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Countertransference reactions to psychotherapy group work with HIV positive children

Kuhn, Julia

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CHAPTER ONE: INTRODUCTION

1.1 Brief overview and rationale

This study addresses itself to understanding the countertransference responses of therapists doing group psychotherapy with HIV positive children. The rationale for this research is compelling in that it engages with the experiences of individuals providing a psychotherapeutic service to a vulnerable sector of society – HIV-positive children – children who are increasingly subjected to many levels and forms of abuse and deprivation (National Children's Forum on HIV/AIDS, 2001) and therefore require a great deal of dedicated care. By addressing questions about the emotional challenges of doing group psychotherapy with HIV-positive children, this research endeavours to think about these challenges in a way that could be helpful for the therapist and the therapeutic process.

The countertransference of the therapist is understood as conveying important information about the patient's state of mind as well as representing the activation of unconscious conflicts in the therapist that may impede the work of therapy (Gabbard, 1995). However, conscious attention to the countertransference may facilitate effective therapeutic intervention through understanding the new meanings that are being co-constructed in the relationship between the therapist and patient (Green, 2004). The issue of the countertransference is therefore important because attention to its meaning has the potential to enhance the therapeutic process. There is very little previous research on this topic (for

countertransference in work with HIV-positive adults see Shernoff in M.B. Sussman (ed), (1995)) and therefore very little is known about the challenges of working with this vulnerable group. In addition, the countertransference in work with children is particularly powerful due to the easy availability of their unconscious material and the intensity of their affects (Lanyado, 1999). The therapist in this context therefore requires skill and support in working productively with his or her countertransference. Further, the emotional impact of working with those with a terminal illness elicit a range of powerful feelings that can be difficult for the therapist to manage productively (Shernoff, 1995). This research, by exploring the meanings of the countertransference in group psychotherapy with HIV-positive children, is positioned to support therapists in working productively with their countertransference by generating new insights about their emotional responses and thereby possibly extending containment for those involved and interested in this work.

1.2 Research Method

This study follows a qualitative research design. Data was collected through interviewing five therapists who have experience in conducting group psychotherapy with HIV positive children. Interviews were semi-structured and conducted with the use of open-ended questions. Six interviews were conducted as one participant agreed to a follow-up interview. The interviews were transcribed and then coded and analysed according to the methodology of thematic content analysis. At the first level of analysis, data was arranged descriptively. A second level of analysis followed, in which descriptive categories were organised into thematic charts according to an explanatory level of analysis. The explanation of the data proceeds according to an understanding of the countertransference responses of the

participants as indicating the alternation between the defences against and an engagement with the work of mourning, according to Klein's (1940) theory of mourning, and Kauffman's (1994) extension of Kleinian theory in his discussion of the dynamics of bereavement groups. Ethical considerations were taken into account at all levels of the research process and are fully discussed in Chapter Three.

1.3 Outline and structure of the study

This dissertation has four main sections. The first is the literature review (Chapter Two). The literature on the countertransference is reviewed, with particular attention to contemporary views of the countertransference as arising within and constituting an intersubjective area of "thirdness" in which new, potential forms of subjectivity are generated for patient and therapist. An overview of understandings of the countertransference from group analytic therapy follows and the articulation between Foulkes' ideas of the "group matrix" and "resonance" and Ogden's theory of the analytic third is demonstrated for the purposes of providing a theoretical rationale for an intersubjective analysis of the data. The following sections of the literature review discuss the psychosocial impact of HIV/AIDS on children, psychotherapeutic interventions employed with HIV positive children and the emotional responses of professional care workers and voluntary caregivers to their work with adults and children who have HIV/AIDS.

In Chapter Three the research method employed in this study is discussed. Chapter Four provides contextual information about the group work that the participants were doing with the children. Background information about the origin and purposes of the groups is provided, as

is information about the psychosocial circumstances of the children who attend the groups. In this chapter the features of the group work with the children are discussed, with an emphasis on those factors that influence the development, dimensions and nature of the countertransference constellations that arise in the participants.

Chapter Five presents the findings of the research and a discussion of these findings. The first section of this chapter discusses those countertransference responses that are considered indicative of group defences against the work of mourning. These include feelings of strangeness and displacement, denial, idealisation, feelings of persecution, rage, rescue fantasies, hopelessness and despair. The second section of this chapter discusses those countertransference responses that are considered indicative of an engagement with the work of mourning. These are the relinquishment of omnipotence, awareness of fusion, containment, tolerating the feelings, finding strength in vulnerability, recognising the child as resilient and promoting the child's autonomy, expression and uniqueness. Engagement with mourning and defending against it are considered alternating processes that do not exist along a linear continuum. The linear presentation of these processes in this research report has been done for the purposes of clarity, but does not do justice to the complex alternations that characterise the mourning process.

Finally, the study is concluded in Chapter Six through presenting a summary of the research findings and a brief discussion of the limitations of the study and suggestions for future research.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This literature review has six sections. The first, "Countertransference" reviews classical and contemporary writing on the countertransference with the purpose of providing a justification for conceptualising the countertransference for the present study as an intermediate area of intersubjectivity that arises between therapist and patient. The second section, "Group therapy and the countertransference" discusses the convergence between group psychoanalytic conceptualisations of intersubjectivity and relational accounts of the countertransference. The review of the literature on psychoanalytic group therapy provides a model for understanding the nature of unconscious group communications and how these find expression in the therapist's countertransference. The third section of this review, "The psychosocial impact of HIV/AIDS on children" reviews the literature on the broad psychosocial effects of HIV/AIDS on the child, while the fourth, "Psychotherapy with children living with HIV/AIDS" reviews some general principles of psychodynamic therapy with children as well as specific therapeutic interventions employed with HIV positive children. The fifth section of the review, "The countertransference in child therapy" reviews the literature on the countertransference with healthy and terminally ill children. The sixth and final section, "Emotional responses of those working with persons with HIV/AIDS" addresses itself to the emotional impact of HIV/AIDS work on healthcare workers and professional and volunteer carers.

2.2 Countertransference

2.2.1 Introduction

This section of the literature review provides an overview of the concept of countertransference, with particular reference to "thirdness", a contemporary view of the transference-countertransference field arising out of observations from the field of developmental psychology and influenced by social constructionism. The idea of "thirdness" is rooted in relational accounts of the interaction between patient and therapist and stresses the co-constructed nature of the transference-countertransference field in which there is a continual movement between intersubjectivity and subjectivity. The importance of the idea of thirdness to the present study is located in its articulation with the notion of the "group matrix" (Foulkes, 1966, 1971, 1977), a concept informed by theories from anthropology and social psychology, and the idea of a shared intersubjective field which is constituted by a dense network of mainly unconscious communications. Lastly, the implications for this understanding of the countertransference for the present study will be discussed.

2.2.2 Conceptualising the countertransference

Prior to the 1990's two theories of countertransference dominated the literature: the "classical position" (Klein & Bernard, 1992, p.207) in which countertransference is defined as the unconscious reaction of the therapist to the patient's transference, and the "totalistic position" (ibid.) in which the countertransference is defined as the totality of the therapist's emotional

reactions to the patient in the treatment situation (Kernberg, 1975b in Klein & Bernard, 1992). According to proponents of the latter, the particular qualities of the countertransference can help the therapist know more about the patient's fantasies, conflicts, defences and relationships, that the patient cannot tolerate, both in the past and the present (Gabbard, 1995). However, the countertransference is also seen as simultaneously representing the unconscious conflicts of the therapist and may constitute a blind spot that can impede the work of therapy through collusion with the patient's defences (Lanyado and Horne, 1999).

Kernberg (1984) coined the term "totalistic definition" and provided an explanation of the mechanics of the countertransference by way of the notion of identification. Kernberg's explanation also provides an account of how the countertransference can impede the work of therapy. He termed this "the chronic countertransference fixation" and understood it, as did Freud, from arising as a consequence of the therapist's conflicts being elicited by the patient's transference. Kernberg's contribution can thus be seen to incorporate the classical definition (through the notion of the "chronic countertransference fixation"), while qualifying certain circumstances under which the countertransference becomes a noxious influence in the therapy.

The classical definition has arisen out of Freud's understanding of and attitude towards the countertransference. Freud understood the countertransference as the feelings and behaviours that arise in the therapist as a consequence of the patient's transference (Lasky, 1993). Freud defined the transference as a form of unconscious resistance through which the patient's past relationships, instead of being remembered, are repeated in the present, in his relationship with the therapist (1914): "The transference is a piece of repetition and the

repetition is a transference of the forgotten past" (Freud, 1914, p.151). Freud noted that the patient's repetition of past relationships in the present is an unconscious compulsion and he asserted that the patient was therefore "obliged to repeat". The value of this repetition lies in the fact that it "conjures up a piece of real life" (*ibid.* p.152), thus giving the therapist an immediate experience of the patient's past relationships, the understanding of which, says Freud, is decisive for the treatment.

Freud's conception of the countertransference is limited to those difficult emotional responses that are elicited in the therapist as a result of the patient's transference. Further, Freud's use of the term relates not just to the affect that is elicited in the therapist as a result of the patient's transference, but, more importantly, to the therapist's enactment of these feelings, and the consequent gratification of the patient's transference. Lasky (1993) asserts that Freud distinguished the countertransference from the presence of the therapist's unconscious "complexes and resistances" in terms of the negative potentiality of the countertransference for gratification, rather than frustration of the transference. In this regard, Freud considered the patient's erotic transference to be particularly problematic. The primary difference between Freud's conceptualisation of the countertransference and the "totalistic" conception, besides the scope of the definition, resides in the valence it is accorded. Freud never considered the countertransference to be a useful tool with which to understand the patient, as did Ferenczi, Deutsch and Kernberg, among others (Lasky, 1993). Instead, Freud considered the countertransference a force against which the therapist must "battle", in order not to be "drag(ged) down from the analytic level" (Lasky, 1993, p.266).

Since the 1990's the conceptualisation of the countertransference as a "third space" of relational interaction between therapist and patient, has gained ascendancy (Benjamin, 2004; Britton, 2004; Green 2004; Ogden 2004). This perspective views the transference-countertransference as arising within and constituting a "third space", a space that represents more than just an interaction between two presumably discrete and bounded unconsciousnesses, that of the patient and that of the therapist. Instead, this third space is conceptualised as an interpersonal field within which a new and mutually constructed psychic experience takes place in which therapist and patient are simultaneously more and less than their individual consciousnesses (Ogden 2004). Complex processes of projective identification and countertransference enactment (the actualisation in the session by the therapist of her countertransference to the patient, manifesting in particular behaviours towards the patient, driven by a dynamic that remains unconscious to the therapist) constitute and take place within this "third space" that is characterised by both regressive and progressive tendencies. The work of the therapist, according to writers such as Ogden (2004) and Britton (2004), is to regain the ability to bring thought to bear on the experience, and articulate this 'third perspective" in a way that facilitates the patient's adoption of an external, reflexive, non-fused position that in turn strengthens the thinking function.

2.2.3 The negative valence of the countertransference

Lasky (1993) maintains that the thinking around the countertransference is contaminated with unconscious feelings of shame and guilt stemming from Freud's negative conceptualisation of the countertransference. Lasky asserts that guilt and shame about the countertransference persist despite the generally accepted recognition of the beneficial uses of the

countertransference (Joseph, 1989; Kernberg, 1984). He likens shame about the countertransference to the instinctual repulsion felt by the parent to his child's faeces, even though at a conscious level the parent endeavours to potty train the child empathically. He concludes, therefore, that the countertransference has a negative valence.

Ogden (2004) asserts that post-Freudian thinking about the countertransference has been restricted by the dualism inherent in these accounts. In totalistic accounts, while the countertransference is seen to arise out of an interpersonal field characterised by projective identification, and is therefore useful as a communication about the patient's state of mind (Kernberg, 1984), it is also understood to emanate from the discrete, bounded and separate consciousness of the therapist who must work at separating out her[1] neurotic conflicts from those aspects of the patient's that are 'imposed' on her through projective identification. Ogden offers an alternative view of the countertransference: He maintains that the concept of projective identification is restricted when it is thought of only as intrapsychic processes of projection or identification, or a summation of the two. Instead, Ogden stresses the interpersonal dimension of projective identification. In this respect he elaborates the notion of a third entity, the 'analytic third', that arises in the intersubjective field. Therapist and patient mutually and unconsciously negotiate a submission of their subjectivities to this 'third subject' for the purpose of transcending the limits of their separate subjectivities. Thus, Ogden maintains that both individuals are transformed through this interaction.

Ogden's thinking is strongly influenced by notions of intersubjectivity developed by relational theorists such as Mitchell, Stern and Bollas. This is demonstrated by his assertion that "living

[1] Male and female gender have been used alternately throughout this document

new healthy forms of object relatedness (that arise in the therapy relationship) as opposed to understanding them is of primary importance to the analysis" (2004, p.186). Further, he hypothesises that a reluctance to fully experience the countertransference by subjugating one's subjectivity to an analytic third is rationalised through adherence to a long tradition in which projective identification is thought of as a form of violence that is done to the therapist's capacity to think and therefore as something the therapist must "get through, put aside, overcome, and so on, in his effort to be emotionally present with the analysand" (2004, p.184). Ogden maintains that the real difficulty resides in the fact that attention to this aspect of the countertransference "involves a disturbing form of heightened self-consciousness" that resembles a dream state and therefore tampers with "an essential inner sanctuary of privacy, and therefore with one of the cornerstones of our sanity" (2004, p.185).

When the intrapsychic dimensions of projective identification are privileged at the expense of the interpersonal dimensions, thinking about the countertransference becomes dominated by an attempt to locate responsibility for the therapist's thoughts and feelings. In the literature this attempt culminates in an uneasy compromise. On the one hand, the countertransference is understood to arise as a result of the patient's projective identifications, in which the patient variously "nudges" (Joseph in Gabbard, 1995, p.477), "coerces" (Bion, ibid. p.476), "attempts to evoke" (ibid, p.477), "enlists" (Ogden, ibid. p.478) and "bullies" (Symington, ibid. p.477) the analyst into thinking the patient's thoughts rather than the analyst's own thoughts. On the other hand, it is conceded that the patient's projective identifications require "a hook" (ibid.) in order to be effective. Here it is thought that the therapist's object relations determine whether a projective identification 'sticks' or not. The therapist must therefore have a "valence" (Bion, ibid.) for the patient's communications. Gabbard (1995) maintains that even when the

countertransference is experienced as an alien force sweeping over the therapist, this is merely the activation of previously repressed self- or object-representations, while Sandler (in Lasky, 1993) points out that both patient and analyst try to impose an intrapsychic object relation on one another. Benjamin (2004, p.24) maintains that this conceptualisation of the countertransference speaks a language of subtle violence and accusation, expressed in the formulation of a "doer/done to" binary.

Theorists promoting the intrapsychic aspects of the countertransference have been at pains to point out that a distinction must be made regarding what feelings belong to whom, and an important part of the work in therapy has been thought of as identifying when the patient is "forcing" (Sandler, ibid. p.478) a role on the therapist. Alternative conceptions of the transference-countertransference as an intersubjective field in which there is an alternating merging and differentiation of the subjectivities of therapist and patient, collapse the subject-object dualism inherent in this perspective, with the result that descriptions of the therapeutic intersubjective experience are empathic, in contrast with many accounts that emphasise the violence of this relationship. For example, Ogden (2004) asserts that, "the task is not to tease apart the elements constituting the relationship in an effort to determine which qualities belong to whom; rather from the point of view of the interdependence of subject and object, the analytic task involves an attempt to describe the specific nature of the experience of the unconscious interplay of individual subjectivity and intersubjectivity" (Ogden in Hanly, 2004, p. 285).

Benjamin's (2004) thoughts about thirdness and empathy in the therapy relationship suggest that shame about the countertransference may serve a defensive function that can be

understood to arise out of the dynamics of the intersubjectivity constituted in the room. Benjamin's ideas thus lend themselves to understanding Freud's negative attitude towards the countertransference as arising out of a defensive function, rather than *causing* the shame felt by therapists about their feelings and associated reactions towards their patients, as Lasky (1993) suggests. Benjamin says that when the therapist withdraws from her patient in an effort to defend against the painful identifications that are activated by the patient's projective identifications, a failure of empathy occurs. Instead, the therapist brings a critical scrutiny to bear on the patient as a defence against the therapist's conflicted internal object relations. Benjamin goes on to suggest that when this critical scrutiny is turned on the analyst's self, she experiences this as shame in relation to her countertransference.

2.2.4 Projective identification

The foundation of contemporary thinking about the countertransference is Bion's (1962) understanding of projective identification as an unconscious communication, formulated in his container-contained model. Contemporary conceptualisations of the countertransference as an intermediate area of thirdness represent an elaboration of Bion's notion of projective identification. What follows is a brief overview of Bion's container-contained model and Kernberg's explication of the implications for understanding the countertransference.

Bion understood the projections of the child into the mother as an attempt to have an 'unmetabolised' experience 'detoxified' or contained by the mother who has a greater capacity to think about and therefore to tolerate the infant's primitive anxieties. In identifying with what the infant projects into her, the mother allows herself, in reverie, to be used by the infant in the

task of metabolising and detoxifying these anxieties. The feelings can then be reinternalised by the infant in a form that is tolerable.

Bion's model is founded on Klein's (1946) concept of projective identification, but extended to encompass the idea of projective identification as an interpersonal event and hence a primitive, non-verbal form of communication. Projective identification is thought to involve a mechanism whereby the projected contents go into, rather than just onto the recipient of the projection (Gabbard, 1995). Projective identification therefore has the effect of changing the external object. Projective identification is thought about here not just as intrapsychic fantasy, but as a process in which the recipient of the projection identifies with the unconscious contents of the projection.

Bion talks about projective identification as the infant's behavioural attempts to elicit in the mother those feelings the infant cannot tolerate. If the mother is well-adjusted to her baby, she can tolerate the fears that are elicited in her, for example that the infant may be dying, and communicate her toleration to the child, thus making these fears more bearable (containment). This process also functions to orient the infant to reality. But if the mother cannot tolerate the projection, she returns it to the infant without having been able to think about it. It is therefore stripped of meaning and it is reintrojected "not (as) a fear of dying made tolerable, but (as) a nameless dread" (Bion, 1962, p.116). In this moment, mother becomes an unthinking, misunderstanding object for the child, the internalisation of which erodes even further the infant's development of an apparatus for thinking.

Bion makes the distinction between "realistic projective identification" and projective identification that functions to jettison intolerable bad objects. In contrast, realistic projective identification is a non-verbal communication with the mother that, if taken in by her in "reverie", becomes the means by which the infant can make use of his sense-data via the thinking apparatus of the mother, and thus to become gradually more oriented to reality, more able to tolerate frustration and therefore to develop the thinking apparatus.

Bion posits that the earliest form of thinking is expressed in the infant's curiosity about psychic qualities. This form of thinking is the outcome of the earliest interaction between mother and child. Bion's theory thus situates the development of thinking firmly in the relational arena. In this respect, Bion maintains that thinking is the link between people, and by extension, between parts of the self: "Thinking is an emotional experience of trying to know oneself or someone else" (O'Shaughnessy, 1986, p.178).

