowledge on the status to one's self and not sharing with other for fear of the view that they will have on them. This is further expressed when Bertrand is being asked about the concept of stigma and his first response to it is that he does not know the word. Now before we get in to the heart of the concept, it is rather a situation unthought-of that a young man of 20 who has been aware of his status for 8years plus and has focus groups that he attends on the sensitization on their illness of HIV is unaware of the word or concept of stigma. After getting to explain to him what it means, we then went further to find out from hi if he has ever encountered such a situation and if yes how exactly did he live it. Getting into the heart of his response, he starts up by saying that "…*no, not really because I think for someone to do that they have to first of all know about my status and most people that I interact with don't know much about it…"* this makes us see that he is doing rather well with the compartmentalization of that information on his status but at the same time he raises

a statement talking of his friends seeing him taking the drugs and getting curious as to why he is taking them and just as the others, he evades the question.

5.1.4.5. Personality building

In the course of this he throws in a comment saying "…*I can still do whatever I want to do at least for now because as long as I don't tell anyone there will be no problem and right now my status remains confidential and the most confidential person right now is me so aside my family members and myself no one else knows so they think I am in good health…"* this brings us back to the same form of confidentiality that exists amongst them that they don't get to share information about their status to anyone. The particularity with which he expresses his own brings about a strong conviction to the fact that he alone should be the detainer of that information and on like the others who rather think they should not share the information because of the fear of what they will think of him or the way they will treat him, he rather just expulses it as something that is no one's business and will just rather keep it to himself and as for the family members who already know it because according to him the best person to keep that information confidential is himself. We see in his speech here some sort of arrogance put forth which is more of a defense mechanism against the vulnerable part of him.

We note Bertrand here as someone with a very eloquent speech and with a lot to say from just a little question so it really called my attention when he was asked about the nature of his relation with his family. The intent of this question was to inquire how on if his status had any impact on the family dynamics and if so, how exactly it did. But on the contrary, all Bertrand had to say about this was "…*well i will say it is rather very well…"* normally with a question like this, one will expect as seen from the other above participants some sort of elaboration as to how exactly the family relations can be considered "fine" as he says by listing a few things that will make him say it's good. And even after giving him an ear and asking to further explain what he meant by good, all he said was just that it was fine. Another striking aspect here was the way he changed his sitting position from someone who cared less by stretching all over the chair and leaning back to sitting upright and folding his arms which was like putting some sort of armor and getting on his guard. This led me to believe that I had touch a point that is very sensitive to him which he will rather not disclose much about and keep it to himself. Much of this gets to be confirmed when he is asked about his personal projects and objectives, he starts by reiterating that he is in premiere in the technical section doing construction and that from there he will like to civil engineering and equally shows interest in agriculture. Here he gets

more elaborate into details of what he wants to do as opposed to when he is asked about his family.

Diving into the nature of his relationship with his peers, this time around not how they relate with him but his own initiative on how he decides to relate with them, Bertrand reveals to us that '*…i think it's normal given that i don't like interacting with them too much because I know when they will get to know of my way of life and how much I am restrained from a lot of things, they will start asking a lot of questions that I will not want to answer so I just rather stay and avoid contact as much as possible…"* from here we see right through that wall that he puts around him as someone who is unattainable to see someone who is rather scared of answering questions that might be directly related to him and the situation that he lives in. this is in some sort a defense mechanism of cleavage where he seeks as much as possible to be uninterested in those around him not really because he does not like them but simply as a means of avoiding his entourage and consequently having to explain his way of life and restrains to others and the things that he does such as the reason for his drugs that he takes every day and eventually the illness he is suffering from. Now as per what he believes as what he is really trying to avoid here is not necessarily having to explain what HIV is all about and that it is only a virus and the real disease is AIDS so for him it is not as bad as it looks but rather his greatest fear is that the people around him who he might have to explain this to may not believe or take it the wrong way and at the same time the exhaustion of having to explain a condition that is not first of all a favorable one and getting to say it over and over again.

Getting to the last phase of our encounter with Bertrand, we sought to make a sort of synthesis between the nature of life's experiences before and after his awareness of his status and to establish if that awareness changed anything for him as to what concerns his identity (who he thinks he is) and from the nature of his response, we note that just like all the others, they really hope it left them unscarred in every aspect but it is never really usually the case. From his explanations, he makes us understand that there were a lot of mixed emotions when he was being told of the situation at hand which was when he was revealed that he was an HIV virus carrier. The circumstances in which they were explained to him made him feel like it was really a very terrible situation and his interpretation of it at the moment was that of hopelessness as that of someone whose all is lost but at the same time, he makes us understand that it was after a while when he got to learn about the meetings that he got to have hopes and assurance that it was not really the end nor the worse given there are situations he considers to be worse than his such as he says cancer and diabetes and more to that, the fact that he has been living with

it all his life and it just happens to be now that he is aware of what the situation is and that it does not change much about the situation.

Bertrand was one of those cases that showed up to be a lot more hopeful about life and with a more accentuated zeal to its regards than the others. The main thing we take from him here is the way he reacts to his situation which appears rather particular from the rest with his show of positivity and which somehow seems arrogant but it is the way he lives by it.

5.1.5. PASCAL

Our fifth participant Pascal presents himself as an intuitive young man with a lot of high moral and religious values and standards that he appears to live by. Not very outgoing and from a physical presentation is unable to take proper care of himself even with necessary resources. Pascal is a 17 years old young man in the class of lower sixth and for this age, he must have had a proper school cursus so far indicating he must be rather well seated as to what concerns his educational background so far and he is a well seated learner and will be in measure to understand what we are talking about also given he expresses himself in both national languages (English and French). More to that, still on identification, Pascal fills the criteria of being aware of their status for over a period of about 2 years as he indicates to us as at the time of this research that he has been aware of his status since 2020. This equally tells us that he has been through the experiences that come along with being an HIV positive adolescent and fills our criteria for this research. The most particular aspect about this case is his accentuation on his beliefs and religion as it is that main axis through which he explains most of the worries and answer that he has as well as the core doctrine for his thought patterns and his belief systems.

5.1.5.1. Stigma on HIV AIDS

Heading to the next phase of the questioning from here which was into the concept of stigma, he begins by affirming to us that he understands what the term refers to. After brief exchange of what it meant, we went into his experience of it and how he can explain or the meaning he gives to it. He starts by giving us as experience that according to him should not be placed as directly related to his status but which I think is actually related to it. This scenario he presents to us is that of just before he came to be aware of the fact that he was a carrier and in his own words, he says "…**:** *um... when I... what I was experiencing was when... I had a skin disease. I'm going to say a mala... I had a... I had a skin... I had a skin problem. Here's even that... well*

here are the marks again. I had a skin problem. It was even on my head…" these skin problems that he has here are actually a secondary manifestation of that HIV that he has and coming to it, he tells us he has actually had a not very positive experience concerning that situation of his skin condition but no one could actually tell what exactly it was and even he himself did not know at the moment, but it got very uncomfortable for him to the extent that he had to go to school, with a cap on his head to cover up the wounds on his head and with that came a lot of questions that are usually not very well received given the condition and coupled to the fact that even if he wanted to give a response to it, at that very moment he won't be able to. These are some of the defining moments that impact a lot on how anyone as an individual will choose to relate with the people around that and if at this very early stage it gets this strained, then it definitely is going to be a rough one along the path of building a more secure attachment as time goes by. This to some extent might explain the number of persons that are being let into the inner circle of the disclosure of this information which according to him are not up to 10. Now going from the fact this is usually not the type of information that one might be ecstatic about sharing, it might to some degree explain why not even the closest family circle are aware of this situation and as per those that are aware of his status as disclosed by him are those of the same faith as him. From here we actually realize from his expressions that he is actually counting on the fact that as they are of the same faith and religious beliefs they would be able to treat him right and not further disclose the information in a way that might make it worse for him as they should have what he refers to as "the fear of God".

5.1.5.2. Significance given to the disease

Regardless, from the collective of the speech takes so far we can piece out the type of life that he has had to live so far to this moment which is that without a mother as at age 6 and although Pascal tells us that they only suspected that she died of HIV, but not certain, we already see him bringing in the picture someone to point a finger at or his situation especially given that it was not asked but he saw it to bring it in the conversation. This already brings into play a sort of push play blame game here. More to that, we see a level of consciousness when he again tries to cover up for the situation that he evoked by trying to bring in a picture of uncertainty as per the information he just revealed by saying they did not really detect the disease in his mother so they don't know for sure if she died of the HIV or something else. Coming back to the third part of it, he presents his father in the picture and explains to us that he now lives with

his father and then proceeded to add to it that the relationship between him and his father is the same and absolutely nothing has changed.

The first element he brings to us here is that his status was more of a motivation for him. In his own words, he says "…*It changed. Because when I knew my status it was like a motivation for me now. It was like a motivation. A motivation for me to go forward, to persevere, to continue…"* this makes us question this answer from two perspectives which are if the situation at hand really occurs to him in the sense that he really gets to consider all the options and potential harm this situation could come along with, or maybe just even the nature of the situation and secondly how exactly does him becoming aware of his status as a positive carrier brings him rather the enlightenment of what he expresses to be a prophetic call over his life. Regardless the questions he raises here, he makes us understand that at some point there was actually a frustration that it brought to the picture where he states "…*It's true that when I first found out, it's true that I was a bit frustrated at first... because I was thinking, but how? How did I manage to get this and everything..."* we are made to understand that subtly there is to some degree a sort of self guilt that is being attached to it that makes for them a rather complicated transition from the state in which they find themselves before becoming aware of it and to the state where after they are aware of their status and the negative socio-cultural tags placed on it, how they are able to find a new dynamic that they will work with?