O'Shaughnessy (1986) speaks about the patient's need for understanding from the therapist. She maintains that the patient's anxiety about not being understood is an anxiety about the therapist's capacity for reverie, meaning a receptiveness to the non-verbal feeling states emanating from the patient's unconscious. O'Shaughnessy asserts that the patient wants understanding based on actual emotional events in the session, and initially these are provided through the therapist's ability to receive the patient's projective identifications, to "be open to his first mode of thinking" (O'Shaughnessy, 1986, p.187). The patient brings material to the therapist to test the therapist's capacity for reverie: "Can the therapist think, notice, remember, tell the difference between truth and lies, and emotionally understand – as opposed to verbally, mechanically, or from books?" (ibid.)

> "The insight the patient gains in analysis rests on primitive introjections which are emotional experiences of psychic reality linked to his analyst. Equally, the analyst's understanding rests on emotional experiences of knowing his patient in the original and deepest mode, i.e. through reception, containment and thought about his patient's projective identification". (ibid. p.189)

Contemporary notions of thirdness extend and elaborate on this understanding of the countertransference as an essential means of receiving the patient's unconscious communications, communications that are transmitted via a number of different sense-modalities and register in the therapist as fantasies, feelings and non-verbal behaviours.

2.2.5 The role of identifications

Kernberg (1984) also understands the countertransference as an important diagnostic tool when the material transmitted by the patient through projective identification can be understood by the therapist. Because projective identification involves a blurring of ego boundaries, it has the effect of inducing a temporary ego regression in the therapist. Following Bion, Kernberg emphasises the importance of the therapist accepting the projective identification and allowing himself to empathically regress during the session so as to remain in emotional contact with the patient.

Kernberg discusses the implications of the therapist's regression under submission to the patient's projective identifications. Working on the premise that countertransference involves the analyst's receipt of the archaic object relations that are projected into him by the patient, Fleiss (cited in Kernberg, 1985) discusses how the analyst's empathy with the patient is based on the duplication in the analyst of the patient's primitive and archaic identifications.

Because this counter-identification involves very early object relations, it implicates the analyst's primitive and dissociated ego identity in which archaic defences, particularly projective identification, prevail. Kernberg lists some effects on the therapist of the reactivation of the therapist's archaic identifications: i) the reappearance of anxiety associated with the early impulses, ii) a loss of ego boundaries and iii) the temptation to control the patient according to an identification of him with an object from the therapist's past.

The therapist also undergoes "temporary waves of regression, including temporary misidentifications of his patient. His patient momentarily becomes his mother, his father, a pupil, a colleague, another patient, or even a projection of the analyst's own self" (Menninger, 1958, p 87). Reich (cited in Kernberg, 1984) notes that countertransference reactions, such as behaving in accordance with the Talion principle in which the analyst returns love for love and hate for hate, manifest as an indication that in the session the analyst has become stuck in these early ego identifications.

Kernberg emphasises that the activation of the therapist's early identifications can provide him with a useful emotional experience from which he can garner information about the patient's anxieties and fantasies. If, for example, the therapist can face the awareness of his aggressive impulses, he can transmit a helpful emotional security to the patient. What is decisive for the treatment however, is the therapist's ability to remain in contact with his mature ego identity and "the adaptive and cognitive structures connected with it" (Kernberg, 1984, p.57). Kernberg maintains that the therapist's loss of ego boundaries occur only "in the sector of his interaction with the patient" (ibid.) and that a compensatory activation of the mature ego functions occurs in order to reinstate the ego boundaries. The therapist's

regression during the session is followed by a "working through" (ibid.) after the hour, in which the stable cognitive function of the mature ego acts as a support towards "the part of the ego in which primitive identifications, defence mechanisms, and impulses have been activated and where ego boundaries have become fluid" (ibid.) When this process fails, the therapist finds it increasingly difficult to snap out of the countertransference and becomes involved in a permanent emotional distortion in regard to the patient ("a chronic countertransference fixation" Kernberg, 1984, p.65).

Kernberg's contribution to understanding the countertransference is an important precursor to ideas about "thirdness" and speaks both to oedipal (Britton, 2004) and pre-oedipal (Benjamin, 2004; Ogden, 2004) conceptions of the intersubjective relationship between therapist and patient. Conceptions of the oedipal third emphasise the third as a space of witnessing that positions the observers as separate individuals using their "mature ego identities" (Kernberg, 1984) to reflect on the complex processes of projective identification and enactment that take place in the session. On the other hand, the pre-oedipal third speaks to Kernberg's notion of the unconscious activation of identifications in the therapist that form the basis of an empathic attunement with the patient.

2.2.6 Countertransference and the analytic instrument

Lasky (1993) maintains that Kernberg's totalistic definition collapses countertransference, in the Freudian sense, into Freud's concept of the "analytic instrument" (Freud, in Lasky, 1993). Freud coined the term "analytic instrument" to mean the affectively rich internal life of the analyst that permits empathy, intuition, insight and understanding. Lasky asserts that in the

totalistic definition countertransference is indistinguishable from the inner life of the analyst at work: "The analyst's entire personality is involved in his relationship to the patient, consciously, preconsciously and unconsciously; countertransference is virtually an ego function of the analyst that has both positive and negative aspects, and it can equally help and hinder the analytic process" (p.280).

Bion's extension of the idea of projective identification as a primitive form of communication (Bion, 1955) prompted thinking about how communications from the patient, experienced as countertransference responses, could be used helpfully in the therapy. The meaning of the countertransference thus came to be thought of as a 'sign' that could be decoded in order to understand an unconscious aspect of the patient's personality that he could not verbalise (Gabbard, 1995). This is the sense in which Freud employed the term "the analytic instrument": the use of the therapist's own feelings and associations to the patient in order to gain insight into and understanding of his inner world (Lasky, 1993). However, Freud assumed that the analyst could receive the "transmissions" (Gerson, 2004, p.82) from the patient's unconscious without distortion and could then decode the latent meaning of these communications. Gerson (2004) notes that Freud's writing must be understood in the context of the unproblematised adoption of Cartesian dualism and the related assumption of observer neutrality, both of which overlook the interdependence of subject and object. Alternative conceptions of the therapist's intimate emotional implication in the therapeutic relationship stress not only more encompassing definitions of the countertransference, but also a valuing of the role of empathy in the therapeutic relationship and a recognition of the use of enactments.

2.2.7 Thirdness

Hanly (2004) characterises the intersubjectivity described by Ogden in his notion of the "analytic third" as "pre-oedipal", from the Kleinian perspective as Ogden stresses that the task of the therapist is to surrender to and sustain an experience of fusion with the patient so that the intersubjective dynamics can be thought about in terms of their expression of the patient's internal world.

In this respect, Ogden says, echoing Winnicott's "there is no such thing as an infant (without maternal provision)" (in Ogden, 2004, p. 168) , "there is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand" (2004, p.168). Ogden terms the unconscious intersubjectivity of the analyst-analysand the "analytic third" (2004, p.169) and thinks of it as a unique subjectivity that is generated by the separate subjectivities of therapist and patient and which "seems to take on a life of its own" (ibid.).

Ogden holds that the analytic third is experienced by both parties within the context of their own personalities and psychosomatic makeup and therefore, although it is a joint construction, it is experienced differently by each. It also privileges the unconscious experience of the patient within the context of the asymmetrical therapy relationship. Ogden's notion of the analytic third rests on his elaboration of projective identification. He provides an account of the interpersonal transaction that occurs in projective identification, thereby providing a fuller description than that afforded only by intrapsychic accounts. Ogden maintains that a "subjugating third" is constituted in the relationship by means of mutual

processes of projective identification between therapist and patient. The subjugating third is one possible form of thirdness that arises within the unconscious intersubjectivity in the room. In the subjugating third, an unconscious alliance is made between therapist and patient to project and receive each other's material for the purpose of experiencing something that neither could experience on their own. In this way the subjectivity of both is transformed so that "the separate 'I-ness'" (2004, p.188) of both are temporarily subverted. Hence, both participate in negating themselves as separate subjects. The projector "disavows an aspect of himself that he imagines to be evacuated into the recipient while the recipient is participating in a negation of himself by surrendering to the disavowed aspect of the subjectivity of the projector" (ibid. p.189). At the same time, both also co-opt each other's subjectivity with their own subjectivity. The outcome of this mutual process of negation and co-option is the analytic third.

Ogden maintains that in this process both parties are limited and enriched, stifled and vitalised. Both consent to this process for the purpose of "disrupting the closures underlying the coherence/stagnation of the self" (ibid. p.192), thereby creating conditions for the transformation of the self. Hence, Ogden maintains that both subjects are changed through this process.

This process brings about a partial collapse of the movement between subjectivity and intersubjectivity. However, "in order for psychological growth to occur, there must be a superseding of the subjugating third and the establishment of a new and more generative dialectic of oneness, twoness, similarity, difference, individual subjectivity and intersubjectivity" (supra). Subjectivity must be reappropriated, but it is a transformed

subjectivity by virtue of its experience in and of the analytic third. "This is achieved", states Ogden, "through an act of mutual recognition that is often mediated by the analyst's interpretation of the transference-countertransference and the analysand's making genuine use of the analyst's interpretation" (supra).

2.2.8 Summary

This review has highlighted contemporary understandings of the countertransference, in particular Ogden's notion of 'the analytic third'. The value of this conceptualisation of the countertransference for the present study resides in its articulation with psychoanalytic understandings of the meaning, role and use of the countertransference in group therapy. Ogden's account extends the utility of the concept of projective identification to privilege the interpersonal, or relational aspects of the therapy dyad, in much the same way that Foulkes understands the decentred subjectivity that occurs in group members as an effect of the communications of the group unconscious. In stressing the mutual processes of projective identification that occur between patient and therapist in the hours, Ogden illustrates a similar process of subjugation of individual subjectivity that is generated in the relationship between patient and therapist, stressing that what is important is not for the therapist to try to work out what belongs to whom, but to surrender to the projective identifications in order to gain access to alternative networks of meaning that have the potential to generate new, healthier forms of subjectivity.

2.3 Group therapy and the countertransference

2.3.1 Introduction

Relational understandings of the countertransference bear much similarity to group psychoanalytic conceptions of the intersubjective field in group work. The confluence of ideas from two-person therapy and group therapy provides the basis for conceptualising the countertransference in this study. The following section provides a brief overview of theories of group therapy, with particular reference to areas of convergence with intersubjective accounts of the countertransference.

2.3.2 Intersubjectivity in the group and dyad.

The last ten years have witnessed an increasing rapprochement between concepts pertaining to the therapeutic dyad and those developed by group theorists. Schermer (1994) delineates the increasing application of psychoanalytic constructs that previously exclusively referred to the intrapsychic dynamics of the mind, to understand intersubjective communication in groups. Similarly, understandings gleaned from group therapy and social psychology have increasingly been applied to theories of individual development. For example, Foulkes' (1966) theory of the group matrix, or group mind, developed under the influence of critiques of Cartesian subject/object dualism, gives recognition to the social character of individual development. Hence Foulkes maintained that the individual's personality is "imprinted vitally" by the group in which he is raised. Bollas (1992, in Schermer, 1994), emphasising that the

internal object is an elaboration of an external object which the individual uses creatively and idiomatically, asserts that the personality is constituted by an 'inner group' that consists of introjects that exist in relationship with each other. The works of Stern (1984), Mitchell (1988) and Atwood and Stolorow (1984) (in Schermer, 1994) elaborate on the intersubjective character of all mental life and communications through emphasising, on the one hand, the interpersonal nature of internal personality dynamics, and on the other, how the patient's material is constituted and decoded in a "bipersonal" (Schermer, 1994, p. 24) field.

Observations and contributions from this body of theory (loosely known as relational theory) have therefore problematised the theoretical distinctions that have been drawn between the group (interpersonal dynamics) and the individual (intrapsychic dynamics). As a result, there is an increasing exchange and application of constructs between group and individual theories. In particular, dualistic conceptions of the transference-countertransference in which the therapy relationship is conceived of as an interaction between two discrete and bounded consciousnesses has increasingly come under pressure. Areas of commonality are being recognised particularly in relation to thinking around the countertransference, as this is a site where there is an articulation of the intersubjective with the subjective.

2.3.3 The individual in the group and the group in the individual

In discussing group processes, Foulkes (1966) stresses that the mental processes going on in any one individual in the group are part of a network which is formed by the group as a whole: "In the group the minds of strangers, with different individual conditioning, react and respond to each other. Their responses, verbal and non-verbal, conscious or unconscious, to

each others' productions can be used as quasi-associations to a common text." (Foulkes, 1966, p.157). Foulkes thought of the network as being constituted in a psychological medium in which individual mental processes "meet, communicate and interact" (1966, p. 154). This psychological medium he termed the 'matrix'. He defines the matrix as "the mother soil in which all dynamic processes operate" (1968, p. 185) and "a psychic network of communication which is the joint property of the group and is not only interpersonal but transpersonal" (Foulkes, 1968, p.182). Individuals in the group are nodes on the network, "producing it while permeated by it" (1968, p. 184). This psychic network is founded on a pre-existing communion that exists between members, the basis of which is their common humanity.

The concept of the group as a network having nodal points of subjectivity represents a departure from the conception of the group as an aggregate of the individuals who compose it. The implication of this is that a decentred subject is invoked who, through subordination to the group, paradoxically experiences over time a fuller and enriched subjectivity.

Foulkes maintains the concept of individual consciousness but employs it reflexively as a term in the binary: individual/group, while recognising that it comes into existence through being constituted by its opposite term. He therefore says that the development of the matrix into an increasingly embracing network of communication and relationships facilitates the definition of group members' individual identities. Individual mind and group mind therefore continually constitute and are constituted within the group matrix. Cultural influences are imprinted onto the personality and what is in the individual unconscious is at the same time shared by the group. In fact, Foulkes writes that during group therapy what are thought of as the inner

processes in the individual are actually internalisations of the forces operating in the group. Foulkes stresses that the borderline of what is “inside” or “outside” is in continual flux in the group and what is important is not to treat each as discrete, encapsulated phenomena but to understand when and why the shift from one to the other occurs.

Foulkes also proposes that the decision to employ the construct of individual consciousness in theory is a matter of pragmatism. In this regard he maintains that intrapsychic, interpersonal and group dynamics are the same processes, each of which can be described from a different standpoint, depending on what aspect of the process is being foregrounded at any one time.

The importance of psychoanalytic concepts that articulate the individual with the social (such as the ‘group matrix’ and the ‘analytic third’) resides in the elaboration of the meaning and use of the countertransference that they afford. In particular, conceptualisation of the analytic third as a transitional object, and extended thinking about projective identification in individual therapy construct the countertransference as a sign of an unconscious interaction occurring between two or more people and in which individual subjectivity is subjugated to a third, intersubjective process that is simultaneously me and not-me, inside and outside (Ogden, 2004). Early group therapists noted how this occurs in groups, and Lewin (1951, in Schermer, 1994), for example, observed that “the whole is greater than and different from the sum of its parts”, while recognising that the group forms a force-field that configures a dynamic which is driven by developmentally earlier forms of relating.

The concepts of containment and projective identification, particularly Ogden's (2004) elaborated view of the role of projective identification in constituting the analytic third, are particularly pertinent to a discussion of the countertransference implications of group dynamics. A brief overview of understandings of group functioning follows in order to delineate the concepts that inform relational accounts of individual-group dynamics.

2.3.4 Group regression

Since Freud (1921) it has been recognised that individuals are subject to regression when they participate in a group. Bion (1956b, in Schermer, 1994) articulated this in terms of the powerful projective identificatory processes that are activated in the group. Under the influence of regression the group tends towards paranoid-schizoid processes with a resulting effect on thinking in which part-object relating predominates. Pre-oedipal material is thrust to the fore under the influence of these processes and fusion, narcissistic defences and primitive phantasy predominate (Bion, 1956b in Schermer, 1994). Bion maintained that the primitive defences of splitting and projective identification play a crucial role in group formation and facilitate transference relations between group members which are dominated by primitive phantasy. However, Horwitz (in Klein and Barnard, 1994) argues that the transference is both intensified and diluted in a group, depending on whether the therapist is encouraging or discouraging the exploration of preconscious and unconscious material. Hence, regression is not an inevitable occurrence in all groups and Bion's (1959b) writings on the functioning of the working group that is oriented to a reality-based task points to his acknowledgement of this.

2.3.5 Group as maternal container

Bion's view of the group as activating primeval chaos against which group members have to defend themselves contrasts with later understandings of the group as evoking a benign maternal transference object for the members, a view that utilises Bion's (1962) later theories, in particular the concept of containment, to describe how primitive unmetabolised states are detoxified through the group's ability to create and sustain connections between one another and their internal object representations (Miller and Rice, 1967, Scheidlinger, 1955, in Schermer, 1994). Kauffman (1994) discusses the maternal transference in the group in a somewhat different way, emphasising a universal tendency for group members to experience the group as the lost body of the primitive mother, thus setting in motion a reworking of the process of mourning that is central to the developmental tasks of individuation/separation (Mahler et al, 1975), or when conceived of from a Kleinian perspective, the movement into the depressive position.

Scheidlinger's notion of the "mother-group" (cf. Kauffman, 1994, p. 154) has wide utility in theorising on group processes and represents an elaboration of Bion's model of the maternal container for the infant's anxieties. Hinshelwood (1994) for example, formulates a conceptual model that facilitates the therapist's maintenance of his thinking function while engaging empathically in the group process. He suggests that under the pressure of the paranoid-schizoid processes activated in the group, the thinking of all group members, including the therapist, becomes distorted. By using a containing 'reflective space' in which members link emotionally, dialogue can be initiated through which members begin to relate via whole object functioning. Hinshelwood maintains that the therapist must endeavour to win this reflective

space against primitive aggression, notably projective identification, but that as the group matures it becomes more established in the minds of the members who then also serve to protect it as a dialogic space during times of intensified group regression. This conceptual model bears similarities to Britton's (2004) "observing third" and Ogden's (2004) "analytic third" and is an illustration of the common conceptual ground that bridges interpersonal and intrapsychic perspectives. It also speaks to Benjamin's (2004) notion of the value of maintaining an empathic identification with the patient as a prerequisite to understanding the new meanings that are co-constructed between patient and therapist.

Hinshelwood's (1994) application of the concept of containment speaks directly to the countertransference in that containment is facilitated by the therapist's capacity to accept, tolerate and understand the group's and individual members' projective identifications that take up residence in her.

2.3.6 The matrix and the analytic third

Foulkes (1971) asserts that "what is called 'the mind' consists of interacting processes between a number of closely linked persons, commonly called a group" (Foulkes, 1971, p. 224). When a group form intimate relationships they create a "new phenomenon, namely, the total field of mental happenings between them all" (ibid.). Foulkes understood the mental field of the group to include, but also 'transgress' the individual. This he termed the transpersonal process of the group. The transpersonal process passes through each individual (like x-rays passing through the body) who elaborates and modifies it in her own way. Hence, "it is mental processes, not persons that interact" (Foulkes, 1971, p. 228).

Writing about the analytic third, Ogden (2004) articulates something very similar: "The intersubjective analytic third is the product of a unique dialectic generated by/between the separate subjectivities of analyst and analysand within the analytic setting. It is a subjectivity that seems to take on a life of its own in the interpersonal field, generated between analyst and analysand" (Ogden, 2004, p. 169). Ogden maintains that there is a particular form of intersubjective thirdness that is constituted in the relationship between therapist and patient and is generated through the process of projective identification. Ogden refers to this form of thirdness as the "subjugating third" in that the separate subjectivities of therapist and patient are temporarily negated. Through the process of projective identification both for a time become "other-to-himself, in part an unconscious being outside of himself who is simultaneously 'I' and 'not I'" (Ogden, 2004, p. 188). This mutually negating process creates a third subject, "the subject of projective identification" that is both and neither projector and recipient. Ogden stresses that both parties subjugate themselves to this particular form of analytic thirdness "for the purpose of freeing themselves from the limits of whom they had been to that point" (ibid.). The third intersubjective entity that is created acts as a vehicle "through which thoughts may be thought, feelings may be felt, sensations may be experienced, which to that point had existed only as potential experiences for each of the individuals participating in this psychological-interpersonal process" (ibid. p. 190).

Similarly Foulkes (1971) says that the group creates a new phenomenon - a group matrix in which mind can be seen to be " a series of events, moving and proceeding all the time" (Foulkes, 1971, p. 224) and not 'a thing' confined to the individual. The transpersonal process generates a "suprapersonal mental matrix" (ibid. p.227) in which dense and complex interactional communications take place. However, Foulkes is at pains to stress that these

communications should not be perceived “as an interaction of individual minds enclosed in each skull” (ibid. p.228). On the contrary, he says that the matrix “includes the individual but also transgresses him” (ibid. p. 229).

2.3.7 The network and Ogden’s elaboration of projective identification

Ogden’s (2004) elaboration of the concept of projective identification speaks fluently to Foulkes’ ideas about the group as a communicative network in which nodal points of subjectivity are embedded. Common to both concepts is the primacy afforded the role and function of communication. In Foulkes’ account, communications occur in response to conflicts that are unconsciously activated in the group. Because these conflicts occur at the level of the primary process, their initial unconscious expression is also subject to the operation of the primary process: “primitive, pre-logical mentality” (Foulkes, 1966, p. 154) and they are cast in symbolic language. This language is communicated and understood unconsciously. Unconscious processes communicate and interact directly with each other and can be brought to light in the group, through understanding all communications, verbal and non-verbal as confirmations, counter-reactions or unconscious interpretations to unconscious content emerging through the group.

Foulkes (1977) coined the term ‘resonance’ to describe a process in which a group member experiences a recognition of or affinity towards some aspect of the group unconscious. He maintains that the resonance “always takes into account the unconscious meaning and the ‘wavelength’ of the stimulating event, faithfully and correctly” (1977, p. 299). Moreover, the stimulating event and the reaction to it “ are in the same key and throw light onto each other:

these two are, as it were, members of the same family and often closely related, - one might say of the same generation" (ibid.). Foulkes maintains that resonance is a good example of communication taking place in the group without any particular message being sent or received, but being purely instinctive. Foulkes' idea of resonance illustrates the "transpersonal" process that occurs in the group and gives support to his contention that group communication creates a new generative entity (the matrix) that operates according to an unconscious pre-logic and in which the subject, through being decentred, becomes more than the confines of her individual subjectivity.

Ogden's (2004) elaboration of projective identification shares with Foulkes' notion of resonance the idea that there is an unconscious agreement or alliance that exist between the communicators. In Ogden's account, the participants in projective identification are both equally complicit in using each other to momentarily become what they could not be on their own: "The projector disavows an aspect of himself that he imagines to be evacuated into the recipient while the recipient is participating in a negation of himself by surrendering to the disavowed aspect of the subjectivity of the projector" (Ogden, 2004, p. 189). Further, Ogden touches on Bion's (1962) assertion that in a projective identification both parties are simultaneously a recipient and a projector and this gives rise to feelings of expansion and vitalisation as well as limitation and coercion. Similarly, Foulkes understands communication in the group as being founded on an unconscious mutual recognition of aspects of each other's subjectivity, aspects that are articulated as if they were the property of the individual but are in fact generated through the group matrix. Ogden challenges traditional conceptions of projective identification in which the recipient is thought to merely play a role in someone

else's fantasy. Instead, he asserts that the recipient plays a role as well as authors the other's unconscious fantasy.

The concordance between the ideas of Foulkes and Ogden lead them to both understand the work of therapy (whether it be group or individual) in a similar way. According to Foulkes, through the process of group communication, the group works its way from the symbolic level of communication to conscious, verbally articulated meaning. The purpose of the group is to promote and maximise communication so as to facilitate the development of this conscious, verbal meaning. The role of the therapist, or 'conductor', as Foulkes terms it, is to assist the group to work towards verbal meaning by using his countertransference to understand the group mind. The conductor is required to remain passive and receptive to the unconscious communications within the group matrix, to which, by virtue of being part of the group, he has unmediated access. However, the conductor plays a specific role in the group and Foulkes conceives of this in accordance with his understanding of the group matrix. The conductor makes contributions "through the group" (1975, p. 293), meaning that what seems to be *an individual's* issue or behaviour is taken up as a product of the group dynamic and addressed within the context of the group so that all the group members can actively participate in uncovering the meanings of the unconscious communication. The work of the group is thus done by the group members who are constituted as decentred subjects.

Similarly, Ogden stresses that in order for psychological growth to occur, the subjugating third must be superseded through the therapist's interpretations of the transference-countertransference and the patient's use of these. This enables a mutual recognition of therapist and patient of each others' separate (yet interdependent) subjectivities and helps

each to release the other from the subjugating third. Ogden says that being within the subject of projective identification (the subjugating third) is only a potential form of being and both parties must "return to oneself" (Ogden, 2004, p. 192). This is not however a return to an original self, but to a "transformed, more fully human, self-reflective" (ibid.) self.

2.3.8 Summary

This review has attempted to demonstrate areas of convergence between conceptualisations of the countertransference in group therapy and those of relational theorists working individually with patients. Understanding the countertransference as an intermediate area in which a shared subjectivity arises, has implications for how the data in this study has been analysed. The emotional reactions and associated behavioural manifestations of the participating therapists have been analysed as a combination of the intersubjectivity generated in the groups as well as the individual subjectivities of the therapists. It is hoped that this methodological approach has found ample justification in the literature reviewed thus far on the intersubjectivity that is generated in dyadic and group relationships.

2.4 The psychosocial impact of HIV/AIDS on children

2.4.1 Introduction

This section reviews literature on the broad psychosocial effects of HIV/AIDS on children as well as the psychological effects on children of their HIV positive diagnosis. The dual nature of this review has been undertaken because most HIV positive children have experienced the illness and death of members of their families, usually their mothers and siblings. These children therefore face a dual detriment – that of the effects of the deaths of their caregivers as well as the effects of their own HIV positive status.

2.4.2 The prevalence of children living with HIV/AIDS

The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS (2004) states that at the time of the study, 2.7 million children under the age of fifteen were living with HIV or AIDS in sub-Saharan Africa. Howard *et al* (2006) state that there are 12.3 million children in sub-Saharan Africa who have been orphaned by AIDS.

2.4.3 The psychosocial effects of HIV/AIDS on children

The International HIV/AIDS Alliance (2003) conceptualises the psychosocial impact of HIV/AIDS on children in terms of two stages. The first is the trauma and stress brought about

as a result of the death of a caregiver due to AIDS, and the second is secondary stress associated with the loss of a home, the poverty spiral, separation and relocation, school drop-out, isolation, lack of care and guidance, lack of food, shelter and clothing, poor access to health facilities and child labour. These secondary stress factors bring about anxiety-depression, withdrawal, concentration problems, aggressive tendencies, suppressed anger, feelings of failure, guilt, despondency, apathy, disorientation and fears for the future. The authors maintain that ultimately these emotional reactions may result in post-traumatic stress disorder. Studies of South African children's emotional reactions concur with the data presented above: on the whole these children's symptoms are internalised and manifest as anxiety, depression and withdrawal, in contrast to externalising behaviour such as aggression and other anti-social behaviours (Richter, 2001).

A review of the literature reveals that the most significant effects of HIV/AIDS on children are as follows: i) disruption of early attachments; ii) witnessing the suffering and death of the caregiver; iii) stigma and discrimination; iv) social isolation; v) multiple losses and vi) disenfranchised grieving. Higson-Smith *et al* (2006) cite disturbed early attachments if the caregiver dies in the first few years of the child's life. Younger children who experience disrupted attachment may struggle to form healthy relationships with new caregivers in the extended family and community and may be vulnerable to later personality pathology and difficulties in relating to others (Richter, 2001).

Many children witness the suffering and deaths of parents and siblings and the way in which a parent's death is handled within the family is critical to the child's future (Richter, 2001; Levine & Foster, 2000). The exposure of the child to the suffering and sickness of her parents can

result in the traumatisation of the child (Higson-Smith et al, 2006, Kluckow in van Dyk, 2005, The Framework, 2004). Children with mothers dying of AIDS have been found to have elevated symptoms of mental illness and behavioural problems associated with high maternal distress and poor parent-child relationships (Levine & Foster, 2000). Early traumatisation may lead to diminished resilience in the face of stress later in life, risk taking behaviour, difficulties forming healthy relationships and increased vulnerability to substance abuse and revictimisation (Classen, Palesh and Aggarwal, 2005 in Higson-Smith *et al*, 2006).

Social isolation of the child can occur as a result of the following factors: loss of the child's home and family assets on the death of a parent; dislocation when families migrate to find work or return to the extended family on the death of the head of the household; the child taking on adult responsibilities (including care of the sick and dying); dropping out of school and stigmatisation (Richter, 2004 in Higson-Smith *et al*, 2006). Kluckow (2004, in van Dyk, 2005) discusses how these factors have the effect of cutting the child off from sources of cultural learning, thereby undermining opportunities for skills development and the development of a culturally-embedded identity.

Stigmatisation of HIV/AIDS results in the imposition of a double taboo on talking to children about the inevitability of death. The resulting secrecy can result in high levels of anxiety for children who, while often aware of the terminal nature of the parent's illness, are prevented from asking questions that can help them to come to terms with their parent's impending death. As a result, children may draw their own conclusions that involve magical thinking. Fears that the child may be responsible for the parent's condition, and anxiety about who will take care of him after the parent's death may preoccupy the child, resulting in high levels of

anxiety and depression (International HIV/AIDS Alliance, 2003). Stigmatisation also contributes to the child's social and economic vulnerability as AIDS survivors are not accorded the same support and respect as survivors of other deaths (Demmer, 2004). The child may also be vulnerable to abuse, neglect and abandonment by the extended family as a result of stigmatisation.

Children affected by HIV/AIDS experience multiple losses. In addition to their parents, many other family members, including siblings, may have died of AIDS. These children lose the security of their relationships and a familiar environment, evoking concerns about their survival and that of their caregivers. The child may also experience survivor guilt (Dane and Miller, 1992 in Siegel and Gorey, 1998). Orphanhood represents a loss of status and the associated dreams about potential future achievements. These are losses that often go unrecognised, and the process of mourning them may not even be begun. As a result, the development of the child's identity may be arrested (Daniel, 2005). Doka (1989, in Siegel and Gorey, 1998) has coined the term "disenfranchised grief" to refer to "a loss that cannot be openly acknowledged, publicly mourned, or socially supported" (Siegel and Gorey, 1998, p.264). Disenfranchised grief interferes with mourning as it intensifies the typical emotions associated with mourning, such as anger, guilt and depression. Unresolved mourning traps the child in a liminal state between identities and can result in the child looking for belonging through anti-social behaviours (Daniel, 2005).

Children who are not told of the death of a parent or a terminal diagnosis, are nevertheless often aware that something is wrong (Adams, 1984; Nagler, Andropoz and Forsyth, 1995 in Daniel, 2005). This awareness may be experienced as a "nameless dread" (Daniel, 2005,

p.196). When the child is told of his parent's death, yet the death is not spoken about, this prevents the child from receiving clarification, validation and support. As a result, the child may delay his grief with negative consequences for his emotional well being later in life, particularly his capacity to form secure relationships with others (Thamuku, 2002 in Daniel, 2005).

The death of the primary caregiver can also result in pathological childhood depression if the mourning process is arrested, leading to an increased risk of suicide (Higson-Smith *et al,* 2006). Where the death of the caregiver is grotesque, painful or stigmatised, or where the child blames himself, complicated grief or traumatic bereavement is a likely outcome (ibid.). Traumatic bereavement is predictive of later psychosocial difficulties that include affect regulation problems, anxiety and mood disorders, and substance abuse (ibid.).

Howard *et al* (2006) report that many signs of psychological distress amongst fostered orphans may go unnoticed. While withdrawal and sadness are most often recognised as signs of depression by the child's caregiver, other indices of depression such as anger/irritability/anxiety, concentration problems, psychosomatic complaints, insomnia and poor appetite go largely unnoticed. Untreated depression can have wide ranging effects on the child, including not coping at school, substance abuse and risk-taking behaviour.

2.4.4. The psychological effects on children of contracting HIV

Developmental considerations

Wiener and Figueroa (1998) write that the diagnosis of an HIV positive status is a crisis point for the child and they way she copes with it will depend largely on her stage of development as well as on the emotional state of the parent when disclosing this information. Children at the stage of birth to latency will be most concerned with the separation from their caregiver when having to be hospitalised, and the discomforts of the illness. School age children may be more concerned by the social isolation that may follow a diagnosis and may demonstrate a strong desire to share with other infected children their experiences of being HIV positive. Children of this age will also be concerned about the impact of the disease on their siblings, the family finances and on their parents.

Writing from a North American perspective, Shaw (1994) says that the most turbulent periods for the HIV positive patient are as follows: at disclosure of the positive status; when the family and peer group learn of the diagnois; when there is concrete evidence of the progression of the disease and when death is imminent.

Emotional reactions to disclosure

Frozen, anxious affect and crying are common reactions in older children to disclosure of an HIV status (Shaw, 1994). Very young children cannot fully understand the meaning and implications of the diagnosis and will respond to the caregiver's emotional state (Wiener and Figueroa, 1998). Some recovery from emotional shock and numbing in the older child is

achieved in the short-term (Shaw, 1994), and the child will behave and interact normally, interspersed with periods of crying, sadness and anger (Siegel and Gorey, 1998).

Most children do not express how they feel about living with HIV. Many children think of the virus as a monster and fantasise about becoming friends with it. Older children may use intellectual defences to gain mastery (Wiener & Figueroa, 1998).

Feeling different, stigma and social isolation

HIV positive children struggle with feeling different from their peers. They fall behind in their school work because of repeated absences and they look physically different from their peers due to the illness. Having to take medication daily is also a constant reminder to the child of his condition and he may struggle between a 'healthy, normal life' and the life of the sickly child. 'Being different, looking different and feeling different' are common themes for these children (Wiener and Figuroa, 1998).

Stigma and discrimination towards those who are HIV positive may result in feelings of shame and guilt in the child (Sherr, 1991) and have implications for considerations around disclosure (Wiener and Figueroa, 1998). While non-disclosure to the child of his status may be founded on the desire to protect the child from stigma, it also denies him support from his environment (Wiener and Figueroa, 1998). When the child is aware of the diagnosis, the need to keep this a secret from siblings, friends and teachers may impose a significant emotional strain on the child (Sherr, 1991). However, being asked questions and having to answer them are also sources of considerable emotional stress for children and sometimes children choose not to

tell others of their status, thereby protecting themselves from being treated as curiosities (Wiener and Figueroa, 1998).

However, when the child has made the decision to disclose her status to others, this can bring great relief. The possibility of friends and teachers finding out about her status is no longer a fear for the child and the stress of having to lie about frequent hospital visits and other aspects of treatment is removed. The opportunity for the child to share with other children her experiences of the condition represents an important turning point and provides mirroring that can help the child to reorganise her self-conception (ibid.).

Loss and fear of dying and death

The child may struggle with the loss of his well lifestyle, physical strength and self-image of health (Wiener and Figueroa,1998). Complying with the medical regime and frequent visits to the hospital may be difficult for the child (Wiener and Figueroa, 1998). Writing from an American perspective, Sherr (1991) says that the child may be overprotected and his play limited as a result of his status. However, this is less likely to be the case in South African where widespread poverty, a high incidence of infection among mothers, lack of access to resources and stigmatisation may instead call for resilience and impose increased demands and responsibilities upon the child.

Ambivalence and a lack of investment in life characterises the experiences of many terminally ill children (Wiener and Figueroa, 1998; Demmer, 2004). Some children exhibit depression with outbursts of anger and anxiety, while others are courageous and steadfast in the face of death (Wiener and Figueroa, 1998). These authors maintain that most children are not afraid

of dying. Rather, it is separation from loved ones and loneliness that is feared. However, each child's behavioural and emotional reactions to death will be unique to the child, reflecting the influences of the child's relationships and past experiences.

Wiener and Figueroa (1998) note that many HIV positive children do not broach the issue of their death, either because they fear being told that they are going to die or because they sense that talking about it is too disturbing for the adults around them. While denial can serve the adaptive function of maintaining hope and moderates the intensity of the fight-or-flight emergency stress response, it also inhibits the integration that is essential for mourning (Teguis, 1994). Wiener and Figueroa (1998) emphasise the importance of the child talking about how he or she wants to be remembered and the benefit to the child of being able to express her thoughts and worries about the family's future after her death.

Experiencing multiple deaths of infected friends and/or siblings places the child in a succession of grief reactions and provoke fears about when her turn will come and whether her experience of dying will be similar to or different from that of the deceased (Wiener and Figueroa, 1998).

Neurological effects of HIV on children

In a study done by Kletter et al. in 1989 (in Sherr, 1991), the authors found that the mental and motor development of HIV-infected children declined over time. The development of HIV-negative children born to HIV-positive parents was also found to lag behind that of unexposed children and the authors suggest this is linked to the environmental effects of an ill mother. This suggests that HIV positive children with ill mothers face a dual detriment. This in turn

has implications for psychotherapy with these children, as cognitive impairment will limit the success of treatment. However, profit can still be gained when the therapist maintains attention to a psychodynamic way of thinking about the work, even though she may only be able to work in a fairly concrete way with the child.

2.4.5 Summary

There is a cascade of psychosocial effects of HIV/AIDS on children. These relate not only to the psychological effects of having contracted the virus, but also to the effects of parental illness and death. The negative effects on the long-term health and well-being of children who have lost their parents to AIDS include increased vulnerability to abuse, difficulty forming secure relationships, depression, post-traumatic stress disorder, increased risk of personality pathology and involvement in anti-social behaviours. Children who have been diagnosed as HIV positive are faced with the task of overcoming shock and denial and coming to terms with feelings of being different, stigmatisation, social isolation, the loss of a healthy identity and fears of dying. Further, children infected via maternal transmission are subject to delayed mental and motor development, with implications for increased risk for social marginalisation and the development of personality pathology.

2.5 Psychotherapy with children living with HIV/AIDS

2.5.1 Introduction

The purpose of this section of the literature review is to set a context for psychotherapeutic work with children living with HIV/AIDS. As such, a range of therapeutic interventions are reviewed in order to provide a comparison to the psychotherapy group work that is being undertaken by the participants in this study. Some general features of psychodynamic therapy and group therapy with children are discussed, followed by a brief review of therapeutic interventions that have been used with HIV positive children, including a brief evaluation of group interventions.