As an attempt to an answer to this question on his part, he brings up to light again the roots of his beliefs which are that found in his religious background and attributes the source of his success in that transition which he earlier on described as rather frustrating and hurting experience, he attributes it to the making of God. This demonstrates the important role that he attributes into the religion that he lives by and in his beliefs and makes us understand here that these beliefs of his holds a very significant role in his day to day life and with how he goes about it. More so, he expresses this more where he informs us of that point in his life that was like a turning point for him into his beliefs more and more which was after his serious illness that he suffered from two years ago and it was from there that it was revealed to him that what put him in that state was HIV and from there he makes us understand that his belief systems enhanced by his status made him come about or rather was the cause of the defining factors in his life which most of them are the elements that consist of his dreams, goals, friends and choice of surrounding where he says "…*it's when after the illness itself, my life actually takes a new turn…*" this new turn he describes and explains further as "…*it's when... it's when... it's after the illness itself that, I become more attached to God, more attached to my dreams, more*

attached to my goal, and then even more attached to my friends; as I said before... before…" this demonstrates to us a link straight to his status that directly influences his choice of friends and surroundings which are some of the pillars according to Erikson which hold the identity of an individual.

5.1.5.3. Behavioral dispositions of others regarding the disease

As per this response, we see here a two way of approaching his response, either that this is not the first time he is answering a question of this nature there by him giving us answers he thinks we want to hear instead of actually responding to the question asked or that he is just unable to mentalize well on the question and better comprehend it. From the nature of his answer, given that he was only asked to describe the nature of the relationship even though it was not that of the parent but we would expect of him here to describe to us aspects of relationships that more practically or better still explain to us how it was and how it is before telling us how for him it has not changed. Here we can actually go for the two hypothesis here and this makes us understand that it is not all aspects of the answers that he wants to share so he sorts of deviates the answer. Regardless of that, we equally learn that he has had a father figure to look up to and it is without doubt that the father figure happens to be a very vital aspect in identity construction for adolescents especially for boys. According to the study carried out by David S. Degarmo (2010) on A Time Varying Evaluation of Identity Theory and Father Involvement for Full Custody, Shared Custody, and No Custody Divorced fathers, This study tested identity theory models of father involvement for 230 divorced fathers of young children aged 4 to 11 followed over 18 months. Research questions were; Do measures of identity salience and centrality of the fathering role predict fathering involvement over time? Does father involvement predict fathering identity over time? and Does father custody moderate these relationships? Involvement was assessed as contact frequency, number of father-child activities, and positive involvement observed during father-child interaction. Comparisons showed that the quantity of involvement differed by custody but there were few differences in the quality of involvement. Fathers did not exhibit significant mean decreases in involvement and custodial groups did not differ in the growth rates for involvement nor identity measures. However, there were significant individual differences in growth rates, meaning there was variance in fathers increasing and decreasing in measures over time. This study came a long way to demonstrate to us the indispensable role of fathers in the identity construction of an individual especially adolescents and this tells us that Pascal probably has a very good father

figure to look up to making it a way for him to move towards that identity construction with much ease than those that don't. well left to see if it is actually the case.

5.1.5.4. Social insertion

From here, we saw the need to clarify the question there by explaining what was needed or rather expected as answer and the actors concerned in the expressions of his answer. From his approach of the answer, we note that he still expands his scope of response to not just his pears but equally to those he considers as members of the same group that he frequents though they happen to be mostly older than him. As per what concerns his peers, he affirms that there has not been any change, at least to my understanding nothing that he will consider as significant. The situations he presents to us here brings another actor in the picture although not earlier known or evoked which is that of the mentor/godfather. He starts by presenting them to us as the first people to know about his status and for him the new situation did not change anything for them. This leads us to believe that it was as a result of a parental concern that might lead them to be protective over the feelings of the young boy. Now this is often a way considered by a lot of parents as a means to spare their children a certain type of pain but at the same time letting them in on their situation often helps them face their situation much better as is the case in treatment through cognitive behavioral therapy. Again, we realize that regardless that, later in his life when he got to know about the situation he felt it much more comfortable and he makes us understand that there are friends with which he shares this situation with by his own will and choice. Here we see a situation that sort of differs from what we earlier on observed above which was that of the parents prohibiting their children from sharing this information considered sensitive and not for the ears of everybody and in this case, so far Pascal has not yet told us if this situation of his has made his parents prohibit him from disclosing the information to others, but at the same time we see him informing us of the liberties that he has in sharing the information when he tells us "…*now, and... now after maybe a few months, so I told my... I told my friends who I'm with. Because we are in a... we are a group actually…*" this actually informs us of the liberties or rather freedom and confidence from his own perspective to actually share such an information which will be considered rather very sensitive. This could be explained as a result of a system of trust that has been built around him. In addition to this, he brings up an aspect that that I find rather peculiar where he says that to some degree it has actually brought them more together and this brings us to the how aspect of this. Now coming to think of it, with such a situation as the discovery of the serology status of an individual

considered a friend might actually as have seen above sort of push the respective people apart rather than bring them together but as seen in this scenario, he makes us understand that it rather brought them together somehow and instead solidified their bond. Yan Lee and P. Lok (2012) makes us understand to this regard that the theoretical perspectives of bonding are delineated, the relationships among bonding to caregivers, friends, romantic partners, as well as teachers, and adolescents' positive developmental outcomes are reviewed to be rather very positive and more so during a period of crisis. Thirdly, with theoretical and empirical support, a discussion on how to promote bonding among adolescents is offered with one of them being a system of trust that is being established between the adolescent in crisis and their caregivers and peers. Finally, a critical review on the cultural issues of bonding is provided and though expressed differently amongst different other cultures there is still a significant role that it plays in its respective ways with the way they are perceived. This might explain the sort of view they have resorted to.

5.1.5.5. Personality building

Beginning on identification, the very first speech he produces informs us on a condition of stutter that he has, thereby making him repeat certain words a number of times. Getting into the very first phase of the questions which was investigating on the nature of his relationship with his peers, he makes us understand that he has some sort of a distorted speech pattern where he basically starts from one idea which does not answer the question asked directly and then moves from there into other aspects which does not really follow the line of idea he started with. For example, when asked the question how he perceived life with his peers, he starts by saying "*…okay, well... my mother has already passed away; she passed away in 2011…"* after giving him a nod as to confirm that I am listening as is done in a clinical interview for him to know he has my attention to facilitate his expressions or rather encourage him to talk more, he moves from there directly and says "*…and..., and it's very likely that it was because of the virus that she died. But we didn't really detect that…"* with another nod here seeing the coherence in his line of expression even though it still has barely anything to do with the original question asked and the intent for that question, there were still some material in this speech which could be used so room was opened for further expressions. At this point, he directly moves into a different new perspective telling us rather about his father and the nature of the relationship with him where he says "*…now I'm living... he's my father; I'm with my father. My dad really, there's no, there's no change. There's no change between me and him.*

Everything is still the same; as it always has been…" the first comment we will like to bring here is that all of the above mentioned which are the stutter and the speech pattern might not be directly related to the condition or HIV status of pascal but at the same time could not be over ruled. Firstly, we noticed this kind of behavior in the other participants where they are being asked a particular question and they start by evading the question by giving an answer that was not directly related to the question there by evading the question being asked and usually as a result of them trying to avoid the memories and emotions tied to that specific question or more like the emotions and memories that are attached to the explaining of the situation surrounding the question asked.

Following up to the second phase of the questioning here, we went into his personal goals and objectives. As earlier explained above the purpose of this question was to find out if their status as HIV positive adolescents impact in any way their goals and objectives. And as earlier noticed, their conception of what they want to be in the near future as goals and objectives always appear to be very vague and nonspecific as earlier discovered in the case of Xavier above where he says he wants to be "a person of tomorrow", here Pascal says "…*well in the short term ... in my head I want to be a young person who has to impact the world. I want to impact the world with my life…"* from the nature of these responses what we see to some extend is the manner in which their objectives or goals transcend what they want to do and is more of what they want to be seen or perceived as. While the other one talks of being a person that can be integrated in the society and accepted by others, here we see another case where he presents his goals as wanting to be someone that will impact his generation and the people around him. This already informs us that in one way or another his condition has had a huge impact on the way he perceives the world around him and the type of impact that he will love to make on it that will somehow be in the form of making the world around him much better and more accommodating with regards to a situation as theirs. It is rather quite remarkable too as to how he has or more like expresses to us his point of view on his experience which appear to be more positively lived if we are looking at it from a humanitarian point of view as compared to others whose expressions of their cases and situations or rather how they live it, they print rather a picture of the hurt that they go through as a result of it.

In another phase of this question, he makes us understand that what he elaborated above was what he considers to be his short term goal, now coming to think of it, it comes in play to greatly support our perception of the nature of his answer which is that he happens to be greatly affected by his status and will just want as soon as possible in the short run to get some sort of

relief from it in his own way which is that of creating an impact on his surrounding, be it physical, social and even what he considers to be "spiritual" which to our understanding will be his fellowship groups and other participants in his religious surroundings. After this, he then brings up to light what he has in mind as his long term goal which is that of wanting to be an electrical engineer. In this light, he brings up an objective here that sounded to us even to this point rather uneasy to grasp which was as per his explanation "…*according to the plan of God that I know, it is... it is to be a prophet... to be a prophet Now I am trying to join that. Joining electronic engineer and prophet. That's the two that are in my head now…"* here he calls it the plan of God and then presents these plans as a merge of being a prophet and being an electrical engineer. To this effect, it makes us to sort of question how he envisages this being done. Probably he has a modus operando in his mind on how to go about it but project planning was not exactly what brought us or what we are investigating on. And talking of what we are investigating on, it was about time we found out how exactly this status of theirs impacts in any way be it good or bad the plans that they have in mind for themselves. As earlier mentioned, this is to find out if and how being a positive carriers of the virus intervene in the establishment or pursuit of these goals. In this particular case, the first thing we notice is that his status actually brings an impact sort of on his status and from all our five participants, this case sort of stands out in the manner in which he sees his status which is in a very positive mindset, one may be even a little tempted to say too positive.

Drawing near to the end of our exchange with Pascal, we saw the need here to inquire about the changes that he makes or rather how he perceives the changes from before he was aware of his status and after he was aware of it and here he fills us in to a great deal of change here as seen by him where he directly hits to the changes of the degree of consciousness with regards to who he is and with regards to his identity and who he believes to be and he lets us in on the fact that this awareness and heightened consciousness was brought about by the disclosure of his status of an HIV positive adolescent. He affirms this by saying "…*before I knew about my status, I really did not know who I was, I thought I knew who I was actually but it turns out I did not know who I was. It was really after discovering my status that I really knew who I was, that is who* Pascal *really is. I became conscious of my potential knowing I am a child who is like this or like that, a child who follows God and lives with HIV, because before I really did not pay much attention to myself or plan my life the way I do right now…"* here we see someone who has become more aware of his surrounding and aims at an impact to it in his own way.

5.2. Analysis

As earlier mentioned, in this segment of this chapter we will be doing a cross references of patterns found in the interpreted data that helps us to better understand the elements picked out in the raw data. From the above data we see that the relationships adolescents have with their peers, family, and members of their social sphere play a vital role in their development. We will proceed in this analysis by taking theme by theme and make cross examinations as to how these various modalities actually more practically contributes or intervenes in the identity construction of these individuals. These themes are chosen by the level of reoccurrence and the number of times they show up in the course of our data collection.

5.2.1. Influence of Personality.

We see here that Identity status is both cause and consequence of personality characteristics. Adolescents who are conformist and obedient and who assume that absolute truth is always attainable tend to be foreclosed, whereas those who are self-indulgent and doubt they will never feel certain about anything are more identity-diffused. This happens to be the case a lot with a good majority of our participants. Young people who are more curious and open-minded and who appreciate that they can use rational criteria to choose among alternatives are more likely to be in a state of moratorium or identity achievement regardless their status as bearers of the HIV AIDS disease, but as for those who are not open minded and are more of yes men most especially for aspects that concern them directly will tend to be more in a situation of identity diffusion. Examples of these situations are the third participant Xavier who when inquired about his future plans he gives answers as vague as "*a person of tomorrow*" and he does not even know or rather cannot explain what he means by a person of tomorrow. Another example is Sophie and john; we clearly see through these cases that the choice that they make based on the personalities are being influenced one way or another by their status as HIV positive individuals. More practically, the conception and conviction of someone like Xavier is proven to be principally governed by what has been given to him by his guardians and parental figures as well as those who live around him. This might be out of some degree of respect that he has for the elder authorities around him but to a greater extend, it actually impacts directly on the way that he decided to interact with other even when there is no direct control of his actions he still has that caution so as not to hurt anyone coupled with the fear of infecting another person. On the other hand, someone like Bertrand has more of an identity moratorium and this is seen through his aptitudes to be able to mentalize on his situation and make the clear cut distinction

between the choices that are proposed to him and the ones that he wants and intentionally go for.

5.2.2 Influence of Family behaviors towards carriers.

One thing that is worth noting here is that each type of family whether biological, extended as in the case of John or even adoptive as in the case of Pascal has their own influence on identity building of adolescents. The interaction that takes place between the family members and with the individual person influences the identity be it in a positive or negative way. Researchers and theorists basically state that an adolescent's identity is influenced by the people around them and the environment in which they live. If a family does not have a proper integration on the subject matter of the situation faced by these carriers of HIV, this will probably create identity diffusion, which means that an individual has not made commitments and does not try to make commitments. This is exactly the case with John who after receiving cold looks of hostility from his family surrounding who also happened to be his extended family such as being refused to share a meal with the rest of his family, prohibited from playing with his other siblings unsupervised, does not have to share house objects with the other siblings and at some points even personal spaces. it pushes him to develop a rather cold shoulder towards them and by extension to the rest of the people that he encounters. Therefore, these concepts provide evidence that a family's attitude (predisposition to a behavior) has influence on an individual no matter if the influence be good or bad. Family also plays a critical role in adolescent identity formation by clarifying their confusion about change and transition and when not well informed on every aspect that the child carrier is going through it ends up rather bad for them. Seeing the case of Xavier, his situation was not revealed to him and as a consequence the manner and circumstances in which he encounters the information had a great deal of impact on the way he started identifying himself and the way consequently the way his peers and surroundings started to relate with him. We see a situation where he is kept in the dark as to his condition by his parents and has to find out but when he relapses and is being carried to the hospitals by the neighbors. This lets the information out and he starts getting but a cold treatment before knowing it was because of HIV where as if he was given the information before hand and properly braced into receiving the information and well prepared from the earlier days on how to live with it the situation would have been much better and consequently the process of identity construction would have been better approached and have a better chance at succeeding.

5.2.3. Influence of Culture

Culture is generally considered as something that is learned and socially shared. Social responsibilities, sexual expression, and most especially belief-system development vary from one culture to another. Culture affects all aspects of an individual's life. Interaction with familial, social and cultural environments helps an adolescent to develop a unique belief system as is the case with Pascal and his strong beliefs in the Christian faith. The type of attitude that a culture holds on a particular topic, can affect the adolescent's identity in both positive and negative ways. In this case is the topic of HIV and the way it is being understood by them in the African culture which is seen more like a taboo or such a great disgrace and from sheer irresponsibility. From the exchange and our choice of participant, all of them were born with the HIV virus which makes it to be not their fault directly that they are carriers of the HIV virus but that notwithstanding it does not change the fact that they are still seen and are treated with the same disgust and negative tag that the rest of the society has for those who contracted the disease from their own carelessness or from an act of an irresponsible sexuality or sexual practice which is usually associated with promiscuity. This perspective or point of view on the disease has a direct impact on the lives of these HIV positive adolescents given they don't even get to have a distinction from the rest and they all get the same reaction from the community around them and it is this shame that is being tagged to it that greatly influences how the relate with any other person and most especially how they relate with themselves and henceforth with the way they build themselves. Another example of such a situation will be that of John and Xavier and with the way they express their frustrations from how they are being perceived and by extension treated by the surrounding around them that are aware of their status. On another note that appears to be positive is that of Pascal who has a rather more encouraging environment and a more adapted cultural insertion with his surroundings with those at his Christian groups and church members who from his own experience have a better understanding of his situation and with their circle have a much more adapted way of interacting with those that are around them given they are in a church and the values that they live by or rather are supposed to live by is what makes the primary environment of Pascal much more suitable and gears him into a state of identity moratorium. He expresses this as "…*as a majority of the group of people I interact with are Christians and they fear God, I believe I can get to be open with them although I know it will not always be everybody that is that way but I try as much as possible to be as open with them as I can. And as I have God and one of my objectives is to be a prophet, there are things that God tell me to tell my brethren and which I cannot ignore so I have to definitely*

go towards them and talk to them. Imagine if God tells me something like that and I don't tell them and something happens to them then imagine what that will look like. And more to that they are mostly my elders so it goes as smooth as it can…" this alone expresses a great deal on how this condition of his HIV positive status and the cultural insertion around him fixes him to a state of identity achievement and moratorium.

5.2.4. Influence of Peers by parental instructions.

Interaction with diverse peers through school and community activities encourages adolescents to explore values and role possibilities. Peer groups can have positive influences on an individual, such as academic motivation and performance; however, they can also have negative influences, such as peer pressure to engage in risky behavior that might not benefit them or even those around them. As we see in the case of Xavier, his peers that are supposed to be around him as a guide to either make him push forward or engage risky are not even there as they are asked by their parents to limit interactions and even those at school that are not aware of the situation get to see just his skin condition which is an extension of his HIV disease and stay away from him. from this angle, Xavier does not even get to the opportunity to properly interact with his peers that so he misses out on what most of these Peer groups also provide such as opportunity to develop social skills such as empathy, leadership and sharing. Susceptibility to peer pressure is known to increase during early adolescence, and while peers may facilitate positive social development for one another, they may also hinder it. In support of this finding, by reviewing literature, it was concluded that achieved identity is related to better relationships with peers. Being a part of a peer group, good, positive communication with peers may provide appropriate social context for adolescent's personal identity development. Adolescents' identity development is positively related with their relationships with peers. Belonging to a peer group and good relationships with peers based on mutual respect and acceptance are positively related with adolescent identity development but when the relationship is not there or limited by third parties (parents and legal guardians) it becomes almost impossible to have a fluid identity built and an achievement of identity moratorium.