2.5.2 Some general features of psychodynamic therapy with children

The function of play

Therapy with children is different from that with adults in a number of important respects. Firstly, the child's verbal expression is limited, not only because she has limited mastery over the language, but also because the child's psyche is closer to the primary processes and communication therefore occurs symbolically, as well as verbally. As a result, children express themselves through play, and it is also in this medium that their natural tendency for discharging tension and discomfort through the activity of their bodies is met (Chethik, 2000). The internal life of the child emerges in play and play is actively used by the child in an attempt to master the conflicts associated with various developmental stages. Chethik maintains that play is an "in between" space, located between primitive behaviour and

verbalisation, which denotes the achievement of symbol formation. In this respect, play can be seen as a "transitional space" (Winnicott, 1980) which the child constructs as simultaneously internal and external, so as to externalise conflicted aspects of the inner life in order to accept and tolerate them.

The child's ego

The child's ego is less developed than the adult's. It is therefore fluid and constantly shifting between primary and secondary process. Because the child's capacity for frustration, pain and anxiety is limited, her ego is subject to regression, particularly under stress. Unconscious material is then expressed in a primitive form through externalising behaviour, or what is termed 'acting out', or through processes of projection and projective identification, or what is termed 'acting in' (Chethik, 2000) in the session.

Due to the weakness of the ego, the child's anxieties and fears can be experienced by him as very intense. Coupled with the child's limited capacity for self-reflection and for imagining the future, tolerance of these anxieties requires a great deal of emotional energy from the child and the containing function of the therapist is of crucial importance. Chethik (2000) maintains that as a result of this the child has little capacity to establish an early alliance with the therapist and easily resorts to flight, whether this be physically running out of the room or engaging in chaotic and repetitive behaviour within the room (Lanyado, 1999).

The child's dependency

The child is very close to her parents as a result of her physical and emotional dependency. Her need for love and approval and her fear of losing her parents and their love shape the

development of her ego capacities and her superego formation (Chethik, 2000). Davies (1999, in Chethik, 2000) cites parental risk factors such as "high parental conflict, family disruption, harsh parenting, coercive family process and child maltreatment" (ibid. p.16) that place the child at risk for developing difficulties.

The child's need for growth

As the child is in the process of development, the therapist works with the conflicts that have brought the child to therapy as well as with traversing the normal tasks of development. The child also grows rapidly and changes to his ego, developments in consciousness and self-consciousness, and the consolidation of his identity require a flexibility and awareness in the therapist. Because new psychic structures are in the process of developing, the therapist provides an important influence in the child's growth. Chethik (2000) maintains that it is in fostering the child's verbalisation that the therapist can help the child's ego to "expand and master" (ibid. p. 20).

2.5.3 Group psychotherapy with children

Schiffer (1984) maintains that group therapy for children has a special value because it is employed during a period of the child's development when "socialisation has become a prominent feature of daily life" (1984, p1). In early latency the child is impelled into the outer world and relationships with her peers by her need to develop her identity. This serves to give her distance from her primary, libidinal objects and thereby provides an opportunity for her to resolve problems associated with her parents and siblings. Relationships with peers give rise to new feelings and attitudes towards people outside the family and this "fosters

identity formation, broadens a child's social parameters, and provides much support during the transition" (1984, p2). Schiffer is of the opinion that these growth tasks are supported in group psychotherapy, and therefore participation in the peer therapy group augments the maturational process as well as provides the necessary treatment.

Reid (1999) maintains that the value of the group for children lies in the acceptance provided to the child, the mirroring function of the group and its role in orienting the child to reality through the presence of differences in perspective. The group also facilitates the exploration of a number of relationships and offers different models of behaviour. Negotiating differences strengthens the child's capacity for self-reflection. Further, because the child experiences the impact of other's behaviour on her and sees the consequences of her behaviours on others in the group, she has the opportunity to see how her projections impact on her relationships with others as well as how she is vulnerable to others' projections. Finally, self-esteem is developed in the group as the child rediscovers aspects of herself that have been suppressed, and comes to value her positive qualities through exercising her strengths and weaknesses, and observing those of other children.

2.5.4 Psychotherapeutic interventions with children living with HIV/AIDS.

Play therapy in the tradition of Virgina Axline is widely used with children affected and infected by HIV/AIDS. As many of these children are traumatised and/or developmentally delayed as an effect of poverty, disrupted attachments and the neurological impact of the HI virus, and therefore have limited verbal ability, play therapy is an effective means of expression. Sand and water play and other tactile play such as finger-painting and play-dough and clay work

provide a soothing function, particularly for the traumatised child, and also give the child the opportunity to safely and repeatedly express aggression and reparation. Play with dolls and toy animals allows the child to re-enact important conflicts in an effort to achieve mastery. This is particularly important for children who have experienced loss, bereavement and traumatisation (Ramsden, 1998).

Techniques requiring the child to verbalise are effective if used appropriately, as they facilitate mastery. In this respect, storytelling, bibliotherapy, exploring dreams, 'three wishes', word association games, 'what if' questions, incomplete stories and sentences and journaling are all verbal techniques that have been used to help HIV positive children communicate in therapy (van Dyk, 2005; Wiener and Figueroa, 1998).

Children who are socially isolated as a result of discrimination and/or emotional withdrawal benefit from cooperative play that a group affords. The acquisition of social skills and the development of empathy are facilitated through relationships with other children, and playing organised games develops the child's ability to follow rules, cooperate with others and take responsibility for his actions (Ramsden, 1998). Life Skills Camps such as the Salvation Army Masiye Camp in Zimbabwe has been hailed as contributing significantly to strengthening the children's ability to cope and develop confidence, trust and problem-solving and decision-making skills (Richter *et al,* 2004).

Psychotherapeutic services for children who have lost a parent to AIDS include the Rob Smetherham Bereavement Service for Children near Howick in KwaZulu-Natal. Children receive individual and group play therapy at this centre. The interventions are designed to

help the child mourn her bereavement and have as a central aim the restoration of hope for the child (*The Star,* 3 November 2001). Memory boxes and books have also been used to assist the child to prepare for the death of her caregiver and to openly grieve once her caregiver has died. The purpose of the memory box or book is to break the silence between infected parents and their children and to give their children a sense of belonging by sharing with them the family history (van Dyk, 2005). Memory books have proven to be effective therapeutic interventions that require only an initial input from a facilitator in the purpose and manner of their compilation. They are thus an empowering community-based intervention that is mostly untethered to professional input.

Creative arts therapy has been widely used with terminally ill children and is an effective medium through which children can non-verbally express their feelings and fantasies (Wiener & Figueroa, 1998). Jungian therapists stress the value of the creative arts in "restoring the authenticity of the child's own visionary activity" (ibid. p.731), an act that allows the child to express pain and trauma, thereby facilitating reparation and healing.

Art and drama therapy has been used effectively with HIV positive children in South Africa (for example, the Firemaker project of the Zakheni Arts Therapy Foundation (Higson-Smith *et al,* 2006)). The gentle, non-confrontational approach afforded through creative expression is particularly suited to children who have experienced multiple losses, dislocation, discrimination and the possibly traumatic death of a parent (Higson-Smith *et al*, 2006).

Creative arts therapies such as art and drama therapy are particularly effective for use with traumatised children. The creation of the art object and expression through drama remain

within the control of the child and therefore pose little risk of re-traumatisation. The non-verbal aspects of the modalities affords the child, who may not be able to articulate the trauma due to its disorganising effects on cognition, the opportunity to express feelings and repeatedly re-enact the event. This represents the beginnings of the creation of narrative, through which mastery over the trauma is achieved (Higson-Smith *et al*, 2006).

Creative arts techniques such as puppetry and story telling are effective modalities for disclosing the child's status to her and for imparting information about the nature and consequences of HIV infection. Creative arts therapy also allows the child to play, an experience that may be rare if the child is burdened with adult responsibilities at home. Drama therapy has been considered a culturally appropriate intervention for HIV positive children as dramatisation is an entrenched form of expression in some South African cultures. Creative arts therapy has been associated with building resilience in children, in particular the development of healthy coping strategies and self-soothing. (Higson-Smith *et al*, 2006).

2.5.5 Group interventions reviewed

HIV positive children have been treated in group therapy with successful outcomes. A psychoeducational group that used play therapy techniques for a group of six HIV positive children around the age of ten years was found to benefit the children cognitively and emotionally. The children appeared to have increased self-esteem and self-control, a decrease in hopelessness and depression and an increased understanding of their illness (Bacha, Pomeroy and Gilbert, 1999).

Psychodynamic group therapy for children between the ages of three and five years infected and affected by HIV/AIDS was run over eight weeks, using art and fairytales (Willemsen & Anscombe, 2001). The authors maintain that the group helped the children to process loss and separation and behavioural changes were noted such as improvements in eating behaviour; containment around hospital and medication; and the formation of close friendships.

Howard *et al* (2006) note that groups in Zimbabwe focusing on psychosocial support for AIDS orphans report good results when they are integrated with other kinds of AIDS support, such as creating memory-books, education support, vocational training, home-based care and voluntary counselling and testing.

2.5.6 Summary

Psychotherapeutic interventions for children infected and affected by HIV/AIDS are multiple and varied. These interventions aim to assist the child to recover from bereavement, trauma, disrupted attachment, emotional stress and to enhance resilience. Life skills such as decision-making and problem-solving, and education about the cause and progression of HIV are promoted alongside interventions that afford expression of feelings and concerns, discharge of aggression, self-soothing and the development of creativity. Companionship, mirroring and the acquisition of social skills are promoted through group therapy while the importance of helping the child to mourn the loss of loved ones is promoted through interventions such as memory boxes and books.

2.6 The countertransference in child therapy

2.6.1 Introduction

There is very little written on countertransference reactions to psychotherapy with HIV positive children and therefore some general features of the countertransference in psychotherapy with children are discussed in this section of the literature review, followed by countertransference reactions to terminally ill children.

2.6.2 Resistance against the countertransference in work with children

Marshall (1982) maintains that the dearth of literature on the countertransference of therapists working with children and adolescents is indicative of an unwillingness amongst practitioners to disclose the difficulties they encounter in their work with children. “The lack of attention to countertransference in the treatment of children and adolescents appears to be due to several factors. The primary variable appears to be the variety and strength of affects evoked in the therapist which in turn produce anxiety, guilt, and a range of defensive reactions. Defences against hostile and sexual feelings appear to be central” (1982, p. 201). Marshall also speculates that the disregard given to countertransference by Anna Freud and Melanie Klein has had the result of deterring “less courageous therapists from formal exploration” (1982, p.165).

Marshall (1982) discusses the culturally influenced defences that are erected against negative and hostile feelings towards children, mentioning the wide-spread occurrence of infanticide

and the “incredible savagery” with which children have been treated in the West (DeMause, 1974a & b, in Marshall, 1982). Winnicott’s eighteen reasons why a mother may hate her infant (1958, in Marshall, 1982) points to the inevitable violence adults may wish upon their children and strenuously defend against. A taboo exists not just against aggression towards children, but also against sexual feelings for children, rendering the relative silence about the countertransference among child therapists not wholly inexplicable. Marshall adds that this silence indicates that the feelings of the therapist are not being used constructively, let alone even recognised.

2.6.3 Countertransference reactions in psychotherapy with children

Sandler (in de la Sierra, 2004) writes that the therapist’s attention to her countertransference as a means of understanding the conflicts and defences of her patient is particularly important in work with children and adolescents where “peremptory wishes and intense conflicts are forcefully externalised onto the person of the analyst“ (p.99).

Bornstein (1948, in Marshall, 1982) delineates some of the factors that limit a therapist’s effectiveness in her work with children. These include “children’s unpredictability, their highly charged affects, narcissism and the closeness of their productions to the unconscious” (in Marshall, 1982, p 164). She discusses how the child’s emotional lability and easy availability of libidinal and aggressive material can be experienced as highly threatening and anxiety-provoking to the therapist. Marshall maintains that “overwhelming feelings of guilt, inadequacy and anxiety underlie many therapist’s attitudes toward their child and adolescent patients” (1982, p 166) and this is a function of doing therapy with troubled young people.

Marshall (1982) lists clues to unconscious-therapist derived countertransference that are particularly applicable to working with children and adolescents, including excessive play with little talk, quick yielding to requests, gratification of the child, particularly gift-giving, any strong feeling, lulling off when a child plays repetitively, physical contact, inappropriate relationships with the parents, preoccupation with changing the behaviour of the child, idealising the child and/or parents and fantasies of rescuing the child from the parents (pp 175-176). King (1976 in Marshall, 1982) discusses rejection, the wish to punish and appeasement-identification as three particularly important countertransference reactions to violent adolescents, while Pinchon-Riviere (1952, in Marshall, 1982) cites competition with the mother, stealing the child from the mother and pregnancy envy.

Chethik (2000) notes that a common reaction amongst child therapist is fantasies of rescuing the child. The child's vulnerability evokes a wish to parent and protect the child from the "bad parent". Feelings of helplessness in response to the child's dependency on his parents, are also common. Chethik also observes that the child's acting-out can provoke strong feelings of anger in the therapist.

In his discussion of the countertransference with ego-impaired children, Schiffer (1984) cites the following difficulties the therapist must navigate in work with such children: the anticipation of children's impulsive behaviour and the management of countertransference reactions to very provocative behaviour, and linked to this, the need to comprehend the etiology of the children's problems, through maintaining a non-defensive attitude to countertransference reactions, and to devise interventions that are markedly different from those usually used in play therapy.

2.6.4 The countertransference with children facing death

Lattanzi-Licht (1991) notes that the caregiver's personal beliefs, values and life experiences that call them to work with terminally ill children, are often protective factors in dealing with its emotional demands. Citing research she conducted with nurses in hospitals in England and Canada who said, for example, "this work teaches you to contribute" and that work with the dying meant "refocusing my own life" (1991, p.301), Lattanzi-Licht emphasises the rewards of this work. She notes there is a great source of inspiration in witnessing the strength, courage and struggles of the families with which caregivers work: "almost universally, witnessing suffering helps us feel grateful for our own blessings" (1991, p.301).

> "Caring for others has a way of clarifying and ordering our own values. We have the opportunity to develop a sense of patience that allows people room to live and die in their own way. There can also be a growing sense of humility at our own lack of control in situations, coupled with a sense of honesty toward our own limits and struggles. And work with dying children and their families helps us develop a sense of trust in the ways families deal with difficulties and distress, handling problems together the best way they can" (1991, p. 302).

However, Vachon & Pakes (1984) discuss how the caregiver's motivation to work with the dying may lead to stress reactions: "Choosing the work to resolve past losses, to relieve feelings of guilt, because of a special sense of calling, to prove that one can care for the dying better than others cared for one's dying relative, or in order to do research on the disease or disorder that caused the death of a family member" (1984, p169) are all motivations that, according to the authors, may put the caregiver at particular risk in situations which thwart these intentions and threaten to upset personal equilibrium.

Lattanzi-Licht (1991) notes that professionals working with dying children will experience some of the feelings experienced by the child's parents. Witnessing the suffering of the child may give rise to great anguish linked to feelings of vulnerability and insignificance, helplessness and powerlessness. She also mentions identification with the child and grief related not only to the potential loss of a relationship with the child, but also in relation to the unfulfilled potential of the child's life.

In her discussion of the professional challenges of this work, Lattanzi-Licht (1991) emphasises the importance of the professional maintaining a clear definition of her role and hence appropriate boundaries with the child and his or her family. Secondly, Lattanzi-Licht discusses the importance of the professional realising her personal limitations: "Unrealistic expectations and grandiose feelings of indispensability are a prime source *and symptom* of distress (1991, p.298. my emphasis). The consequences of the professional exceeding her resources and ability to cope are symptoms ranging from dissatisfaction to a diminished sense of self. Others include a loss of perspective resulting in small concerns becoming obstacles, or an exaggerated sense of self-importance; heightened emotionalism; decreased tolerance that manifests as irritability, criticism and complaining, along with decreased productivity; emotional distancing; feelings of depersonalisation; depression and a diminished sense of self.

Death has a particularly negative valence in medical science. The death of a child threatens the doctor's sense of omnipotence and this may manifest as feelings of frustration, anger and depression (Benkhe et al, 1984). In a similar vein, Vachon and Pakes (1984) understand anxiety, frustration and guilt in caregivers at the death of a patient in terms of the frustration of

gratification that those in the healing professions come to expect from caring for patients that get better. When the reality of death, and hence our human condition, is denied, death is experienced as a failure, with potentially negative effects for the practioner and his relationship with his patient. However, when the positive aspects of death are valued, helplessness in the face of death and the pain of loss are more tolerable. Receptiveness to the pain of bereavement is a protective factor for the professional's mental health as well as an essential aspect of a helpful relationship between the terminally ill child and the professional.

2.6.5 Summary

The literature on the countertransference with children emphasises difficulties that are peculiar to working with children. These include not only the intensity of the child's affects, the ready availability of primitive material and the relatively weak nature of the child's ego, but also the widespread discomfort amongst therapists to discuss the countertransference elicited in working with children. Literature on the countertransference with terminally ill children emphasises the therapist's personal history of bereavement as a potential source of enrichment and vulnerability in her work with these children, and the reward associated with the work. The importance of the therapist working through her feelings about her own mortality has also been emphasised. Finally, a cursory discussion of the physician-patient relationship has been presented in order to highlight how defensive omnipotent mechanisms can have negative therapeutic effects for patient and practitioner.

2.7 Emotional reactions of those working with persons with HIV/AIDS.

2.7.1 Introduction

While a significant body of research has been developed over the last twenty years examining the impact on professionals of those working with people infected and affected by HIV/AIDS, this has mostly been confined to medical and paramedical workers in hospital, clinic and hospice settings in the West. There have been a few studies exploring the emotional impact of this work on social workers (for example, Wiener & Siegel, 1990; Dhooper, Royse & Tran, 1987-88 in Wiener & Siegel, 1990; Dunkel & Hatfield, 1986) and even fewer undertaken in the local context (see for example Demmer, 2006).

Much of the literature on the emotional responses of those working in the field of HIV/AIDS care has grown out of research on burnout suffered by professionals and volunteers working with AIDS patients and is written from a western, mainly American context in the early stages of the pandemic, when it was largely restricted to men engaging in male-to-male sex. This literature is therefore limited in its relevance for healthcare workers in South Africa where the disease has progressed along the lines of social inequality (Demmer, 2006). Further, some of the research documenting burnout in workers in the western context has been criticised as emotive, relying on anecdote and speculation, lacking rigour and validity and therefore presenting recommendations rooted in hope rather than in proven experience or empirical research (Miller, 1996). There are also significant differences in the conceptualisation of terms relating to burnout research from those relating to countertransference research,

resulting in limited applicability of findings from burnout research for a study on the countertransference. What follows is a brief review of the literature on burnout in the field of HIV/AIDS care and the emotional impact on social workers and voluntary caregivers of working with HIV/AIDS sufferers. The terms 'care workers' and healthcare workers' have been used interchangeably and refer to volunteer and professional caregivers and professional medical (doctors, nurses and paramedical staff) and mental health workers (mainly social workers).