To another extend, some of these participants still get to make friends with peers as a result of the various social environments where they are not supervised by these parents such as school and in some of these gatherings, most of the peers are not aware of their status as HIV patients and here to some degree they get to work with and interact with these peers, but regardless, the

rules already inculcated in them at home makes them either to get into it with restraints or become rather rebellious and go all out in their quest for these experiences.

5.3 DISCUSSION

5.3.1 Repercussions of HIV on adolescents.

Many people, particularly as they age, can develop health conditions that are persistent, long-term and can impact their quality of life. These conditions, often called chronic conditions, may not be life-threatening but may shorten a person's life span or reduce their quality of life. Since AIDS was first tested in 1981, it has become a priority public health issue/problem and has been recognized as a psychological emergency. There are many adverse mental health side effects that are associated with HIV infection, including psychological problems, psychiatric and neuropsychological disorders, and social, domestic and occupational disruption. HIV infection is generally considered to have more and worse effects on mental health than other diseases. This is explained by the fact that HIV infection is associated with a unique set of psychosocial stressors, which are both multiple and powerful, coming from three sources: the stresses associated with chronic and life-threatening illnesses in general, and the stresses associated with AIDS illness in particular. We can then have from here only a glimpse of what this evaluation can be like for adolescents still finding their paths.

5.3.1.1 The disease on a psychological plan

People with HIV must cope with the multiple psychological stresses associated with disability and/or chronic illness These include depression, the anxieties of eminent threat to physical integrity and well-being; to self-esteem and future plans; emotional balance; performance of usual social roles and activities; and the stress of having to adjust to a new physical and social environment. In addition, HIV patients experience the psychosocial stresses associated with a life-threatening illness, as well as the idea and reality of death itself and the fact that it actually could be quicker than what will be considered normal for the others who are healthy. These tensions include threats to life and fears of dying; an increased sense of personal vulnerability. anticipatory grief reactions; and great emotional distress. The stresses experienced by HIV patients are said to be similar to those experienced by people with cancer. The primary source

of stress for AIDS patients is existential questions about the future, longevity and quality of life.

On another level, one of the greatest psychological effect that this disease has is that of suicidal thoughts and to some degree even an attempt. Coming to look at the origin of these, when on an emotional level the patients are not balanced which in some cases also extends from the fact that other spheres in life is not adding up for them and there is no way out on the quality of life, these patients actually start considering the option of ending life on their own and at this point the speech patterns start changing and there is a care free attitude with examples like; they stop taking their drugs regularly and on time; limit interactions even with those who chose to stay close to them as a form of emotional support systems there by severing attachments with their surrounding and finally in the worst case scenario actually pass to the act itself anyway they can.

5.3.1.2 The disease on a cultural plan

Coming to think of the HIV disease from its origin and the people amongst which they were found, it made a very huge impact on the nature of which people perceived it. In its first appearance and when it started getting rampant in the late 80's and started drawing attention, the most group of people that this disease was found in or who tested the most positive were mostly homosexual men and drug addicts which in many cultures especially in African countries today are still considered culturally not fitting, unadapt and even to some extend a taboo. Knowing anyone who was and even to some extent in this modern day who is a carrier of this disease called HIV is still seen as a rather questionable person and hardly ever taken serious. This reinforces the stigma that is laid on the disease as they are being considered as people who were wayward with their lives and have been sexually irresponsible.

To some other extent, it is see as some curse from an ancestral divinity that the transgressor is being inflicted with and has to suffer repercussions for a transgression or cultural line that has been crossed. This is the kind of line of belief that is help by someone like john and Bertrand on the aspect of the cultural significance that they hold with regards their HIV situation. This has had a great turn of impact on the way they believe in the things that happen around them, john for example after being pushed around by his cousins and other brothers in the house, the first thing he tell himself is that it is some sort of ill luck that is causing such situations around him. This sort of mentality is what where what happens around them is left to be interpreted in the hands of "luck" greatly shapes who he is as a person.

5.3.1.3 The disease on a social plan

In second place, are work and financial concerns, followed by self-esteem, friendships, social life and health issues. Their current concerns are in the same order as those of cancer patients, although cancer patients are more concerned about their health and their health and family. However, other tensions specific to HIV and AIDS patients are added to this stress These tensions can be explained by two general characteristics of AIDS that distinguish it from other chronic or fatal diseases. One specific set of stressors relates to the uncertainty created by the particular nature and prognosis of HIV infection. The factors that contribute to this uncertainty are: the high mortality rate; the young age of those affected; the contagious nature of the disease; transmission of the virus through sexual contact; and the concern of a long incubation period and the lack of a cure for the disease. Another distinct set of stressors comes from the fact that HIV infection leads to social stigmatization and thus to a greater sense of social isolation than other chronic or life-threatening illnesses. For someone like Xavier, he faces a hard time extending a hand of friendship to another person as a result of the way the disease presents itself on him and the secondary effects on his skin condition and this pushes Xavier to isolate himself in order to avoid situations where he will have to explain the kind of situation he is experiencing to others as a result of what he has earlier experienced from those he has had to reveal his experiences to. HIV infection equally leads to a double stigma: first, it is a serious, fatal disease, which is deadly and, moreover, contagious; secondly, it is associated with stigmatized groups, in particular gay men and people who inject drugs. This suggests that although the resulting discrimination is not as severe as in the other places, stigma clearly exists in Cameroon seeing the situation is such that the knowledge on the subject matter that they have is just negative and one that fuels the negative aspect of that stigma more and more.

5.3.1.4 The disease on an economic plan

HIV AIDS affects economic growth by reducing the availability of human capital and the available labor force Without proper prevention, health care and medicine that is available in developing countries, large numbers of people are developing AIDS. People living with HIV/AIDS will not only be unable to work, but will also require significant medical care. The forecast is that this will probably cause a collapse of babies and societies in countries with a significant AIDS population. In some heavily infected areas, the epidemic has left behind many orphans, who are cared for by elderly grandparents.

The increased mortality in this region will result in a smaller skilled population and labor force. This smaller labor force will be predominantly young people, with reduced knowledge and work experience leading to reduced productivity. An increase in workers' time off to look after sick family members or for sick leave will also lower productivity. Increased mortality will also weaken the mechanisms that generate human capital and investment in people, through loss of income and the death of parents. As the epidemic progresses, the age profile of those infected will increase, though the peak is expected to stay within the working age population. HIV disproportionately infects and impacts on women, so those sectors employing large numbers of women e.g. education, may be disproportionately economically impacted by HIV.

By killing off mainly young adults, AIDS seriously weakens the taxable population, reducing the resources available for public expenditures such as education and health services not related to AIDS resulting in increasing pressure for the state's finances and slower growth of the economy. This results in a slower growth of the tax base, an effect that will be reinforced if there are growing expenditures on treating the sick, training (to replace sick workers), sick pay and caring for AIDS orphans. This is especially true if the sharp increase in adult mortality shifts the responsibility and blame from the family to the government in caring for these orphans.

On the level of the household, AIDS results in both the loss of income and increased spending on healthcare by the household. The income effects of this led to spending reduction as well as a substitution effect away from education and towards healthcare and funeral spending. Having a closer look, one will realize that households with an HIV/AIDS patient spent twice as much on medical expenses as other households. With economic stimulus from the government, however, HIV/AIDS can be fought through the economy. With some money, HIV/AIDS patients will have to worry less about getting enough food and shelter and more about fighting their disease. However, if economic conditions aren't good, a person with HIV/AIDS may decide to become a sex trade worker to earn more money. As a result, more people become infected with HIV/AIDS.

5.4 The interpretation of AIDS on the plan of stigmatization, prejudice, segregation, insults, shame and guilt.

Discrimination against people on the basis of physical or mental infirmity is common and creates a considerable burden for sufferers. There has been considerable debate about the prejudice against people with disease resulting from human immunodeficiency virus (HIV) infection. Despite reticence about discussing their infection, a good number of patients still received negative reactions from confidants. The implications of this results from the full disclosure of the information to people thought at the moment to be confidantes. From all of the participants that we have in this study, all but one affirms to have had an encounter or experienced a situation of stigmatization and some like john even mention it before it is brought up. As for the participant Sophie who is affirming to not have experienced this kind of situations explains it as resulting from the fact that she has had a formal embargo from her parents from telling anyone and as a result, with no one knowing it limits the possibility of this becoming an escalated situation. Living with such a situation, there are two types of carriers. There are the healthy carriers, they have the virus but the external damage it causes to the skin and the physical appearance is not there and then on the other hand there are the non-healthy carriers who suffer the secondary effects of the disease even more with external symptoms on the outer look. Amongst our participants, we have a healthy carrier such as Bertrand and non-healthy carriers like Pascal and Xavier. From just these two aspects, life for the two sets of participants are definitely not the same given that for the non-healthy carriers, when they show up in public, the first thing that is noticed is their skin condition and the effects of the virus on their physical body like skin disease and a very pale body and look. This makes the presentation of life for them much more complicated as they have to always give an explanation to what they are facing in order to not get judged whereas at the same time they still have to avoid talking about what exactly it is still for the same reason of avoiding to get judged and in this case prejudice is usually almost impossible to avoid.