2.7.2 The unique burden of care generated by HIV/AIDS

A number of authors have pointed out that work in HIV/AIDS generates a unique burden of care (Miller, 2000; Moreland and Legg in Miller, 1996). Others (Kleiber, et al in Miller, 2000) maintain that while the burdens of care have not yet been proven unique, the media attention given to potential for stress in this context, has been. In this regard, Miller (2000) maintains that the high profile given to the HIV pandemic by the media, due in some degree to stigma and fears associated with myths about transmission and contagion, has functioned to compound the stress of working with those who have contracted the virus.

Van Dis and Van Dongen (1993 in Miller, 2000) suggest that the following issues are unique to AIDS care: i) secondary stigmatisation of working with a stigmatising disease, ii) identification with and emotional involvement with clients who may share the carer's sexual orientation, iii) the absence of a cure for HIV and the terminal nature of the disease, iv) the intensity of the pandemic and the high number of infections, v) fears of contagion, and vi) exposure to death and dying.

2.7.3 Personal predispositions of professionals working with those with HIV/AIDS

Idiosyncratic responses by nurses, doctors and paramedical staff to care of those with HIV/AIDS is noted by some authors (Miller, 1996; King, 1993). In their discussion of the emotional impact on doctors of caring for people with AIDS, Vaillant et al. (in King, 1993) note the high incidence of suicide and substance abuse in medical doctors generally, and comment that "psychological disorder among doctors is often related to early life problems and adjustment prior to professional training" (King, 1993, p.135). "It would seem", the authors go on, "that people are drawn to work in a specific field because they identify personally with the needs of patients who suffer from that disorder" (p. 137).

Miller (1996) states that burnout amongst professionals in the field has increasingly been found to be a function of denial of the health worker's emotional needs while continuing to give care to others. For example, clinical psychologists have been found to face considerable obstacles to admitting and responding to occupational stress, including the threat of lost credibility, lost equality with 'well' colleagues, lost job security and the fear of becoming a client (Walsh, 1990 in Miller, 1996). In contrast, it has been found that therapists with a high capacity for empathy towards their patients and clients have a corresponding openness to their countertransference (Peabody and Gelso, 1982 in Dunkel and Hatfield, 1986) with the result that signs of impending burnout are recognised and appropriate steps taken.

2.7.4 Fear

Fear of contagion, fear of social contamination and discomfort with the sexual dimension of AIDS are common reactions amongst health workers (Bennett, 1992; Cooke, 1986 in King, 1993; Eakin and Taylor, 1990 in Miller, 2000). Miller notes that although advances have been made in understanding the mechanisms of and risks associated with contagion since the outbreak of the epidemic in the 1980's (particularly the fragility of the virus), fears of contagion remain persistent and widespread. For example, research conducted by Horsman and Sheeran in 1995 (in Miller, 2000) in the United Kingdom, revealed that 52% of nurses felt that patients should be routinely tested for HIV on admission, and 19% of nurses felt that HIV-positive patients should be isolated in hospital. Stigmatisation of AIDS patients amongst healthcare workers was particularly pronounced in the early stages of the pandemic. For example, physicians interviewed in the late eighties and early nineties believed that AIDS patients were more responsible for their condition, more deserving of what had happened to them and less deserving of sympathy and understanding (Kelly *et al,* 1987 in Wiener & Siegel, 1990).

2.7.5 Stigma and discrimination

Stigma has been found to be a significant stress-producing factor in HIV work (Bennett *et al,*1991 in Miller, 2000). Horsman and Sheeran (1995 in Miller, 2000) attempt to explain health care workers' amplification of the risks associated with working with AIDS patients and the resulting heightening of occupational stress, as an effect of social contagion (referred to elsewhere as 'secondary stigmatisation', for example, Bennett *et al*, 1996) related to the

stigmatisation of the disease. The association of HIV/AIDS care with marginalised and stigmatised social groups negatively affects perceptions of health care workers in this field, not only in the work place but also in their personal and social relationships (Miller, 2000).

Cooke's (1986, in King 1993) research findings reveal that the stigmatisation around the disease introduces new strains into the relationships between caregivers and their families, friends and partners. For example, 66% of physicians said their family expressed concern about their involvement in the treatment of AIDS patients (Bresolin *et al*, 1990, in Miller, 2000) and 41% of health staff said they had received negative comments about their HIV/AIDS work, mostly from family and friends (Barbour, 1995, in Miller, 2000). Although Wiener and Siegel (1990) found a higher proportion of support (57%) among family members of social workers doing AIDS work, this respondent group nevertheless reported that family anxiety or anger about their AIDS work remained a significant source of discomfort for them. Negative attitudes have also been reported from colleagues, with nurses in Sydney, for example, reporting negative remarks and discrimination in the work place (Bennett, 1992a, in Miller, 2000).

Fears of social contagion have been reported in studies examining doctor's perceptions of the impact on their clinical practices of treating people with HIV and AIDS (Bredfeldt et al, 1991,Taylor et al, 1990, both in Miller, 2000). Reluctance to be known to be treating these patients has been associated with the fear of attracting unfavourable presumptions about sexual orientation and morality. This association has also been found in a comparative study of nurses in the United States and Zimbabwe (Munodawafa *et al*, 1993 in Miller, 2000). 30% of the nurses in the United States feared that they would be seen as gay if they contracted

HIV/AIDS, while 74% of those in Zimbabwe had concerns that others would think they were prostitutes. Based on these findings, Miller (2000) suggests that fears of social contagion are founded on prejudice against homosexuals, sex workers and injecting drug users. In this regard it is unsurprising that homophobia and negative moral attitudes were reported as significant countertransference reactions in social workers who work with persons with AIDS (Dunkel and Hatfield, 1986; Wiener & Siegel, 1990).

2.7.6 Relationships with patients and their families

The long-term nature of the condition, characterised by multiple, episodic periods of acute illness requiring hospitalisation, results in staff forming intense, long-term relationships with their patients and their patients' families (Bennett *et al*, 1996; Morin & Batchelor, 1984 in Miller, 2000). The development of these intense relationships has been understood by some researchers as the provision of compensation, on the part of the health care worker, for the therapeutic limits of care for AIDS patients (Visintini *et al*, 1995, in Miller 2000). The emotional attachment of staff to their patients makes it particularly distressing for staff to observe their patient's decline, particularly when neurological features such as dementia are implicated (Ross & Seegar, 1988; Miller, Gillies and Elliott, 1996 in Miller, 2000).

Miller and Gillies (1996, in Miller, 2000) identify managing the distress of relatives as a major source of stress for HIV/AIDS staff. In research done in Scotland, health workers reported that having to provide psychological support to relatives of the patient was the most demanding aspect of the work (Barbour, 1995 in Miller, 2000). Cooke's (1986, in King 1993) research findings reveal difficulties around adherence to strict codes of confidentiality. Health

workers may be placed under enormous pressure to maintain divided confidentialities and loyalties and may become ready targets of attack when these go awry.

Miller (1996) notes that patient care and the relationships that care workers develop with their patients paradoxically also give the greatest occupational satisfaction. 36% of nurses in a study by Brennan (1988, in Bennett *et al*, 1996) reported that they experienced their friendships with their patients as emotionally rewarding. Demmer (2006), in researching the effects of AIDS work on professional caregivers in KwaZulu-Natal, found that it was their relationships with their patients and the families that was experienced as the most rewarding aspect of the work. In this regard, the caregivers cited the following as sources of work satisfaction: providing non-judgemental care to a stigmatised population, establishing relationships with their patients, providing comfort and support, providing education and helping family members and friends.

The relationship with the patient has been found not only to buffer the stress of working with persons with HIV/AIDS, but also to increase this stress. Identification with the patient (usually on the basis of sexual orientation) can make the care worker vulnerable to profound emotional distress. An increased fear of death was reported in a significantly higher number of care workers identifying themselves as gay or lesbian than in heterosexuals. This result was associated with self-identification of possible risk for HIV, as well as with gay patients for whom no cure could be offered (Horstman & McKusick, 1986 in Miller, 2000). Dunkel and Hatfield maintain that overidentification with the patient results in the fusing of the personal needs and professional responsibilities of the worker, in extreme cases generating symptom formation. However, identification with the patient population has also been found to be an important source of reward. For example, gay male nurses working in the field reported a

sense of new-found freedom from prejudice and secrecy and described how their close affiliation with patients enhanced their status with colleagues and carers (Bennett, 1992a in Miller, 2000). Studies on gay HIV/AIDS volunteer workers reveal an enhanced sense of belonging to the 'AIDS cause' and the consolidation of a positive gay identity associated with doing something for the 'gay family' (Maslanka, 1996 in Miller, 2000).

2.7.7 Anxiety about death

Fear of death and dying has been found in numerous studies (Maylon and Pinka, 1983 in Wiener and Siegel, 1990; Cooke, 1986 in King 1993; Dunkel and Hatfield, 1986). The highly fatal nature of the disease, coupled with intense relationships with their patients, activate high levels of anxiety about dying amongst care workers.

Dunkel and Hatfield's (1986) research with social workers found fear of the unknown and fear of contagion to be closely linked to fear of dying and death. Although this research was conducted in the early stages of the pandemic, before the means of transmission of the virus were confidently known, the fear of death has also been a recurrent response in later research, suggesting that this reaction may be linked less to a realistic risk of contagion than to the psychological impact of witnessing death, particularly when it is the untimely death of a young person.

Demmer's (2006) research on professional caregivers in KwaZulu-Natal found that continual exposure to death and dying raised participants' anxiety about death. One participant reported that she felt like she was "living in a ghost world – the world of the living dead"

(Demmer, 2006, p.103). Interestingly, these participants also reported that few of their clients were receptive to grief counselling, preferring, after the death of a family member, to focus instead on the day to day struggle to secure food in the face of extreme poverty. Demmer maintains that a culture of delayed grieving has come about in an attempt to cope with high rates of fatality and the implication for organisations providing care to AIDS sufferers is the imposition of rigid boundaries against mourning. This leads to professional caregivers experiencing high levels of displaced anxiety such as fear of dying in a bus crash on the way to work. Demmer found that religious faith is an important coping mechanism for these caregivers.

Working with the terminally ill challenges careworkers and other professionals to deal with their feelings about pain, illness and confront their own mortality (Glass & Hastings in Demmer, 2006). Dane and Miller (in Demmer, 2006) maintain that careworkers in the field of HIV/AIDS are often uncomfortable talking about death and have as much difficulty accepting the reality and finality of death as do other people, death being associated with loneliness, fear, loss of identity and a sense of rootlessness. As a result, caregivers are often chronically traumatised by the work (Garfield in Demmer, 2006) and this may act as a barrier to providing appropriate and humane care (Demmer, 2006). In these instances, caregivers may develop professional detachment by seeing their patients as different to themselves, or deny the personhood of the person who is dying as a way to avoid thinking about their own vulnerability to death (Dunkel and Hatfield, 1986).

The terminal nature of the disease and the absence of a cure provoke feelings of helplessness in care workers (Dunkel and Hatfield, 1986; Bennett, 1992 in Demmer, 2006;

Grossman and Silverstein, 1993; Bennett, Miller and Ross, 1995 in Miller, 2000). Dunkel and Hatfield (1986) discuss how a denial of helplessness can be an adaptive defence by maintaining hope for the AIDS patient and for the effort to find a cure. On the other hand, denying helplessness can result in the utilisation of omnipotent defences whereby the worker exercises magical thinking in an attempt to gain control of the situation. When this fails, profound feelings of guilt and personal failure can arise, with negative consequences for the quality of care provided.

In this respect Behnke et al's (1984) discussion of the social and personal factors that influence the paediatrician's response to the death of a child patient, is illuminating. Citing social expectations that doctors achieve a complete cure of their patient's illnesses, the authors emphasise that on the death of a patient, the paediatrician may experience profound feelings of failure. Allied to social expectations of doctors' presumable powers over death are doctors' unconscious fantasies of themselves as omnipotent. Inevitably the experience of the death of a patient reminds the doctor that they have only limited control over their patients' health. The authors maintain that when conceptions of the power of medical science to conquer suffering and delay death are disappointed by reality, "death becomes the enemy that is unconquerable, and its positive aspects are no longer valued" (ibid. p.70). The resulting effect on the doctor may include despair, a sense of meaninglessness, lack of empathy towards patients, exhaustion and burnout, particularly when the patient is a child. Unable to resolve the death of a patient, the doctor may protectively distance herself from her patient, seeing him as an interesting clinical problem instead of as a human who is dying. In this case the doctor may exhibit no reaction following the death of her patient or profound

emotional turmoil characterised by rapid oscillation between withdrawal, anger and over-involvement.

2.7.8 Bereavement overload

Bereavement overload has been widely reported amongst those caring for HIV/AIDS patients (Dunkel and Hatfield, 1986; Ross and Seeger,1988, in King, 1993; Piemme and Bolle, 1990 in Miller, 2000). In particular, the young age of those dying from the disease has been reported as a significant source of stress for care workers (Ross and Seeger, 1988 in King, 1993). The scale of the epidemic in the 1980s and early 1990s in the West resulted in high numbers of patient deaths, and care workers reported emotional exhaustion from the psychological burden of caring for those with a terminal illness, and unrelenting bereavement. Demmer (2006) maintains that since the widespread use of antiretroviral medications in the West and the resulting prolongation of the lives of those who test seropositive, there have been fewer studies into the effect of ongoing bereavement on care workers. However, Demmer points out that the reality in the developing world, South Africa in particular, is very different, with care workers continuing to be exposed to ongoing fatalities.

Multiple loss of patients and bereavement within the peer group takes a psychological toll on health workers, resulting in feelings of being unable to 'escape' from work, distrusting colleagues and experiencing diminished problem-solving abilities (Miller, 1996). King (1993) notes that the results of these sorts of pressures on caregivers may be "psychological distress leading to over-identification with patients or neglect of their normal care, evasion of emotional issues, avoidance of dying patients or hypochondriacal fears of infection (p.134).

Care workers may also become the targets of the displaced grief of friends and family of the deceased (Cooke, 1986 in King, 1993).

Wiener (2005) emphasises that bereavement overload in healthcare professionals can be mitigated if the professional can maintain a balance between identification, personal investment and emotional detachment.

2.7.9 Anger

Grossman and Silverstein (1993) discuss the anger felt by social workers in relation to their work with people living with AIDS. Anger towards colleagues who discriminate against people with AIDS and who are homophobic are common reactions, as is anger towards clients who continue to engage in risk taking behaviour. The authors also report that anger is directed at colleagues who are HIV-positive and do not share this information until the disease can no longer be hidden. However, the authors also note that when a social worker discloses his or her positive status to colleagues, this generally precipitates at crisis at the work place and a heightening of tensions.

Shaw (1992) mentions anger at God and the world and the tendency to attribute blame as common countertransference responses of psychotherapists working with those living with HIV/AIDS. Dunkel and Hatfield (1986) maintain that anger may arise due to feelings of helplessness, fear and guilt and may result in 'blaming the victim'. Anger towards the client may provide a protective distancing but may also lead to irrational, explosive and unpredictable behaviour towards the AIDS sufferer and the blocking of empathy. The authors

stress that anger primarily serves to defend against grief and caution against misdirecting it as outrage towards institutions and individuals who appear to promote moral and political obstacles to humane and effective treatment of those with HIV and AIDS.

2.7.10 Guilt

A guilt response to those with HIV/AIDS has been reported amongst nurses working with children (*Saturday Star*, 16 October 2002) and is associated with non-disclosure of the child's HIV positive status to him or her. Survivor guilt, while frequently reported amongst friends and families of those who have died of AIDS (Teguis, 1994; Maasen, 1998; Demmer, 2004) has however not been mentioned in connection with care workers treating AIDS patients.

2.7.11 Rewards

Reward associated with caring for those with HIV and AIDS has been found to be an important buffer against stress and burnout (Bennett, Ross and Sunderland, 1996; Miller, 2000; Demmer, 2006). Amongst doctors, it has been found that AIDS care management and its problems promotes a sense of professional identity, or *communitas*, and the intellectual stimulation derived from the work acts as an important source of reward. Voluntary and professional care givers and social workers report that gratitude and appreciation for their care, expressed by patients through positive feedback is one of the main rewards of doing the work (Bennett *et al,* 1996, Demmer, 2006). The sense of 'making a difference' is an effect of positive patient feedback and contributes to ongoing motivation to do the work. Haines (1987 in Bennett *et al,* 1996) and Demmer (2006) describe the reward of experiencing this

work as a form of spiritual and emotional growth. Relationships with patients and their families and the sense of making a contribution for 'the gay family' have also been mentioned as sources of reward, as previously discussed in this review.

2.7.12 Summary

This review illustrates some of the differences and similarities between respective conceptualisations of the countertransference and burnout. Burnout can be considered the behavioural manifestation of a constellation of regressive countertransference responses, including denial, rage, rescuing, helplessness and despair and is thus only one possible dimension of the countertransference. The studies reviewed above have as their focus the negative impact of the work on professionals with a view to developing strategies to maximise productivity at the workplace (Miller, 2000), but does not explore the psychic dynamics that underpin the phenomenon, and it is therefore limited in terms of its contribution to the proposed research topic. Further, it maintains exclusive focus on professionals' experiences, largely in isolation to understandings of the implications for their relationships with patients. An exploration of the countertransference begins from a somewhat different starting point. The value of examining the countertransference lies in the possibilities for greater insight into the emotional challenges for therapists of working with HIV positive persons, with a view to enhancing therapeutic engagement with patients. Such a study therefore addresses itself to the intrapsychic and interpersonal dimensions of the therapist-patient relationship.

CHAPTER THREE: RESEARCH METHOD

3. 1 Aim of the Research

The aim of the research was to investigate the totality of the therapists' emotional responses and their defences against them (the countertransference) in their work with groups of children with HIV/AIDS, in order to better understand the emotional challenges of working with this vulnerable group, and the implications of these for the therapeutic process.

3. 2 Research Questions

Research questions were open-ended and exploratory:

1. What emotional responses and associated behavioural manifestations stand out for therapists in reflecting on group work with HIV positive children?

2. What sense do therapists make of their emotional and related behavioural responses to this work?

3. How do therapists' emotional and related behavioural responses appear to have impacted on the work of therapy?

3. 3 Research Design

As the aim of the research was to explore the emotional experiences of the participants and the meanings they attach to these experiences, the research was suited to a qualitative design. This design is suitable as qualitative methodologies are concerned with developing an account of networks of meanings and relationships, rather than the testing of hypotheses or the establishment of causality, as per quantitative research (Neuman, 1997). Further, qualitative research, with its emphasis on self-reflection (Shotter, in Henriques, Hollway, Urwin, Venn and Walkerdine, 1984) is well suited to explore subjectivity, defined by the Oxford Concise Dictionary of Sociology, as "the self-conscious perspective of the person or subject" (Marshall, 1994, p. 519). Questions relating to the countertransference are intimately associated with issues of subjectivity (Ogden, 2004).