On a plan of segregation, most often they are put apart or separated from the others who are healthy in order to reduce the risk of the virus spreading be it in a family, school or other social setting where their status is known. it is usually sometimes explained to them that it is for the good of everybody and to some degree it is, given it is seen as a way to limit the spread but at the same time does not really take into consideration the emotional aspect or reality lived by the other person that is being segregated from the rest. A typical example from our study is

John who is living with the extended family and as a means to keep them healthy he is being separated from the others by his parents that he is living with and from his point of view he tells us that he understands why they had to separate him from the others in almost every aspect but at the same time it does not change the way he is being looked upon or the way he feels as a result of not being able to feel free around siblings and peers.

As serious as the situation appears to be, there are still other questions that when not addressed they can cause a lot of emotional damage to HIV carriers and that is the insults that some of them get to endure as a result of this situation that they live in. most often it does not even have to be outright insults but just slangs and comments that make them feel less a person or that will have to remind they every time of their situation and how bad it is. This brings them in a situation that they have to live in their communities with their heads low to the ground out of shame and worry of what who is going to say next.

The question of guilt related to HIV is usually seen from the view point of the carriers themselves who contacted the virus in a later point in their life. In this case of ours, most of these children are born with theirs and they only get to find out later that they did not come out healthy. In this case, a greater part of that guilt will rather reside in the parents who probably out of lack of proper medication or health care and in some cases just even pure negligence make them have children and the come out to be HIV carriers as well. The situation here will be that of intense guilt knowing they could have done something to change the situation but nothing was done. Some of these kids grow up to hate their parents and these feelings of hate directed towards them further intensifies the guilt that is being suffered by their parents. That not-withstanding, there are equally some of these kids that caught the HIV disease in the course of their lives and were unable to avoid being infected and in this particular case there is always that back regret situation of “had I known”.

5.5Suggestions.

Coming to look at the above analysis, some of the suggestions that can be made to these young adolescents in order to improve their well-being come up to be indispensable. They need to be engaged in certain tasks and Some of them are as follows:

- Engage them in warm and open communication, thereby making a free and trusted space for them to be able to communicate especially at home so this way their worries and thoughts can be better expressed and understood.

- Initiate discussions that promote high-level thinking at home and at school and every other environment where they frequently find themselves.
- Provide them opportunities to participate in extracurricular activities and vocational training programs.
- Provide them opportunities to talk with adults and peers who have worked through identity questions and HIV situations and why not even both. That way they can know they are not alone and can have some sort of ideal to look up to.
- Negotiate with adolescents, especially when establishing limits, and explain your reasoning. By making sure they get your point of view on the decisions you
- Take the adolescent's point of view into account when reasoning with him or her, no one understands the situation they are going through better than them.

GENERAL CONCLUSION

Our work titled “HIV AIDS experience and identity construction in HIV positive adolescents” has been brought to you from the view point of psychopathology and clinical psychology. The purpose and orientation of this study was to investigate the contributions of the experience of HIV AIDS to the process of identity construction in adolescents that are living with HIV AIDS following up treatment and placed on anti-retroviral drugs. This is what explains why the problem of this study is to find out how being an HIV positive adolescent contribute to the already chaotic period of adolescence in what concerns the molding and formation of identity. That is how we got to the question of *“how does being HIV positive contribute to the identity construction of an HIV positive adolescent?”* using the theoretical approach of Erik Erikson on the processes of identity formation in order to get to the objective of our study which is to apprehend the aspects and particularity of HIV in adolescents and how their identity is being built in these new circumstances different from that of a child considered healthy. To do this, we had to make use of the exploration of antecedent scientific works relating to the subject matter in order to make a run down of what has already been done so far.

We then got into a literature review on HIV, understanding a sick child, psychology and HIV, ties and attachment amongst others. We reviewed the literature on HIV, life experience, early maladaptive patterns and other key concepts in our topic. Regarding the state of affairs on HIV, we worked on the generalities, namely: its history, its specificities, its modes of transmission, the techniques of its diagnosis and the different issues of the treatment with antiretroviral drugs. In addition, we spoke of disease as an alteration of health as a result of the body's inability to use its organic defenses against toxic-infection or to resolve its psychological conflicts (Sillamy, 1967); thus emphasizing the anthropological conception of disease in traditional black Africa in general and in particular the conception of HIV. We have thus linked HIV to trauma. As for the notion of lived experience, we have elaborated it according to the phenomenological conception and the meaning that it refers to in psychology. As for what concerns identity construction, we see their susceptibility in experiencing emotional instability and imbalance coupled with other exterior pressure from the outward surrounding so we went towards theories that will better orientate our study.

In the next phase concerning the operational framework and methodology, we elaborated our hypothesis that come up from the evaluation of our explanative theories which are that of Erikson and the psychoanalytic approach, coupled with the theoretical framework of other works, we have used this theoretical approach to interpret the results of the analysis. However, we have used a specific methodological approach. However, we opted for the qualitative method, based mainly on the case study. This method was chosen because of its ability to provide an in-depth analysis of the phenomena in their context of emergence. According to our inclusion and exclusion criteria, we retained five (5) participants for the study. These participants were young adolescents, a girl 18 years of age and four boys aged 16,17,19 and 20 years old. Following up treatment at the CHU hospital Yaoundé and all part of a peer support focus group.

After the development of the interview guide, the data was collected through semi-structured interviews. With each participant, we had two interview sessions. After transcribing these interviews, the technique of thematic content analysis of the interviews, which focuses on the identification of significant themes, was used to analyze the results. From the interpretation and analysis, we can pick out that the experience of HIV AIDS have a clear impact on the identity construction process of young adolescents right from the emotional, to the cognitive, psychosomatic and behavioral level and all this starts even before the the children are being made te revelation of what they are actually going through and although the information might bring some closure, but it still is a hard pill for hem especially after understanding what it actually stands for. As soon as the disease is announced, several early patterns such as the punitive, shame/imperfection, abandonment, emotional over-control, mistrust and fear are put in place and influence the processing of information by these youngsters. It is therefore from these patterns that they adopt coping strategies centered on emotions such as avoidance, denial, guilt and shame. Regardless this, there are still others who are able to better process it with the help of those around them and they come up to have a better view of life regardless severity of the condition.

In summary, the results obtained give a psychopathological and clinical relevance to our study. As a perspective, we plan to continue to question, through an in-depth clinical study, the contribution of schemas in the emotional, behavioral or relational experience of people living with a chronic illness. With regard to the implications of this study, the management of HIV/AIDS has become a global public health concern, and today we talk about the global

management of this pandemic. This study has shown the need for psychological support for people living with HIV/AIDS as soon as they are diagnosed. It also showed the importance of taking into account the events that marked their childhood and adolescence. This should be done by stepping up the recruitment of clinical psychologists in the HIV/AIDS care sectors.

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ANNEXES

Annex 1 : Attestation of research CHU

REPUBLIQUE DUCAMEROUN
Paix – Travail – Patrie

MINISTERE DE LA SANTE PUBLIQUE

REPUBLIC OF CAMEROON
Peace – Work – Fatherland

MINISTRY OF PUBLIC HEALTH

C U H C U
YAOUNDE

CENTRE HOSPITALIER ET UNIVERSITAIRE DE YAOUNDE
YAOUNDE UNIVERSITY TEACHING HOSPITAL
Tél. : 22 31 25 66 Fax 22 31 25 67
Site web : www.chu-yaounde.org
DIRECTION GENERALE
CELLULE D'APPUI PEDAGOGIQUE, DE LA RECHERCHE ET DE LA COOPERATION
BUREAU DE LA CAPRC

N° 196/AR/CHUY/DG/DGA/CAPRC

AUTORISATION DE RECHERCHE

Dans le cadre de la rédaction d'une thèse de fin d'études, en vue de l'obtention de son Master en Psychologie, Monsieur NGEH David NKARNYU est autorisé à mener une recherche au CHUY sur le thème : « HIV aids experience and identity construction in an HIV positive adolescent ».

Ces travaux se dérouleront dans le service du CTA sous la supervision du chef de service.

Toutefois, il devra obligatoirement déposer un exemplaire de sa thèse au CHUY (bureau de la CAPRC)

En foi de quoi la présente autorisation lui est délivrée pour servir et valoir ce que de droit./-

Yaoundé, le 30 MARS 2022
LE DIRECTEUR GENERAL

Centre Hospitalier et Universitaire Yaoundé — Le Directeur Général

Pr. Arthur Essomba

COPIE :

- CAPRC
- BSF
- SUPERVISEUR
- CHRONO

Annex 2: Bachelor's degree success testimonial

REPUBLIQUE DU CAMEROUN
Paix-Travail-Patrie

UNIVERSITE DE YAOUNDE I

REPUBLIC OF CAMEROON
Peace-Work-Fatherland

THE UNIVERSITY OF YAOUNDE I

ATTESTATION DE REUSSITE
AU DIPLÔME DE LICENCE
BACHELOR'S DEGREE SUCCESS TESTIMONIAL
N° 5783 /2019/UY/FALSH/VD/PAC/CSDPR

Le Doyen de la Faculté des Arts, lettre et Sciences Humaines de l'Université de Yaoundé I atteste que :
The Dean of The Faculty of Arts, Letters and Social sciences of the University of Yaounde I certifies that

M./Mlle : NGEH DAVID NKARNYU — **Matricule :** 15F443
Mr./Miss — *Registration number*