The ontological assumptions that underlie the research aim are critically realist, according to the distinctions made between various ontological stances by Ritchie and Lewis (2003). A critical realist stance assumes that an external reality exists that is independent of our beliefs and understandings about the world but that this reality is only knowable through socially constructed meanings. Thus, the emotional experiences of participants working with HIV positive children are assumed to exist external to and independent of the researcher, but these experiences are organised into meaning-systems or schemata that are subjectively constructed by the participants. Critical realism is situated within a philosophical tradition that privileges the notion of the "epistemological third" (Hanly, 2004) and therefore resonates with current psychoanalytic theories about the analytic third (the transference-countertransference field). The idea of the analytic third is also underpinned by a critical realist ontology as it

expresses an interplay between the intersubjective co-construction of meaning and the subjective interpretation of this intersubjective relationship, both of which are ultimately referenced to an objective reality (Green, 2004; Ogden, 2004). There is therefore a concordance between the ontological assumptions underpinning the research aim and those underpinning the methodology.

The epistemological assumption that derives from a critical realist stance is interpretivism. Interpretivism assumes an interaction effect between the researcher and the social world and is concerned with exploring and understanding the social world using both researcher's and participants' understandings (Ritchie & Lewis, 2003). Henning (2004) emphasises that the role of the researcher in an interpretivist framework is that of a co-creator of meaning. The assumptions of the interpretivist frame are that the researcher's observation is fallible and that all theory is revisable. Theory is therefore thought of as metaphor, rather than as scientific truth, which represents a substantial deviation from the positivist framework. The goal of interpretivism is to construct reality through a number of different viewpoints acquired through different processes of observation. Observation here is not meant in the positivist empirical sense of privileging observer neutrality and objectivity, but rather refers to an engagement by the researcher with a diversity of information, such as the individual's description of her or his "intentions, beliefs, values and reasons, meaning-making and self-understanding" (Henning, 2004, p. 20), and in which the researcher foregrounds her complicity in influencing the outcome of the research (Kelly, 2006).

Thematic content analysis is one of the methodologies in the interpretivist stable and has been selected as the methodology with which to analyse the research findings. Thematic

content analysis enables the researcher to engage with the data in a cyclical process of decoding and encoding in order to draw out networks of possible meaning (Guba and Lincoln, 1985), while rooting the analysis in the lived experience of the participants (Kelly, 2006). One of the methodological implications of an interpretivist stance is an emphasis on the "capture of insider information" (Henning, 2004, p.20), in keeping with the interpretivist epistemological assumption that reality is known only through subjective perception. In-depth interviews were used to gather data, and this method is well-suited to the research aim as it permits and facilitates participants' expressions of their experiences, feelings, meaning-systems, values and beliefs.

3. 4 Sample

As the aim of the research was to conduct an in-depth investigation into the full range of therapists' emotional responses and related behavioural manifestations, purposive sampling ensured that respondents were selected who were particularly informative and therefore could provide meaningful information with which to address the research questions (Ritchie & Lewis, 2003). This sampling method was also chosen as the target population is a specialised one (therapists working in a particular way with a very specific patient/client) and therefore somewhat difficult to reach (Neuman, 1997).

In accordance with the methodology (as described by Neuman, 1997), participants were found by: i) utilising the judgement and expertise of a therapist already known to the researcher and who is experienced in doing group psychotherapy with HIV positive children, and ii) by making contact with care centres for AIDS orphans and the paediatric and

psychiatric departments of state hospitals in Johannesburg and Cape Town in order to identify individuals doing group work with HIV positive children. Five individuals agreed to participate, two of which were identified through the expertise of the therapist known to the researcher (who also participated), while two others were found through the researcher's endeavours. All participants were white females.

Participants were selected in terms of their experience in conducting group psychotherapy with HIV positive children. Participants were diverse in terms of their training: three were art and/or drama therapists working from a creative arts model and two were clinical psychologists. All of the participants had run groups with HIV positive children using a broadly psychodynamic approach.

3. 5 Data collection

In-depth, open ended interviews were used to capture "insider" knowledge (Henning, 2004, p. 20) and they yielded rich and nuanced data. The flexibility afforded by a loose, exploratory and open-ended interview protocol facilitated the eliciting of a range and depth of feelings, perceptions and memories (Lewis, 1979) and was therefore well-suited to exploring the emotional responses of the participants and the meanings they attached to them.

One participant made herself available for a follow-up interview and six open-ended interviews were therefore conducted. Participants were interviewed in their homes or in private at their places of work. Interviews were recorded and lasted approximately an hour

and a half. The interview material was transcribed for analysis and is included in Appendix seven.

A loosely structured interview schedule was used (see Appendix 4) to facilitate a broad focus on the research questions while limiting, as much as possible, prior assumptions of the researcher (McLeod, 2004). The schedule consisted of a few open-ended questions, the intention being to facilitate a spacious and free-flowing interview in which participants could speak about what was important to them and have the opportunity to reflect in an unpressurised manner on their emotional responses and the meanings attributed to them. In many of the interviews, participants talked about and reflected on specific responses for the first time, and in these instances the interview itself became a vehicle for meaning-making, as previously unconscious reactions came to light. As a result of this, the interviews were often an exploration in which the participant and the researcher were jointly engaged, and resembled conversations (Henning, 2004) rather than standardised interviews.

Kvale (in Richie & Lewis, 2003) uses a traveller metaphor in which the in-depth interview is likened to a journey taken by two companions, one the interviewer ("the traveller") and the other the interviewee. "The meanings of the interviewees' stories are developed as the traveller interprets them" (2003, p.139). Central to this metaphor is the notion that knowledge is not transmitted "like water down a pipe-line" (ibid.), but is created and negotiated. The interviewer participates in a particular kind of "transformative" conversation with the interviewees: "The traveler ….. asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of *conversation* as 'wandering together with'" (Kvale, 1996, cited in Richie and Lewis, 2003, p. 139).

The conversational nature of the interviews resulted in a process of co-construction of meaning, in keeping with the methodologies of the interpretivist paradigm. In this process of meaning-making, both participants and the researcher engaged with their emotional responses - the participants reflected on their emotional reactions and their associated behaviours in relation to their work with the groups of children, and the researcher engaged with her own emotional responses to and intuitive understandings of the participant's account. This process demonstrates the interpretivist observation that the qualitative interview is generative, as new thoughts and knowledge are created during the process (Ritchie and Lewis, 2003). For an example of this, see the interview with J, Appendix 8, pp 267 - 268.

Individual interviews were chosen over using a focus group because it was felt that the sensitive nature of the information requested by the researcher may probe vulnerabilities in the participants during the interview process. Requesting that participants expose themselves on a matter difficult to talk about at the best of times (Marshall, 1982), in front of strangers in a group setting, may have been experienced as threatening (Pines & Schermer, 1994), whereas a one-on-one interview could provide the confidentiality, containment and sensitivity required to explore difficult feelings in a manner that compromised neither the dignity of the participant nor the quality of the data. Notes were taken by the researcher after some of the interviews on possible themes and significant material. These were incorporated into analytic memos and functioned to facilitate creative thinking around interpretation of the data.

3.6 Data Analysis

The research method considered best suited to meeting the aims of the research is Thematic Content Analysis as it is underpinned by a critical realist ontology. Further, as a hermeneutic methodology, it facilitates the interpretation of the data, in contrast to phenomenological approaches that are limited to descriptive accounts. As the countertransference is a derivative of the unconscious, the data yielded in this study is rendered meaningful through an interpretation of its possible unconscious meanings. Hence the applicability of thematic content analysis to the aims of the study.

Ragin (in Neuman, 1997) states that qualitative methods are data enhancers with the aim of illustrating key aspects of cases more clearly. Henning warns against using a thematic content analysis to produce "superficial and naively realistic" (Henning, 2004, p. 102) findings through merely collating the data as "a set of systematised empirical items" (ibid.). Holliday (in Henning, 2004) refers to this as "thin description" which "simply reports facts, independent of intentions or circumstances" (ibid. p.104). Henning emphasises the importance of "interrogating" (ibid.) the data through a process of systemising, organising and rationalising the data in a way that *changes* the data. The data is "worked" (ibid. p.105) in the process of building the interpretive text.

The implication of this for the research in question is that a collation and summary of the participant's emotional responses, behavioural manifestations and the meanings they make of these represents only the descriptive stage of the analytic hierarchy (Ritchie and Lewis, 2003). In order to work the data and therefore arrive at an interpretation, or what Ritchie and

Lewis (2003) call the explanatory stage, a deeper level of meaning has been constructed through explicit reference to psychoanalytic concepts upon which the researcher's understanding of the data has been based. This method in which analysis of the data is informed by the researcher's psychoanalytic understanding has previously been used by Reid (2003) in her research on "replacement children". While Reid ensured the validity of her findings by means of triangulation that chiefly involved checking her analysis of therapy sessions with a supervising psychologist and against the patient's history, these means have not been available in the present study. Therefore, care has been taken to root explanation in the participants' experiences and to this end, extensive use of quotations has been made.

Prior to the first stage of analysis, the data was converted from verbal to written format by transcribing the recorded interviews. The first stage of analysis comprised of reducing the data through a process of encoding (Guba & Lincoln, 1985). Henning (2004) maintains that line by line coding runs the risk of fragmenting the material with a resultant loss of meaning. As meaning is developed through a network of associations that do not exist in a linear relationship to each other, she advocates coding the data in chunks. Each interview was therefore divided into paragraphs containing one or two interlinked themes. Only those parts of the data that related specifically to the transference-countertransference were coded.

The following aspects of the data were considered when coding: i) the expression of affect and related behaviours in the countertransference; ii) the child's circumstances and related expressions of affect and behaviour in the transference; iii) the meaning the participant attaches to the transference-countertransference and iv) participant's account of the impact on therapy. Contextual information relating to how the groups are constituted, the purpose of

the group, its duration and the number and ages of children in the groups, etc. was not analysed, but merely collated and has been presented as background information about the groups in chapter four.

Participants spoke about the transference-countertransference in an interconnected and organic way, providing a circular or spiralling retrospective account that did not assume a linear narrative. Indices of the countertransference were interconnected with and interdependent upon each other – the behaviour of the child, the participant's memories of her own childhood, the feelings that came to the fore in the interview, and more rarely, the meaning the participant made of these feelings and her awareness of how they impacted on the therapy.

From a thorough reading of each interview, units of meaning were assigned codes that covered the substantive content (reported feelings, attitudes, behaviours, motivations and views of the participants) (Ritchie and Lewis, 2003) and kept closely to the words of the participants. In this way, initial codes were anchored in the data by reflecting the words of the participants as much as possible, according to Ritchie and Lewis' (2003) exhortation that the actual words used by participants must be reflected in order to illustrate i) how a phenomenon is conceived, how important it is, the richness or 'colour' it holds, and ii) nuances in perspective and description in the content of the participant's account. Some examples of the codes that were developed include 'therapist's vulnerable child part', 'possible to be vulnerable and okay' and 'separate from child vs enmeshment'. Formulating codes by using the language of the participants served to replicate participants' own constructs, thereby rooting thematic construction in participants' lived experiences (Kelly, 2006).

Coded data was arranged into thematic categories through reference to the theory. The thematic categories identified key dimensions and mapped the range and diversity of each theme (Ritchie and Lewis, 2003). For example, the code cited above, 'separate from child vs enmeshment' was grouped under the heading, 'awareness of fusion' with similar codes from other transcripts such as 'unravelling what's yours and what's theirs', 'hard to distinguish mine from theirs' and 'voicing my feelings or theirs'. This subtheme was placed in the thematic category 'containment and holding' in accordance with Kernberg's (1984) theory on 'working through' identifications in the countertransference and Bion's concept of how containment enables thinking, as opposed to enmeshment. This analysis reflected the participants' own understandings of the relationships between containment, thinking and awareness of fusion and therefore represent the descriptive level. For example, L is asked to talk about her reflection that it was important for her to work with her feelings of needing to save the child. Her response reflects her understanding of the relationships between thinking and witnessing, awareness of enmeshment and containment. She replies:

> Basically what I was meaning was using my therapeutic powers in not colluding, just to keep some kind of space, that I was there as a kind of individual, not to be emotional, because I can be very emotional, not all consumed by my sadness (while watching the little girl draw her dead mother), but to remain as the someone who would be the container as well. That was important for them to have.

Once thematic categories had been constructed they were applied again to the raw data to see if they were plausible descriptors (Ritchie and Lewis, 2003). This process generated a descriptive level of analysis which served to organise the data so that it could then be thought about at the level of explanatory analysis.

As the participants are not naïve informers, but are well-versed in the psychodynamic discourse on the countertransference, there were times at which they interpreted their countertransference responses through the discourse of psychoanalytic language. For example, C interpreted the "rage" she experienced, while watching a child in the hospital die of AIDS, partly as the child's projective identification. However, participants' understandings of the countertransference have not just been taken at face value, but have been interrogated in the analysis to present an interpretation which offers a coherent account of the possible unconscious dynamics occurring in the groups to which the participants belonged. This explanation however represents only one possible way of understanding the data.

Further, the participants thought of the countertransference in terms of two models, namely therapist-induced countertransference and patient-induced countertransference. However, a third model for understanding the countertransference has been employed in this study, namely, the 'analytic third'. This concept has utility in bridging intrapsychic conceptions of the countertransference (from individual psychotherapy) and interpsychic conceptions of the countertransference from group psychoanalysis. Thus, the data has been analysed as an oscillating communication of the intrapsychic dynamics of the individual participants, on the one hand, and on the other, as a communication of the interpsychic dynamics to which the participant is subject in her role as a group member. The explanatory level of the analysis thus reflects subjective ('therapist-induced') as well as relational conceptualisations of the countertransference.

While some aspects of the countertransference were highly personal to an individual participant, other aspects were reported in every interview. Further, each

countertransference configuration had its own unique dynamic. This presents a challenge in terms of making findings as the countertransference, in order for it to be rendered meaningful, cannot be stripped from its context, i.e. the interpersonal relationship within which it arose, as well as the unique meanings the participants' attached to their responses. However, to present each countertransference configuration in its totality would provide an excess of description without working the material in any meaningful way to generate new insights about the nature of therapeutic interventions with HIV positive children.

Therefore, a second phase of analysis was conducted and represents the movement from descriptive analysis to explanation. Thematic categories that generated the descriptive level of analysis were thought about at an explanatory level, with reference to the theory. Thus analysis comprised a back and forth movement between induction and deduction. The material has therefore been thought of in terms of the way in which the countertransference functions as a sign of the progressive and regressive psychic tendencies of the groups (Pines and Schermer, 1994).

Conceptualising the material in terms of regressive and progressive tendencies is based on a primary distinction that emerges in the material. This distinction lies on the axis 'disclosed/non-disclosed'. Data from participants facilitating groups in which the children have not had their HIV status disclosed to them reveal a much greater presence of binary oppositions (thought of by the researcher as indicative of defensive splitting), and also contain numerous self-reflections by these participants on the impact of working under the secrecy imposed by a sanction on disclosure to the children of their HIV positive status. Thematic categories relating to secrecy, denial and idealisation of the therapist ('keeping a secret',

'pushing the illness out', 'too good a mother' and 'a mulungu holds the wellness') were generated from the data relating to non-disclosed groups but were strikingly absent from the data relating to disclosed groups (see Appendix 6). These themes were seen to arise in a context of secrecy about HIV and were therefore thought to represent a heightening of the defences against death, particularly idealisation, a trend that was absent in the data from the other groups.

On the basis of this distinction, the data could be thought about as indicating a site of mourning and the differences in the data as indicative of defences against mourning or as signs of progressive movement towards integration. The latter position would be characterised by feelings of grief, sadness, acceptance, hope and an increasing capacity for containment, as opposed to denial, idealisation, omnipotence, rage and despair. This analysis is driven by psychoanalytic theories on mourning and the defences against it, particularly Klein's (1940) theory on mourning.

Defences against mourning were evident in all the groups and must be seen as part of the alternating process of the work of mourning, in which engagement with mourning and defending against it are at any one time in the foreground (Kauffman, 1994). A second level of thematic grouping was therefore generated in which initial themes were placed in one of two categories – regressive tendencies ('defending against death and dying') and progressive tendencies ('engaging with death and dying'). This analysis grew out of an explanation of the various permutations of the participants' countertransference responses as reflecting the group's engagement with (progressive tendencies), as well as flight from (regressive tendencies) mourning, based largely on Klein's (1940) theory of mourning and Kauffman's

(1994) extension of Klein's theory in his understandings of the dynamics of the bereavement group. Hence, 'containment and holding' was placed into 'engaging with death and dying' according to a deductive analysis of containment as essential for an engagement with death and whole object relating and thus, for the work of mourning. Thematic charts are presented in Appendix 6.

At the explanatory level then, a theory describing the possible mechanisms that generate the countertransference responses has been formulated. This theory is naturally one that speaks of the unconscious dynamics of individuals in the context of the group process. Harre (1991) maintains that the descriptive taxonomy finds justification in the explanatory scheme. In this study, the explanatory level serves to excavate sites of mourning from the data, thereby rendering a meaningful description of the countertransference as a representation of the intersubjective-subjective interplay of regressive and progressive tendencies in the work of mourning.

In this research, the explanatory level of analysis has been driven explicitly through deduction from the theory, particularly the psychoanalytic theory on group work (Kauffman, 1994; Pines & Schermer, 1994), the analytic third (Britton, 2004; Green, 2004; Ogden, 2004) and mourning (Freud, 1917; Klein, 1940; Kauffman, 1994). As such, it cannot represent the generation of new theory as per the grounded theory methodology of Glaser and Strauss, but rather the use of existing theory as a lens through which the data is viewed in order to yield one possible way of understanding the material. The data could have been analysed through many other concepts and theories that would have yielded different networks of meaning. The results of this analysis can be thought of as one of many possible versions of reality and

therefore as metaphor, in keeping with the epistemological assumptions that underpin the interpretivist framework in which the research is positioned.

3.7 Ethical considerations

Potential participants were contacted telephonically to invite them to participate in the study and to provide them with details concerning the nature, objectives and process of the research. The Information sheet (Appendix 1) was emailed or faxed to those who requested more information. For those who agreed to participate, an interview time and venue was agreed upon.

Participants were asked to sign their informed consent (Appendix 2) and a guarantee of confidentiality was provided. Participants were informed that they were free to not respond to any question they did not wish to answer, to terminate the interview at any time and to withdraw from the research without detriment to themselves.

Participants were interviewed in private, at a time and a place that suited them. Separate consent to tape the interviews was requested (Appendix 3). Tapes were stored in a filing cabinet in the home of the researcher and will be destroyed on successful completion of the research report. The transcriptions were kept in a filing cabinet in the home of the researcher.

Confidentiality was maintained in the presentation of the data in the following way: Any details that could identify participants were omitted from the transcripts and the final report. While participants were asked to speak in detail about their confidential case material, the

researcher ensured the confidentiality of their clients by omitting from the transcripts and the final report any identifying particulars of clients mentioned in the interviews. As the completed research will be housed in the university library, the public will have access to the analysed data. However, the original list of participants is available only to the researcher and her supervisor.

Participants were told that should they experience the interview as emotionally stressful and feel that they would benefit from receiving emotional support, the researcher would discuss options in this regard with them, including providing them with telephone numbers of psychologists who were willing to make themselves available for consultation. However, after the interviews, none indicated a need for this.