Né(e) le : 06/07/1997 **A :** NKAMBE
Born on At

A subi avec succès les épreuves sanctionnant l'examen de fin de troisième année et a capitalisé un total
Has successfully fulfilled the requirements for the award of the Bachelor's Degree having earned a total
De 180 crédits pour le cycle de LICENCE
Of 180 credits

Filière : PSYCHOLOGIE — **Session de :** Rattrapage 2019 — **Cote :** C
In — *Session* — *Grade*

Spécialité : PSYCHOPATHOLOGIE ET CLINIQUE — **Moyenne Générale Pondérée (MGP) :** 2,169 /4
Specialisation — *General Point Average*

En foi de quoi la présente attestation lui est établie et délivrée pour servir et valoir ce que de droit
In witness whereof the present testimonial is given with the privileges thereto pertaining

Système de notation/Grading		
MGP/4	Cote	Mention/Grade
[2-2.3[	C	Passable/Pass
[2.3-2.7[	C+	Assez-Bien/Fair
[2.7-3[	B-	Assez-Bien/Fair
[3-3.3[	B	Bien/Good
[3.3-3.7[	B+	Bien/Good
[3.7-4[	A-	Très-Bien/Very Good
4	A	Excellent

Yaoundé, le
Yaounde, the
23 SEPT 2019

Le Doyen
The Dean
Christiane Félicité Ewané Essoh
Professeur

N.B. Il n'est délivré qu'une seule attestation de réussite; le titulaire pourra en faire établir autant de copies certifiées conformes qu'il voudra. Le diplôme lui sera délivré ultérieurement.
Only one success testimonial is issued ; it is in the interest of the owner to make as many certified true copies as he/she may desire.The certificate will be issued later

Annex 3: Request to carry out data collection

Ngeh David Nkarnyu

davidnkarnyu@gmail.com

677247212/695889936

The director of the University hospital

Yaoundé I (CHU)

Sir

A Request to Carry Out Data Collection in Your Institution for A Masters Research Thesis

It is with great honor that I come to you soliciting for permission to carry out the data collection for my research master's thesis in your institution.

I am a masters student at the university of Yaoundé I Ngoa-ekele, department of psychology specialized in clinical and psychopathology matriculation number **15f443** working on the **topic HIV AIDS EXPERIENCE AND IDENTITY CONSTRUCTION IN AN HIV POSITIVE ADOLESCENT**, and I believe your institution will be able to help me gather the information that I need for the advancement of this work

While waiting for a favorable response, receive the expressions of my heartfelt gratitude.

Researcher

The director

Attachment

- Photocopy of national ID card
- Attestation of research
- Research protocol

Annex 4: attestation of research

REPUBLIQUE DU CAMEROUN
Paix-Travail-Patrie
****
UNIVERSITE DE YAOUNDE I
****
FACULTE DES ARTS, LETTRES, ET SCIENCES HUMAINES
****
DEPARTEMENT PSYCHOLOGIE
****
BP 7011 Yaoundé

REPUBLIC OF CAMEROON
Peace-Work-Fatherland
****
UNIVERSITY OF YAOUNDE I
****
FACULTY OF ARTS, LETTERS AND SOCIAL SCIENCES
****
DEPARTEMENT OF PSYCHOLOGY
****
PO box 7011 Yaoundé

Yaounde, the..... 11 JAN 2021

ATTESTATION OF RESEARCH

I, the undersigned **JACQUES-PHILIPPE TSALA TSALA** Professor of Universities, Head of Department of Psychology at the University of Yaoundé I, certify that Mr. **NGEH DAVID NKARNYU** Matricul **15f443** is in a Master II research cycle in Psychopathology and clinic.

His research is under the supervision of Pr. **Ketcha Wanda Germain Magloire** titled **« HIV AIDS Experience and family reconstruction with an HIV positive Adolescent »**. Data collection will be done in the city of Yaoundé. Please do kindly provide him with any non-confidential information that may allow him to meet his academic goals.

In witness whereof, this certificate is issued to him to serve and assert that of right.

The Head of Department

Jacques-Philippe TSALA TSALA
Professeur des Universités

UNIVERSITE DE YAOUNDE I * DEPARTEMENT DE PSYCHOLOGIE * THE UNIVERSITY OF YAOUNDE I * DEPARTMENT OF PSYCHOLOGY * Le Chef de Département / The Head of Department

Annex 5: transcribed interview

Participant number 1.

Name: JOHN

Age: 19years

Ethnicity: Beti

TOA: 7years

Investigator: the first question is at what moment were you made aware of your status?

Participant 1: *it's been practically 7 years today that I was told of my status although before then I was already on medication and just did not know why.*

Investigator: so do you go to school?

Participant 1: *yes, I do*

Investigator: so how is life with your peers?

Participant 1: *the first thing I will say is that the relationship with my classmates and friends are stable, at least for those who do not know because I chose not to tell them. Actually I don't find any difference between me and them given they don't know if I am suffering or not so it does not really affect my school milieu*

Investigator: so do you have peers that are aware of your status?

Participant 1: *yes, I do they are mostly my family members.*

Investigator: and how is life like with them?

Participant 1: (brief hesitation*) well it's true that on my mother's side there is my aunt that I was first of all living with and honestly with her children it was not going well given that I was always having a feeling of rejection from them but right now I think it's getting better.*

Investigator: and how did you get to handle that situation?

Participant 1: *usually before I used to go and report to my father that I was stigmatized by my cousins and most often there was a lot of discrimination amongst us and I felt really bad about it so my father tried to arrange the problem with my aunt.*

Investigator: how does your status contribute or intervene in your personal goals and objectives?

Participant 1: *actually my status is a bother to me because of my consciousness of it but I don't think it is an obstacle for me to do whatsoever because if I want to carry out an objective I will do it and it does not hinder me in any way, though sometimes I think to myself that in the near future it might become a hindrance to some certain things but so far it's not really a bother.*

Investigator: what are some of your objectives that you are looking forward to?

Participant 1*: actually I am a student in the class of "premiere D" and I will have my BACC if God permits by next year. After that, I will tell papa (his father) that I want to integrate the medicine school. So it is after my BACC that I want to get into that field of medicine so I can help children also because I know it is not easy.*

Investigator: earlier on you talked of stigma, can you please explain to me your understanding of that word?

Participant 1: *actually, when I was stigmatized I always wanted to leave the house because they made me feel like they did not want me amongst them and they did not want me to live with them (family members) and I don't even have the right to sit with them where ever they are. It was only after when I came here to the CHU that I met Dr. Kamdem and she was the one I spoke to about the situation and she called papa and that is how papa went to see my aunt with whom I lived and spoke with her.*

Investigator: how did this affect you at an emotional level?

Participant 1: *at an emotional level, it really hurt. It really hurt me to think that I didn't have a place amongst my brothers. It got so bad that even in the quarter where I stayed, the neighbors started looking at me a type. It's true they never told them that I was suffering but they said things about me that even my friends in the quarter refused to be around or with me. This hurt me so much that I did not even want to play with them again until I came back and saw Dr. Kamdem.*

Investigator: can we continue?

Participant 1: (with a sad face) *yes*

Investigator: what significance do you give to your status? As in what meaning do you give to it?

Participant 1: *as a significance that I can give to my status, actually I just tell myself that these are things that happen in life and now I just have to live with it because the way I look at it, anyone going through such a situation does not have to give up.*

Investigator: as for the people who surround you like family, friends and even just neighbors who are aware of your status, before they knew and even before you knew and then the situation of after you knew, can you make the difference in their situation towards you?

Participant 1: *yes of course, I think before, the difference between my brothers and me was there because before they knew, we were always together, we shared everything and told each*

other everything. But immediately they knew that I was seropositive their behavior just changed and even their manner of living with me just took a turn that even I did not understand.

Investigator: on the other hand, now how did you or do you interact with your peers?

Participant 1: *well personally I take a lot of precautions just so that I don't hear one day in the house that there is a newly infected person there or anywhere around me because even if it is not my fault, my conscience will tell me that I have something to do with it that is why firstly all my materials are personal and I don't accept anyone touching my things anyhow. So for that one its ok.*

Investigator: and now at your end will you consider yourself outgoing as in someone who is willing or open to go make new friends with others?

Participant 1: *NO*

Investigator: can you tell me more?

Participant 1: *well concerning friendships with other people, actually I don't know how to run after people anymore but when I realize that you are interested or motivated in what I am doing, then at that moment I can consider you as a friend.*

Investigator: What about a girlfriend, do you have one?

Participant 1: *yes*

Investigator: is she aware of your status?

Participant 1: *For the moment she is not aware of it. Concerning sexual relations, there is none, we haven't had any intercourse I am still preserving myself, actually we are both preserving ourselves. Presently we are two years together and this is the second year given we started two years ago.*

Investigator: what is the nature of your relationship with her like, how would you describe it.

Participant 1: *actually it is very good, we do everything together, its true one time she asked me some questions about my drugs because I took them two times successively in front of her which gave birth to a lot of questions that she was asking me. But still I did not tell her the truth so right now I think it is ok.*

Investigator: and now for one final question, does this situation change in anyway who you are?

Participant 1: *no. I dint think so given that I dint think of myself as different from any other person again because I know that if anybody could have realized their dreams then I can too so there is no difference amongst us.*

Investigator: and would you say there is a difference between the you of now and you before?