A clearance certificate was received for this research from the Human Research Ethics Committee (non-medical) of the University of the Witwatersrand, protocol number IH61101 (Appendix 5).

CHAPTER FOUR: CONTEXTUALISING THE FINDINGS AND DISCUSSION

4.1 Introduction

This chapter provides a background to the findings and discussion that are presented in chapter five. As such, it presents an introduction to the psychosocial circumstances of the children who attend and a brief overview of the central themes that the children bring to the groups. Finally, the features of group work with the children are discussed in terms of the particular countertransference pressures that are brought to bear on the participants. This chapter finds a rationale in the assertion that a discussion of the countertransference is rendered meaningful by understanding it as a representation of the subjectivity and intersubjectivity that is generated within and through the analytic third (Ogden, 2004). Hence, the children's life circumstances and the emotional themes that they bring to the groups provide the reader with an introduction to the transference component of the analytic third. As the purpose of this chapter is merely to contextualise the findings that are presented and discussed in chapter five, the countertransference responses of the participants are not discussed here, in order to avoid repetition.

The following section provides background information about the children who attended the groups, in order to provide context for the material that emerged in the sessions and the associated countertransference responses of the participants.

4. 2 The children's life circumstances

4.2.1 The families

Children living in the Christian mission children's home

The children in L's groups live in a children's home located in an informal settlement. The home is funded and managed by a European Christian mission. Groups of children live together in self-contained cottages, each headed by a Xhosa-speaking "mama" who is responsible for their care and discipline on a day-to-day basis. The home is also regularly attended by nuns who assist in other aspects of the children's care. Initially twenty children occupied a house, cared for by one "mama", but currently fewer children live together under one roof. As the home is run by a Christian mission, the children follow a routine of religious observance that includes prayer and bible education. They are therefore familiar with Christian iconography such as the crucifixion and the Madonna and child, and concepts such as the resurrection, heaven and hell.

Several times a year international volunteers between 18 and 20 years old come to work at the home for periods of six months to a year, resulting in a pattern of what L terms "serial abandonment" of the children. For many of the children their arrival at the home is their third or fourth placement since losing their mother or primary caregiver. Because the home is run and managed by American and European members of the mission, the primary language at the home is English. Volunteers also converse with the children in English, with the result that many of these children do not adequately consolidate their mother tongue.

The children exhibit high levels of problematic behaviour such as breaking windows continually, pelting stones at passers-by and being physically aggressive towards each other and the caregivers. It is not uncommon for the children to bite another child or adult so hard that blood is drawn. Limit-setting with a disruptive child by sending her to her bedroom has at times resulted in an intensification of the behaviour, with the child destroying her bedding and belongings.

L attributes the children's challenging behaviour to their experiences in the home of repeated abandonment and living in overcrowded conditions in which their nurturance needs were not being met:

> Children needing to have their space and claim their space and have attention. And although the children weren't related to each other, there was a lot of kind of sibling dynamics - they were all living together. In the early days there were 20 living per house and my sense was that the children didn't have a space that was their's. And there was a constant fight to have their own space, to be seen and to be heard and to have attention. And the extraordinary thing about the organisation really was that there were people coming in and out of those children's lives like a train station.

Children attending Hospital A and B

The children that attend groups at the hospitals come mainly from lower-middle class and impoverished families. Often one or several members of the family is ill with AIDS. This may be a sibling and/or one or both of the parents. Many of the children in the groups have lost their mothers to AIDS and fathers are often absent or abusive. Children whose mothers have died are usually being taken care of by the extended family, often a granny or aunt. Some of the children have been separated from their siblings after the death of their mothers.

4.2.2 Multiple losses

Most of the children have experienced multiple losses as many members of their families have died. They are familiar with death, more familiar at their young ages, observes J, than are the therapists they see. Those children whose mothers have died, or are critically ill, are cared for by members of their extended families or placed in homes (such as those in L's groups). Some do not have the benefit of having a primary caregiver, having instead to continually move between different members of the family.

Children whose mothers have died are vulnerable to neglect, particularly if their caregiver is herself ill. Even if the child's physical needs are being met, there are few sources of emotional support available to them. C says that under these circumstances the children are forced to become precociously independent.

In the children's home in which L works, on many occasions children were placed in the home when their mothers were still alive but very ill. Children in the home spent a lot of time playing out strong fantasies about having a mother, demonstrating their "desperate and basic need just to have a primary caregiver" (L).

Sometimes a child is not told of her mother's death and in those instances when the children are told they are seldom allowed to attend the funeral. Death is met with secrecy. The child therefore has no opportunity to openly mourn, bringing about a state of "disenfranchised grief" (Doka, 1989). L speaks about the culture at the home of silence and secrecy around death:

> One of the taboos was the idea of death. There was a lot of not talking about a parent dying, the organisation getting away with not giving the child too much information about that, not assisting them through the process, so things like not being allowed to attend her mother's funeral, which just seems so obvious. But anyway, it was not obvious to everybody. I mean there were a lot of things that weren't spoken about.

The children have not only lost parents, siblings and other loved ones. They have also "had their sense of immortality challenged". They have lost their idea of themselves as healthy, their sense of themselves as resilient and, as J notes, "the behaviour they see in other children when they cut themselves and don't have to chase people away, saying, 'don't touch my blood!'". C says, "They've seen their parents die, they know they have the same illness. They're dealing with their own mortality at the same time".

When the parent of a child dies, the child enters a period of liminality, described by Van Gennep as "the transition during a rite of passage" (in Daniel, 2005, p. 195). According to Daniel, "the death of a parent initiates a three-phase rite of passage: i) separation from status of 'son' or 'daughter', ii) a period of liminality with rituals of mourning and finally, iii) a re-aggregation into a re-formed social network with a new status as a 'child without parents'" (Daniel, 2005, p. 195). If the child is able to mourn the loss of the parent, she will emerge from this transition and take on her role in a new status. When there is a taboo on talking about death, the child's grief is 'invisibilised', thus prolonging the experience of liminality for the child. This may lead to a sense of being trapped in the role of an "outsider", with the result that the child may become increasingly marginalised and seek belonging in socially unacceptable ways.

In her discussion of the impact of silence about and secrecy around the death of a parent, Daniel (2005) stresses that without the words and language to name what has happened, children develop frightening fantasies about the death of the parent.. Even when children are not told about their parent's death (the child may be told for example that mother has gone on a long journey), they know that something is terribly wrong but are not given access to language about it, with which they could begin to make meaning of the experience. This gives rise to a "nameless dread" (Daniel, 2002, p.197). Both of these factors heighten the child's anxiety, resulting in maladaptive coping strategies. Thamuku (2002, cited in Daniel, 2005) notes that when bereaved children are not given the opportunity to grieve openly, they delay the mourning process, to the detriment of their personality development, particularly the capacity to form satisfactory emotional relationships. Doka (1995) terms this "disenfranchised grief" (in Daniel, 2005, p. 197) and defines it as "grief that people experience from a loss that is not, or cannot be, openly acknowledged, publicly mourned, or socially supported" (ibid.). According to Bowman (1999, in Daniel, 2005), children are particularly vulnerable to disenfranchised grief, because of cultural taboos around discussing death and dying with children. Bowman discusses children's disenfranchised grief in connection with the shattering of their dreams when they experience the loss of "an emotionally important image of oneself, one's family or one's situation; the loss of what might have been; abandonment of plans for a particular future; the dying of dreams" (in Daniel, 2005, p. 197). When the child's shattered dreams cannot be openly mourned because her grief has been disabled, the development of a new identity is thwarted and the third phase in the rite of passage, namely the re-aggregation into a new status and new social networks, cannot be achieved.

As a result, the child remains fixed in the liminal state. A person in this state of liminality is made invisible by the community, because she defies categorisation and therefore has no social reality – "they must be hidden because it is a paradox to see what ought not to be there" (*ibid*. p.197). Daniel (2005) argues that a child trapped in this liminal state may effectively be deprived of personhood, marginalised from social networks and sources of cultural learning. The consequences of this include the loss of opportunities for skills development and the development of a culturally-embedded identity and a heightening of vulnerability to abuse (Kluckow, 2004 in van Dyk, 2005).

4.2.3 Living with HIV

Most of the children participating in the groups were infected via mother-to-child transmission at birth. Some, however, were infected with HIV as a result of rape. All are currently on anti-retroviral therapy and are relatively healthy. Although the children are well the medication has unpleasant side-effects, such as causing nausea, stomach cramps and a painful rash. It is also difficult for the children to take as it is very bitter.

The stigma associated with the disease results in the marginalisation of the children within their communities and their families. They are also stigmatised if they have lost their mothers. Many of the children are developmentally delayed, possibly as a result of the HIV. L speculates that possible neurological damage from HIV may be the cause of disorganised, chaotic and disruptive behaviour in the children. Their status as 'orphans' as well as their disabilities cause them to be "specialed out" (K) at school, even when their status has not been disclosed. They are therefore generally bullied and very lonely.

It is not uncommon for the caregivers to be extremely anxious about others finding out about the child's status. In one case a little girl is given her medication in secret in the cupboard. The children are well-rehearsed in denying their illness to others in case "the school may think we have HIV and we don't" (K). There are also very real risks in disclosing their status to others. While one of the intentions of secrecy is to protect the child from stigmatisation, J says that the child also develops a belief that there is something physically as well as morally wrong with him, and shame is therefore a central feeling for these children. This is expressed by J as follows:

> It's an underlying shame feeling as well. It's about non-disclosure, not talking to your friends because on the one hand, it's a thing of protecting yourself. But I also think the fact of having a secret says that there is something undisclosable about you. There's something bad about you that you can't tell other people because they won't understand.

The marginalisation of the HIV-positive and orphaned child was mirrored in the children's isolation in the mission home. In the early stages of L's involvement at the home, before the widespread use of ARV's, most of the children were chronically ill and were prevented from going to school, instead remaining isolated in "a fundamentalist Christian kind of environment which was all too insular and bizarre" (L). This may be an example of how the orphan, trapped in the liminal zone, is 'invisibilised' and hence deprived of personhood, as Daniel (2005) has discussed. Presently the situation is different however, as the children now attend school.

The imposition of secrecy on the child silences him, robs him of autonomy and instills in the child's relationship with caregivers a pattern of solicitous reversal of care. Many of the children's relationships are centred on protecting parents, siblings, friends and the school

from knowledge of their status. C talks about how this is acted out by a little girl in one of the groups:

> The little girl in the group I'm thinking about, she uses her pretty cuteness, that's her little defence, so she smiles nicely and looks pretty and doesn't want to say anything. It's hard to talk in a group about stuff because my family doesn't talk about it, my mommy doesn't want me to say anything to anybody else. But ja, for her to find a voice in the group is so important and I think that, when you link it back to her family and what's happening there, I don't think she has much of a voice there.

Mothers who have transmitted the virus to the child at birth often fear that the child will reject them for giving them the illness. Sometimes the care-givers fear that if the child is told her status she will get sick and die. K recounts the caregivers' insistence that their children are not told their status when they join the group. These children are usually told by the caregiver that they go to the clinic because they have high blood pressure or asthma. However, K believes that the children do know at some level that they are being treated for HIV but they have no space to talk about their condition. Here too a state of "disenfranchised grief" is instituted.

4.2.4 Conclusion

The children that participate in the groups are deprived physically and emotionally, are dislocated and particularly vulnerable if their mothers have died. The children have suffered multiple losses but are seldom able to mourn their parents, siblings and their health. Because of their caregivers' fear of stigma, many of the children are not told that they are HIV-positive, yet seem to sense that there is something shamefully different about them. Many of those children who do know their status have few opportunities to make sense of it because talking

about it is widely discouraged in their families. The secrecy and silence that surrounds death generally and their own condition in particular institutes “disenfranchised grieving”, a psychological state in which grief is split off and the work of mourning cannot be done (Doka 1995).

The vulnerability of the children, their split off grief and, where mourning work is being done, their intense sadness, evoke a range of powerful countertransference feelings and behaviours in the therapists that work in regressive and progressive directions in the therapy. These responses and the deeper group dynamics of which they speak are discussed in chapter five. The following section provides a brief overview of the central features of group psychotherapy with the children.

4.3 Doing therapy with the children

4.3.1 Introduction

Therapy with children brings particular countertransference pressures to bear on the therapist, due to the child's tendency for regression and the resulting expression of primitive affects and part-object relations (Lanyado, 1999). In the psychodynamic group, the primitive affective "ring of fire" (Pines and Schermer, 1994) that is evoked as a result of group regression further intensifies the countertransferential challenges for the therapist. This chapter discusses the features of doing group therapy that are reported by the participants, in order to highlight the countertransferential challenges of this work. These features include the symbolic nature of the children's expressions, the mirroring function of the groups, maintaining boundaries, and how the groups function to engage with and defend against the work of mourning.

4.3.2 Features of group work with the children

The participants report that doing group therapy with the children is characterised by its intensity, not only rising out of the themes and affects the children bring to the work, but also due to the strong and sometimes conflictual feelings that are elicited in the therapists, feelings that may remain present for many hours after the group has closed. Working with the children in a group is different from working with them individually and children also relate differently in therapy than do adults. The transparency of their defences, their easy access to their emotions and their limited capacity for verbalisation pose particular challenges for the

therapists. Sometimes these challenges threaten to overwhelm the personal resources of the therapist, and exhaustion was cited frequently by the participants as a result of doing the work.

The children's honesty and their courage to be vulnerable provoke strong feelings of empathy in the therapists and a desire to protect and nurture these children. The themes relating to the children's multiple bereavements elicit an intensity that is both exhausting and affectively rich for the therapists and quickly knits the participants together into a shared intimacy with one another.

4.3.3 The children speak a symbolic language

The children express themselves through play and, as J phrases it, "are not engaged verbally like adults are". At times the therapists find this difficult to manage, particularly when disturbing material comes out in play, material that cannot be given meaning through a process of verbal articulation. K says, "You can't talk, you know, children aren't engaged in that kind of way. So you're kind of holding that and wondering". The smaller children, who are around the ages of five and six, do not have the vocabulary to name feelings and find it difficult to understand the links between the feelings and behaviours that come out in play during the session, and their experiences (of loss, for example) outside the room. Here too, the therapist may be left holding the child's primitive, unmetabolised feelings and may need to be highly inventive in containing the child with language and gestures that do not compromise the therapeutic frame, but that can be understood and used by the child. In this regard S says, speaking of the children's need for touch and her struggle with feelings of re-enacting

the children's neglect by maintaining the frame, "How do you take a child off your lap and tell him to sit on a cushion?", while L speaks of her ability to comfort a distraught child by demonstrating symbolic containment to the child through rocking and soothing a doll.

Children who are older (around the age of 10 and therefore in the stage of concrete operations) are more able to articulate their feelings and experiences and use language more effectively to construct meaning about their difficulties. Here the participants speak of the development of a co-creation of meaning and mutual containment through the child's ability to openly and honestly acknowledge painful feelings.

4.3.4 The mirroring function of the group

The acceptance that the group offers is an important part of its function. C describes how the children experience relief in being in a group with others "who are the same as me", an experience they seldom have elsewhere in their lives due to stigma and the child's sense of being different. On one occasion the children's delight at belonging to a group where they were accepted with their HIV status found expression in a suggestion that the group have matching T-shirts made and visit schools to perform plays about living with HIV. C says, "There can be this sort of euphoria that I'm okay, I'm so accepted in the group, everything's alright and I can go forth and spread the news and everyone will accept it." In these instances the group's euphoria must be tempered by reality, and an equally important function of the group is to validate the child's experience of stigmatisation and to encourage the child to be discriminating about disclosure. Providing acceptance of the children's HIV status in the group represents the creation of an alternative culture in which the children are given "a place

where they can talk about how horrible it is to have HIV" (J) and therefore, a "space to be" (K). The group as a place of acceptance provides the members with an experience of "communitas", the sense of "equality and comradeship between those jointly undergoing ritual transitions" (Turner, 1974, in Daniel, 2005, p.198), and an affective environment in which empathy and identification with the child arises.

While the mirroring function of the group promotes the therapy space as "a relationship of difference" (J) that generally does not find expression in the outside world, it exists concomitantly with a "shame boundary" relating to the recognition that the children's condition is a socially abject one. This establishes an affective environment in which the therapist is subject to powerful alterations in subjectivity as a result of the prevalence of projective identifications within the cloistered and regressed group space (Pines, 1994). The therapists are thus particularly prone to identify with the child and this provides an important experience in empathy, but also activates the therapists' archaic object relations, not only relating to the pining and persecution experienced at the zenith of the depressive position (Klein, 1940), but also to the early narcissistic conflicts relating to the loss of omnipotence and the resulting feelings of shame (Kauffman, 1994). However, the mature ego functions of the therapists provide containment for the group's primitive affects, and primitive omnipotence and narcissism can be worked through once again, facilitating the flow of mourning and a corresponding increase in the capacity for containment.

The mirroring function of bereavement groups has been found to be their primary therapeutic value (Foulkes, 1948), providing recognition, validation and empathy for these children, many of whom have been subjected to disenfranchised grieving. However, it is the task of the

therapist to secure group space in which grief can be safely expressed. This requires a capacity in the participants to tolerate the reality of their own mortality, a process that activates primitive conflicts and "visits upon the internal object world disturbing and uncanny powers of very great magnitude" (Kauffman, 1994, p.166). As a result, the participants struggle with periods of painful and emotionally exhausting internal work.

4.3.5 The child's need to play and fear of play.

Children at the preoperational stage are less skilled in engaging verbally with their feelings and need the help of the therapist to 'language' their experiences. Children at this age engage more readily in play as an expression of their inner worlds, as well as a means through which to master conflictual internal relations (Chethik, 2000). Until the child and the therapist are able to make meaning of the child's feelings and experiences through understanding her play, the therapist may be left struggling to hold the unprocessed elements of the child's inner world, elements that may be split off through dissociative, repetitive play and projective identification, or strenuously defended against through aggressive, anxiety-ridden acting out that renders play impossible.

When the group is acting out under the influences of primitive defences, productive play gives way to chaotic, disorganised, aggressive, anxiety-ridden acting out. This is demonstrated in L's account of the early days of her work with groups in the mission home. Particular attention will be given here to L's experience in order to highlight the intensity of this specific countertransferential challenge, arising as a consequence of the children's weak and fluid ego boundaries and the intensifying of the children's transference relationships to authority,

indexed to the mission home environment. This discussion explores how containment in the groups was achieved by way of the bounding functions of the therapist's mature ego.

In the mission home, the children could not play productively until their anxiety had been contained and L recounts how the pressure on her to enforce boundaries initially had the effect of rendering her impotent as a therapist. She says that in these early days a major challenge was "trying to operate as a therapist when I almost became a policeman most of the time". She stresses how difficult it was for her to maintain her own containment when "there would be children flying around the room, trying to kill each other, breaking windows". L speaks about the difficulties of managing the children's behaviour in a way that could contain them, rather than punish them, and how the dynamics in the mission home continually constructed a permissive/punishing duality that found expression through racial difference.