Participant 1: *yes, there is a great difference because before when I just started treatment and I was taking my drugs, there were days that I did not take them and I will say "I won't take them today, I will take them tomorrow" and I asked myself why am I even taking them and*

when I was given the information, from that day till today I have never skipped one day without taking them and I know it's now a part of me so I just have to deal with it.

Participant number 2.

Name: SOPHIE

Age: 18years

Class: 3eme Espagnol

Ethnicity: Banjoun

Religion: Christian (catholic)

Quarters of residence: Carriere

TOA: 2012

Investigator: do you go to school?

Participant 2: *yes*

Investigator: what class are you in?

Participant 2: *3eme espagnol*

Investigator: the first question is when did you learn about your status?

Participant 2*: in 2012*

Investigator: how would you describe life in general, be it in school or at home or anywhere else, how will you describe it?

Participant 2: *well its going on fine*

Investigator: ok, how exactly will you describe "fine"?

Participant 2: *well i go to school and my mother gives me everything that i want or that i ask for, as for my friends I don't have any problems with them, everything is just fine.*

Investigator: do you have any of your peers who are aware of your status? And if yes how does it go with them?

Participant 2: *yes, i have friends who know that I have HIV so as they already know, (pause) how will I even say this? Well they take care of me actually. They protect me all the time even though sometimes I feel it's too much but I think it's just their way of showing me they care.*

Investigator: ok, next question, do you have personal objectives in life? Be it short long term?

Participant 2: *yes, I do*

Investigator: ok, tell me about them.

Participant 2: *i am into ready-made, things like stylist and modeling and I want to deal in it.*

Investigator: does your status have an impact on your objectives? if so how?

Participant 2*: me I even just consider that I don't even have anything, i just like to do my things as if there is nothing even because there isn't.*

Investigator: are you familiar with the word stigma?

Participant 2: *no, I don't know what that is*

Investigator: (after explaining what stigma is) so have you ever experienced such a situation?

Participant 2: *no, I don't think I have ever experienced something like that given that the majority of people who know me are not aware of my status so it does not bother me much.*

Investigator: next question here is what significance do you give to your situation or your status.

Participant 2: *you say significance? Hmm I don't know me oh.*

Investigator: how can you describe your relationship with your family, be it the close or the extended one like say cousins and nephews and all the rest, how would you describe your relationship with them?

Participant 2: *they treat me very well, from both ends of the family I think everything is ok, that they bring me to the hospital is already enough, I think they are doing enough and one day one day it will finish.*

Investigator: now can you tell me how you interact with your peers? The first question was to know how they interacted with you, now it is to know how you interact with them.

Participant 2: *"anh", me I disturb a lot of.*

Investigator: and what exactly do you mean by disturb?

Participant 2: *sometimes, even most times I don't like taking my drugs because it is just too much and they scold me a lot, any little thing I want to do on my own they don't accept like even to go out they refuse and always want me to stay in the house*

Investigator: how is the "they" you are referring to?

Participant: *my father.*

Investigator: and what about your peers?

Participant 2: *(Exclaims) NOOOOO my classmates don't know, they are not aware and my parents told me to keep it that way.*

Investigator: ok, last question for you. Does your situation change in any way who you are? If yes, then how?

Participant 2: *no, I don't think so. The same me of before is still the same me of right now though I will really like for things to change faster.*

Participant number 3.

Name: Xavier

Age: 16years

Ethnicity: Eton

Religion: Christian (catholic)

Class: 4eme

Quarters of residence: Commissariat Etoudi

TOA: 2019

Investigator: the first question is when did you know or was made aware of your status?

Participant 3: *it's my parents that informed me about it. I always knew I was sick of something but I never knew what exactly it was before my parents told me that it was HIV*

Investigator: ok, and when exactly was this?

Participant 3: *it was about 2016 like that.*

Investigator: are there any of your classmates or your peers in the quarter where you live who are aware of your status?

Participant 3: *no, it's only my family members who are aware. Just my family and some of my neighbors.*

Investigator: how would you describe life with your peers? Be it those who are aware of your status or not.

Participant 3: *what i can say is that things have changed a lot especially with the people who are aware because at first i was afraid of the way they will start treating me and behaving around me when they found out. And I was right*

Investigator: ok, so how would you describe life with your neighbors like?

Participant 3: *well with the neighbors it was not so bad, at least with the older ones because even before i knew they were already aware of the fact that i had that disease so they were like afraid that I will also contaminate them so they started staying away from me and they told their children to stay away from me too, at least that is what I think because nobody wanted to come beside me again and I don't get to even play or talk with them. It's like they were scared of me or something.*

Investigator: do you have some goals or personal objectives that you will like to achieve in life? If so, please share them with me.

Participant 3: *yes, I do, I will like to be a person of tomorrow.*

Investigator: ok, and what exactly do you mean by a person of tomorrow?

Participant 3: *by working, i want to have a good job like every normal person and be a big businessman. At least that is what my father wants me to do.*

Investigator: and what about you? what will you like to be?

Participant 3: *i will like to be an engineer.*

Investigator: ok, that's nice. So tell me, does your status in any way affect your plans? And if they do tell me how.

Participant 3: *well I don't think so much even though I ask myself sometimes if people will want to work in the same place as me if they knew I have this disease because even just the people in my quarter already behave somehow. Well I cannot know but I think maybe that is why my father wants me to do but business that way I will have but something of my own and not answer to other people.*

Investigator: ok, are you familiar with the word stigma?

Participant 3: *NO*

Investigator: (after explaining what stigma is) now with your status, have you ever had a situation with stigma?

Participant 3: *yes, I think I have experienced something like that before.*

Investigator: can you tell me about it?

Participant 3: *well it is usually when I am taking my drugs. Some of my friends in school will be looking at me a type and even though they don't know that this is what I am suffering from, they just look at my skin and be saying I must have a very bad condition and sometimes they are even afraid to come near me.*

Investigator: ok. So what significance do you give to your status, what does it mean to you?

Participant 3: *it signifies a good thing for me because I am already used to it and very soon they will find a vaccine for it that will conquer the illness.*

Investigator: for those who are aware of your status, how do they behave towards you?

Participant 3: *honestly like I told you before its only my neighbors who are aware, the others are not aware of it. My parents asked me not to tell anyone.*

Investigator: of course, I am talking of those who are aware.

Participant 3: *one day I think it was in 2009, I fell very sick and my parents were not around and it was my neighbors that were there and they took me to the hospital and that was where they discovered that I have a very serious illness what the doctors told them that I have that disease. That is when the neighbor that lives beside us calls my father that I am seriously ill. That is when the doctor prescribed me drugs that I have to take every day. My mother was sick*

also but after sometime my mother was healed so they said I have that illness and my mother was surprised but they gave me drugs that I should be taking.

Investigator: so tell me, how do you interact with your peers?

Participant 3*: I am waiting for the right time to tell them, right now I don't think I can tell them because I don't know how they are going to take it if I tell them now that I have that illness. Only the fact that I am taking my drugs every day and they are seeing it and they are already asking a lot of questions, I don't know exactly how they would react if I tell them now that I have that illness.*

Investigator: right now I will like to know if your status changes who you are? If yes, how?

Participant 3: *right now with my friends they don't know anything yet and every day they try to question me that what am I taking the drugs for, and they are suspecting that I have that illness but I don't want to admit it and I keep telling them that it is nothing. Some of my friends that used to even come to the house and we play video games together some of them no longer come again and maybe they think I will infect them or something but I don't know.*

Participant number 4.

Name: BERTRAND

Age: 20years

Ethnicity: Bamileke (bacham)

Religion: Christian (catholic)

Class: premiere F4 Masonry

Quarters of residence: Mbankolo.

TOA: At age 14

Investigator: the first question here is at what age were you first made aware of your status?

Participant 4: *it was at the age of 14.*

Investigator: so how would you describe life with your peers.

Participant 4: *well life is marvelously well given the sickness i have is not as terrible as others, some don't even have a cure. with my own I am very ok health wise and I can do everything that I want to do and even with my illness I can still do whatever I want to do at least for now because as long as I don't tell anyone there will be no problem and right now my status remains confidential and the most confidential person right now is me so aside my family members and myself no one else knows so they think I am in good health.*

Investigator: so how would you describe life with your family right now?

Participant 4: *well i will say it is rather very well*

Investigator: do you have any personal objectives?

Participant 4: *well right now i am in F4 and i am doing construction and with that i will like to do engineering in construction. I am equally interested in agriculture.*

Investigator: does your status in any way have an impact on your goal and objectives? be it long term or short term. If yes, how?

Participant 4: *well as I earlier on mentioned, it cannot hinder me from my objectives in any way. I believe that even as we carry this disease it does not stop us from accomplishing what we want. I believe this because we are in good shape and we will continue to be in good shape as long as we are taking our treatment to the letter we will always be in good health*

Investigator: are you familiar with the word stigma?

Participant 4: *no, I am not.*

Investigator: (after explaining what stigma is) have you ever experienced such, if yes, what is your experience with it?

Participant 4: *no, not really because I think for someone to do that they have to first of all know about my status and most people that I interact with don't know much about it, my friends in school only sometimes see me taking my drugs and ask a lot of questions and its true when I don't give them a straight answer they begin to look at me a type but I try not to mind much because I think it's better than telling them and they start looking at me bizarrely.*

Investigator: the next thing I will love to know is what significance do you give to your situation?

Participant 4: *for me it signifies just a syndrome and not really a disease, and as long as we keep following up the orders given by the hospital, we will not contract the disease itself. So for me it's just a virus and very soon they will find the anti-virus and we will all go back to normal. And even though it's not all that bad I still believe it can get much better and I am hoping for it because the thing of taking drugs everyday gets really boring.*

Investigator: so my next question is how do you interact with your peers?

Participant 4: *well i will say i interact with them in the same way and i think it's normal given that i don't like interacting with them too much because I know when they will get to know of my way of life and how much I am restrained from a lot of things, they will start asking a lot of questions that I will not want to answer so I just rather stay and avoid contact as much as possible. That way its keeps things normal with us because I who is the carrier of the virus I will be more affected in that situation given that a lot of people don't know that HIV is just a virus and it is AIDS that is the disease so I try to take it as normal as possible but having to explain that all the time is not really easy so I just try my best to avoid situations that will make me have to be explaining them.*

Investigator: after explaining the notion of identity to you, did this status of yours change anything about you or do you think it changes who you are.

Participant 4: *well to be honest the news is always not an easy one for whoever receives it and when i received mine i definitely had a shock because when it was being told to me i felt it was something that was really serious and for a moment it felt like my own was over. But then again I came to realize that it has always been there and after I have been coming here to these meetings I got to see that following the appropriate treatment I can keep to it and still get to have a normal life but that obviously took a lot of time and I believe with time it will get better. And I can get to have my own children some day and they won't have that virus.*

Investigator: ok, so tell me, before you were aware of your status and after you knew, what has changed?

Participant 4: *well a lot of things have changed because before I used to feel so alone in this world and it honestly felt like my own was over. But when I got to understand that it was not an end it itself then there I learnt from my errors and then continued and adjusted my life. Although I know already that not everything can go back to normal again so I just try to take life the way it is now. After all there are more disease that kill more than what I have such as cancer and diabetes who don't even get to eat what we eat so I count myself very fortunate*

Participant number 5.

Name: PASCAL

Age: 17years

Ethnicity: bamileke (bangam)

Religion: Christian (Pentecostal)

Class: lower sixth

Quarter of residence: cite-vert Yaoundé

TOA: 2020

Investigator: how long have you been aware of your status?

Participant 5: *two years, two years… this year is making two years*

Investigator: how would you describe life with your peers?

Participant 5: *I can talk in French non?*

investigator: any language

Participant 5: *okay, well... my mother has already passed away; she passed away in 2011.*

Investigator: Right

Participant 5: *and..., and it's very likely that it was because of the virus that she died. But we didn't really detect that.*

Investigator: Right

Participant 5: *now I'm living... he's my father; I'm with my father. My dad really, there's no, there's no change. There's no change between me and him. Everything is still the same; as it always has been.*

Investigator: so here I'm talking about a peer group. So whether it's friends, ...

Participant 5: *my entourage?*

Investigator: yes, your entourage, friends, comrades, in the same age group.

Participant 5: *Well the majority of those... the majority of those I'm with..., and who really know this, there's been no... there's been no change. We're still together and everything. So there's no... there's no change. There's no change between them and me; when I told them. Because when I myself was... That and we detected in 2020, we... Well, it was only me, my father and my godfather who knew. It didn't change anything between me and my mentor.*

Investigator: right

Participant 5: *now, and... now after maybe a few months, so I told my... I told my friends who I'm with. Because we are in a... we are a group actually;*

Investigator: right

Participant 5: *so I told my friends who we are in the group with here together*

Investigator: uhun

Participant 5: *and they didn't... it didn't change anything between us; like... so there wasn't like often we say distance and stuff. So there wasn't that between us. It's even more than that... it's made us even more closed... we're even more closed to each other. We've even become more solid.*

Investigator: do you have any personal goals in life?

Participant 5: *uh... yes*

Investigator: what are your goals?

Participant 5: *I want to... I already said that... in my life...*

Investigator: both in the short and long term eh.

Participant 5: *yes. In the short term as well as in the long term, no?*

Investigator: yes

Participant 5: *well in the short term ... ; in my head I want to be a young person who has to impact the world. I want to impact the world with my life.*

Investigator: right

Participant 5: *whether it's... whether it's Christian, whether it's on a spiritual level, whether it's on an academic level or even socially, I have to impact with my youth.*

Investigator: Right

Participant 5: *well in the long term, I'm looking at becoming an electronics engineer*

Investigator: Right

Participant 5*: well my mission... the mission I have according to the plan... according to the plan of God that I know, it is... it is to be a prophet... to be a prophet Now I am trying to join that. Joining electronic engineer and prophet. That's the two that are in my head now.*

Investigator: Okay and with your status does it change anything in terms of your goals?

Participant 5: *No; when I knew my status*

Investigator: whether it was good or bad

Participant 5*: It changed. Because when I knew my status it was like a motivation for me now. It was like a motivation. A motivation for me to go forward, to persevere, to continue. It's true that when I first found out, it's true that I was a bit frustrated at first... because I was thinking, but how? How did I manage to get this and everything... but as I know that God is with me. When I went to pray; I had this assurance there that no; everything is going to be okay. And that's how when I actually received that assurance, it was like a boom and it led me to go even further. Because it's a... a... It was even after I got sick. Because, when I was... I'm... so that people know my status, I got sick in two thousand and twenty, until I was interned here.*

Investigator: uhum...

Participant 5*: it's when after the illness itself, my life actually takes a new turn.*

INVESTIGATOR: uhum

PARTICIPANT 5*: it's when... it's when... it's after the illness itself that, I become more attached to God, more attached to my dreams, more attached to my goal, and then even more attached to my friends; as I said before... before.*

INVESTIGATOR: right

PARTICIPANT 5: *uhn that's it*

INVESTIGATOR: Right. And are you familiar with the word stigma?

PARTICIPANT 5: *stigma?*

INVESTIGATOR: Yes stigma.

PARTICIPANT 5: *No oh. Well...*

INVESTIGATOR: Are you familiar with that word?

PARTICIPANT 5: *Familiar that is?*

INVESTIGATOR: do you know what it means?

PARTICIPANT 5: *yes I know what it means.*

INVESTIGATOR: right.

PARTICIPANT 5: *I know what it means but...*

INVESTIGATOR: now my question is... does it affect you?

PARTICIPANT 5: *well..., it doesn't really affect me eh. The stigma..., it doesn't really affect me.*

INVESTIGATOR: Well, have you ever experienced that?

PARTICIPANT 5*: well, I've experienced it but it wasn't directly related to my status in the sense that it was the HIV but at that time I did not know yet so I think it was not related to my status.*

INVESTIGATOR: right...

PARTICIPANT 5: *um... when I... what I was experiencing was when... I had a skin disease. I'm going to say a mala... I had a... I had a skin... I had a skin problem. Here's even that... well here are the marks again. I had a skin problem. It was even on my head.*

INVESTIGATOR: uhun

PARTICIPANT 5: *it was so much on my head; it was like the wounds. So I had to go to school with a cap on.*

INVESTIGATOR: uhum

PARTICIPANT 5: *so, there..., the others were making fun of me all over the place and everything. Well, it used to frustrate me. After ... after a while, I understood that... they do that because they don't really know. They don't know what they are doing. So, after that I continued to live normally. And until it was... it started... when it started to end... when it ended even the others started to get close to me. And I, I'm not someone that I'm going to push away man. I sort it out. Because even when... even when I fell... even when I had the disease there, there are some people who didn't let me go. There are some who continued to be my friends. To be my intimates. That's how it is.*

Investigator: OK, thank you.

Investigator: the previous question was how many people around you are aware of your status?

Participant 5: *well I will say more than 10, can't tell the exact figure.*

Investigator: so how can you describe their behavior towards you?

Participant 5: well its rather good, like I said it is even more after their discovery of my illness that they have become more attached to me and we are more bonded together even.

Investigator: how would you describe the nature of your interaction with them?

Participant 5: *as a majority of the group of people I interact with are Christians and they fear God, I believe I can get to be open with them although I know it will not always be everybody that is that way but I try as much as possible to be as open with them as I can. And as I have God and one of my objectives is to be a prophet, there are things that God tell me to tell my brethren and which I cannot ignore so I have to definitely go towards them and talk to them. Imagine if God tells me something like that and I don't tell them and something happens to them then imagine what that will look like. And more to that they are mostly my elders so it goes as smooth as it can.*

Investigator: ok, the last question for today is that before you were aware of your status and after it, did it in any way change who you are? if yes then how?

Participant 5: *well I can really say it has changed who I am eh, because before I knew about my status, I really did not know who I was, I thought I knew who I was actually but it turns out I did not know who I was. It was really after discovering my status that I really knew who I was, that is who* Pascal *really is. I became conscious of my potential knowing I am a child who is like this or like that, a child who follows God and lives with HIV, because before I really did not pay much attention to myself or plan my life the way I do right now, because I told myself that everything was fine and it was alright even though there were already some signs that showed up in me that I really did not take serious at first but I always asked myself why I am always falling sick and why is my skin like this and other things but it's after now that I understood my status and saw why I was always falling sick and now that I am on medication I no longer fall sick as often or as usual as I used to do before. Regardless that, just knowing that it is a life long illness so far I now had to gain more consciousness of myself and put myself in order.*

Investigator: ok, that will be all for today and in the case where I need more information I will call you and we can take off from there ok.

Participant 5: *ok, you're welcome.*

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