L reveals that while permissiveness associated with racial difference was invoked as an explanation for the children's aggression, there was a deeper dynamic underlying their behaviour, and understanding this helped her to work more effectively with the children. Recognising that the children's behaviour was an expression of their unmet dependency needs and a reaction against their silencing, L limited the groups to three so that she could give more of her attention to each child in the session. Consequently, the holding that she could offer the children in smaller groups facilitated the emergence of very intense material relating to the children's bereavements.

While L understands the children's chaotic and disruptive behaviour in the sessions as negative attention-seeking, the intensity of the material that was elicited when the children

were more contained also suggests that the group's behaviour may have been an expression of the group 'homeless mind', an effect of the shearing of meaning from experience as a result of a failure of containment. As long as the children's losses were not being contained but defended against by silencing, these experiences were unmetabolised and therefore remained at the level of "the unthought known" (Bollas, 1987), expressed through aimless and chaotic behaviour. When an initial degree of containment could be achieved through the holding function of boundaries, the group's experience could be organised and find expression through play. Containment rendered the full intensity of the experience coherent enough to make it available for expression. In this regard L says:

> Once we could get to that stage where all children were involved in one kind of play, things would feel kind of more contained, we'd be in the same place, but often the kind of material that would come out of the play would be quite overwhelming, there would be quite sort of intense themes and structures.

4.3.6 The child's innate understanding of death and dying

Those children around the age of six and younger, being at the "preoperational stage" of cognitive development, have a limited capacity to understand the implications of being HIV-positive. However, older children have more cognitive resources and therefore may go through a protracted period of anger and depression after being told their status.

While the therapists speak about the children's limited capacity to understand the implications of their status, they also speak of noticing in the child an "innate understanding of death and dying" that is not necessarily articulated verbally. For example, L talks about being struck by how contained the five and six year olds in her groups were when she disclosed their status

to them. She understands this as having to do with the long preparatory process that served to help the child incrementally work through already present knowledge that "something is not right". Similarly, C relates how a six-year old girl brought to the hospital in the final stages of AIDS was never told that she was dying, but came to an acceptance of her death without verbalising this: "The (child has an) acceptance, you know. Eventually it was a case of she knew, and it was never worded as such, but there was definitely an idea that she knew and an okayness with it". K speaks of her sense that the children, although they have not been told their status, know, at some level, that they are being treated for HIV at the hospital.

The participants' reports of the children's awareness of their condition and prelogical understanding of dying reiterate the findings of research on terminally ill children who have not been told their diagnoses (Waechter, 1984). Compared to chronically ill children, the terminally ill children in these studies demonstrated a strikingly higher level of awareness of knowledge of their diagnosis and a corresponding preoccupation and anxiety about loneliness and dying. These findings have been explained as the child's perception of and sensitivity to the changed affective tone in his environment, particularly parental anxiety that is communicated non-verbally (Waechter, 1984).

4.3.7 The centrality of death in the groups

The theme of loss is central to all of the groups. The children bring the losses of their parents, siblings and other loved ones to the sessions. Underlying the feelings of loss is the experience of death and dying. L speaks movingly about her experience of having to "play sick" with the children, in the role of the patient, before being "crucified" by them and having to

"die and go to heaven". Reflecting on it in the interview she says, "It brought me closer to what at the time was maybe the core of the work. It wasn't just about having lost a parent, dealing with a sick relation, or loss issues. It was about death and dying".

L was working with children prior to the widespread use of antiretroviral therapy and therefore the death of children in the home was not an uncommon occurrence. Although antiretroviral therapy has prolonged the lives of the children with which the other participants work, and therefore the children's preoccupation with their own deaths is not foregrounded as it was in L's groups, the loss of the child's loved ones, as well as the loss of her identity as 'healthy' and the foreshortening of the child's future nonetheless constitute bereavements that occupy a central position in the groups.

While some of the children in the groups may not be old enough to have a cognitive understanding of death, Klein (1940) maintains that children who have traversed the depressive stage of emotional development (in the first year of life) experience mourning after a loss.

The young child's response to her impending death is thought to be different from the adult's response to death because the child's cognitive abilities are not yet fully developed. The child's understanding of death is founded on the ability to grasp the concepts of irreversibility (the permanence of death), nonfunctionality (the cessation of life-defining functions at death) and universality (the understanding that all living things die) (Speece and Brent, 1987). However, the capacity required to grasp these concepts is only fully developed in adolescence.

While the child's ability to understand the concept of death is dependent on his cognitive age, Klein's theory of mourning suggests that once the child has achieved whole object relating, he is able to mourn a loss. The very youngest child in the groups will thus experience the death of the parent as a loss, over which he will need to mourn.

The children in the groups have experienced multiple losses. Klein (1940) asserts that it is not just the death of a beloved that is mourned, but also the loss of anything of significance: "Any pain caused by unhappy experiences, whatever their nature, has something in common with mourning. It reactivates the infantile depressive position, and encountering and overcoming adversity of any kind entails mental work similar to mourning" (p.164). The baby experiences depressive feelings that reach a climax just before, during and after weaning. This early mourning is revived whenever grief is experienced later in life.

The children are thus faced with the task of mourning the loss not only of their caregivers, but of their health, dreams, friendships (as a result of stigmatisation) and, if the family has been separated by the death of the caregiver, the loss of their homes and possibly their siblings. In normal mourning, "the poignancy of the actual loss of a loved person is greatly increased by the mourner's unconscious phantasies of having lost his internal good objects as well. He then feels that his internal 'bad' objects predominate and his inner world is in danger of disruption" (Klein, 1940, p.156). According to Klein, the central task of mourning is to repair and restore in the ego the parental imagos as good, loved objects. Where no actual death has occurred, the effect is similar: the loss, whether it be separation from the parent or the loss of an aspect of one's identity, reactivates anxiety about the early loss of the good internal object (the prototype of which is the mother's breast) and results in the re-experiencing of

annihilation anxieties. The task here is that of mourning: the reinstatement of the good object in the ego.

In their group work with the children, the participants find themselves submerged in a maelstrom of grief, some of which is split-off and dissociated. In their attempts to contain and make meaning of the powerful feelings elicited in the countertransference, the participants are faced with working through previously unmetabolised aspects of the infantile depressive position. Confronted with the children's bereavements and the ubiquitous presence of death in the groups, the participants make contact with their 'vulnerable child' parts and are confronted with their own earliest losses.

4.3.8 Conclusion

The group work with the children is intense and affectively rich and it brings particular countertransference pressures to bear on the participants. The symbolic nature of the children's expressions, their limited use of language, the transparency of their defences and the accessibility of unconscious material constitute an environment characterised by very primitive affects that are communicated predominately through an early form of communication, namely projective identification. This environment is conducive to the participants developing powerful identifications with the children. Further, the centrality of the themes of death and dying in the group confront the participants with their own unmourned losses and render the work of mourning central to the life of the groups.

The following chapter explores the countertransference responses of the participants as signs of the alternating process of defending against and engaging with the work of mourning. Early anxieties associated with the loss of the good object are activated in the participants as a result of the projective identifications to which they are subject in the groups. Further, the participants are also confronted with death through their knowledge of the terminal nature of the children's illness. Even if the reality of the child's condition is never acknowledged in the group, it is always present in the mind of the therapists, because while the child may not know her status, or cannot speak about it because the needs of her significant others prevent her from doing so, the therapists know that every child in the group will face a foreshortened future and a possibly painful, premature death. The participants are thus confronted with death and faced with the task of mourning multiple and varied losses.

Where powerful social constraints exist on talking about the illness and its consequences, as for example in the non-disclosed groups, death, although ubiquitous, cannot be engaged. Grief therefore must be denied. This has particular implications for the dynamics of the non-disclosed groups, dynamics which reflect as compromise formations in the therapist's countertransference. In those groups where the child's HIV status is openly known and spoken about, the painful work of mourning is also defended against at times. Here there is an alternation between tolerating the sadness, helplessness and disillusion that emerge in the process of mourning, on the one hand, and, on the other, defending against these painful affects until such time as the group can once again contain the mourning process.

CHAPTER FIVE: FINDINGS AND DISCUSSION

5.1 Introduction

The countertransference responses of the participants to the group work with the children are presented in this chapter, and integrated with a discussion of the possible meanings and significance of these. The countertransference is thought of as a sign of the unconscious dynamics of the intersubjective relationships that arise in the group matrix (Foulkes, 1971). This chapter therefore provides an explanation of the participants' countertransference responses as representations of the underlying group work of engaging with and defending against mourning.

The process of mourning is characterised by a reflexive engagement with grief, helplessness and rage, alternating with defences against the pain of mourning: denial, idealisation, omnipotence and blaming (Kauffman, 1994). Mourning plunges the bereaved into a long night of 'wrestling with the angel' (Genesis 32:24-28): as the work of mourning is slowly achieved, the associated suffering is gradually infused with a sense of meaning and a corresponding enrichment of the ego. When, however, the pain of loss cannot be tolerated, mourning is split off and the reality of the loss remains unmetabolised, yet continually returns to the life of the group like a ghost haunting the fringes (Kauffman, 1994), making its presence felt in the countertransference as feelings of anger, flights of idealisation and omnipotence, meaninglessness and an aching despair.

The first section of this chapter introduces the participants' journeys with the children, at what is perhaps, the beginning: that place of strangeness and confusion that marks it as a liminal zone, a place where things are ambiguous and ordinary reality is inverted in the face of death. The participants wrestle with this strangeness in an attempt to come to terms with a changed reality in the presence of death. This section of the chapter describes the defensive constellations against mourning that are experienced in the groups. These include: feelings of unfairness; denial; idealisation; rescuing; helpless rage; despair and meaninglessness. The following section traces the process through which the participants finally surrender to suffering, and the new networks of meaning that emerge to transform the participants' perceptions of the children from victims to resilient, empowered and active agents of their lives. Omnipotence, helpless rage and despair give way to an acceptance of vulnerability, a sense that there is meaning in the experience of dying, a vital hope and an acceptance of death as being central to what it means to be human. The object world is kinder because the good objects have survived. The second section of this chapter therefore presents those countertransference responses of the participants that relate to an engagement with the work of mourning. These include: becoming comfortable with death; embracing helplessness; containment and holding; finding meaning; and recognising the child as strong and resilient. The process of mourning is likened to a rite of passage in which the internal world is reordered out of the chaos into which it is thrown in the face of death. With a reordering of the internal world come transformations in the ego: the good, loved object is reinstated, a process through which the ego is also strengthened and enriched (Klein, 1940).

5. 2 Struggling to understand in the liminal zone

"I try to get my head around it," says J, "because, as I keep saying, it makes so little sense". Struggling to make sense of 'children born with a death certificate' is a central emotional response to working with the children: "There was another questioning as to why they were positive", says S. "The children in my group were all born with HIV. That I found very difficult. How do you make sense of that for the child – that this is what they're born with, they're born with a death certificate."

'Children born with a death certificate' represents an inversion of the natural order. The collapse of the polarity in the terms of the binary: birth/death, constructs, in the imagination of the participants, this aspect of the world as a disordered, strange place where the usual equation of birth with life is inverted and hence, the conceptual order is disturbed. K says, pointing to the inversion of the mother from nurturer of life to the bringer of death; and of her milk from good food to poison:

> What must it be like to be born with HIV? And to get that from your mother? How does the child make sense of that – that you are born with, you are given this thing? And to have milk that is bad – its good food but it's bad for me, and now I'm taking medicine, it's horrible, but it's good for me.

Inversion of the natural order is experienced at different levels by the participants as they struggle to make sense of the children's condition. "There's a dear little thing, she's 8, so her dad shagged around and gave the mom HIV, but she's bearing the brunt of that, someone gave her HIV for a present", says J. A world in which a new born child seems to receive HIV from her parents as a gift to welcome her into life is a frightening, bizarre state of affairs that

defies the logical processes upon which the coherence of the natural world appears to rest. In this regard L says,

> I suppose it's easier to accept if someone was sleeping around, knowing about HIV and not protecting themselves, you know. It's easier to see there's an action and a consequence in the world that we live in, where we're so educated about it, and making that choice. But a whole bunch of people aren't making any choice at all. A lot of women's husbands wouldn't be faithful, and of course children would be born exposed to the illness.

A reality in which the suffering of the innocent cannot be avoided through the law of consequences is experienced as a frightening place of strangeness where the limits of the self are challenged. Daniel (2005) discusses how the process of mourning is akin to a rite of passage as the bereaved reorganises his internal reality to adapt to the loss of the loved object, an adaptation that also brings about a concomitant change in identity. This process of reorganisation and adaptation to a new reality is undertaken in what Turner has termed, "the liminal zone" (1967 in Daniel, 2005), a figurative (and sometimes physical) space that is set apart from ordinary life and in which the work of mourning is undertaken. Klein (1940) notes that mourning resembles pathology, and in this respect, the liminal status of the bereaved is constituted as much through the disruption in the subjectivity of the bereaved, in a manner resembling a kind of manic-depressive illness (Klein, 1940), as it is through social rules of grieving that allow for tolerance, for a specified time, of the emotional disruption caused by a bereavement. "Death is mystical;", writes Kauffman (1994), "it is the ultimate mystic; it is the locus of unknown, uncontrollable and ultimate reality, whose appearance within known, contained and ordinary reality is *disruptive*" (p.161). The social rules of grieving thus function as an attempt to contain death, and thereby protect the social order from its painful and disturbing power (Doka, 1989): "The realm awakened when the bereaved is submerged in the hyper-cathected internal object of the deceased is a threat to social order. Social rules of

mourning serve not only the function of recognising individual and family grief…., but of protecting the social or group order from the power of death present in the pain of the bereaved" (Kauffman, 1994, pg. 165).

The liminal state is "an ambiguous state: the 'passenger' passes through a period of paradox and confusion, betwixt and between customary categories, they are at once no longer classified and not yet classified" (Daniel, 2005, p.197). Henderson (2002) thinks of the liminal state as a 'borderland' where identity is ambivalent and "where opposites flow into one another and exchange meanings, such as inside-outside" (in Daniel, 2005, p.198). L describes her experience of this in her work with the children: through the sexual transmission of HIV, the act of love becomes its opposite – an act of death. Similarly, when a child is conceived and then infected at birth, the growth of a new life is transformed into the task of dying:

> I think it is a difficult thing to accept which is crazy, because I work so much with it, but it doesn't make any sense why there should be this thing called HIV. On any level, you know, why women should contract it from their husbands, the whole act of love and why that should happen, that kind of shadow side, why a child should be born with it.

Kauffman's (1994) explanation of the effect of death on the internal world is useful to understand why mourning the lost object is experienced as a liminal state. Kauffman maintains that the experience of loss may not be sufficiently contained by the deceased object alone, with the result that death becomes ubiquitously present. All the objects in the internal world are felt to be dying as grief saturates the self and the internal world: "the internal object of the deceased and the effect of the death is scattered about the internal object world of the bereaved – everywhere and nowhere death and the beloved and the

primitive affective range of grief are present". (Kauffman, 1994, p. 155). This brings about a destabilisation of identity as the object world is thrown into disarray and unmetabolised aspects of split off primitive grief give rise to a frightening host of bizarre, ghostly and dreadful apparitions. A sense also arises of the internal world being disrupted by an emptiness or strangeness and that a part of oneself has died: "Dread, shame and fear prompt a dissociation of tender, intimate and vulnerable links to the object world" (Kauffman, 1994, p. 168). There is a sense that one is no longer kept company by one's good objects (Klein, 1940) and intense feelings of loneliness, alienation and difference arise and one becomes a stranger to oneself: "The stranger is the one who inhabits a space of ambivalence, in which one is not quite 'us' or 'them'" (Ahmed (2000 in Daniel, 2005, p. 197). Feelings of loneliness, difference and alienation may then be projected onto diffuse external objects, rendering the world a place of strangeness, simultaneously experienced as persecuting.

The sense of strangeness, difference and stigma that infuses the internal world in the wake of a loss suggests that the stigmatised liminal state is a mutually negotiated projective identification occurring between the bereaved, and the 'normal well'. According to Ogden (2006), a voluntary subjection to the projective identifications of the other occurs in order to transcend the limits of the self; thus, submission to exile in the borderland serves to facilitate the construction of a new identity reordered to accommodate a reality in which the loved object is absent, yet integrated in the ego. By becoming a "stranger" (Ahmed in Daniel, 2005) one becomes 'other', in stark opposition to those who are not bereaved and who therefore represent the pre-bereavement identity. Leach (in Cohen, 1994) maintains that identity is always only constituted in opposition to the other, while Barth (ibid.) asserts that identity is articulated at the boundary where it can be "modulated to and moderated by that of the other"

(*cf.* Cohen, 1994, p.9). Why this should be so is explained by Freud (1917): the constitution of identity occurs through the ego's internalisation of the loved qualities of its lost objects (the 'other'), the prototype of which is the mother's breast.

Winnicott's (1957) notion of the potential space in which transitional phenomena occur, is also a borderland: a space where the object, in the process of being symbolised, is neither wholly internal nor external, but ambiguous and therefore an object of 'play', possessing some of the qualities of the external object, while simultaneously perceived by the ego as partly its own creation. Being in the liminal zone of mourning can therefore be thought of as the occupation of a potential space in which the lost loved object is represented as neither wholly internal nor external, as the ego grapples to accept the reality of its external absence. Gradually this process yields a transformation of the loved object from a living to a deceased, memorial object (Winnicott, 1974), as well as a transformation of the ego as it integrates the loved qualities of the deceased object, now symbolised, and therefore perceived as a creation of the ego and hence, a part of it (Freud, 1917). However, this process can also be retarded. If the ego cannot tolerate the pain of mourning, or if there are social sanctions on talking about death and dying, the operation of defences such as denial, idealisation, omnipotence and identification may keep the bereaved trapped in the liminal state, grieving silently, indefinitely and pathologically, and unable to effect the transformation of identity necessary to take up a new role as a functional member of society (Daniel, 2005). Stigmatisation may also result in an arrest of mourning as a result of the subjection of the stigmatised subjectivity to powerful projective identifications that constitute continual attacks on the good object.

5.3 Denial

When the ego cannot bear the pain associated with losing the loved object, defences operate to deny this painful reality. Klein (1940) asserts that partial and temporary denial is an important defence while the ego reorganises itself to cope with loss. Closely bound up with denial is splitting and idealisation, and these defences enable the ego to assert itself against internal persecutors. Partial and temporary denial operates to prevent an engagement with mourning, until such time as the good maternal object can be sufficiently stabilised, by way of idealisation, to allow reintrojection (Klein, 1940). Kauffman (1994) notes Klein's assertion that mourning can proceed only when the good object is sufficiently stable to be introjected. However, he also maintains that it is through processing loss, particularly the loss of primitive omnipotence, that these objects become stabilised.

The defences of denial and idealisation in the non-disclosed groups that S and K run, can be seen as an attempt to develop primitive narcissism and omnipotence into more cohesive psychic organisation, thereby strengthening the ego sufficiently to engage with the work of mourning. Idealisation of the white facilitator can thus be understood as an attempt to reinstate the mother as healthy, active and functional, and this is dependent on splitting off the unwell mother as dangerous, abject and negated. Klein (1940) discusses how the child's idealisation of the mother is an essential intermediate step in early mental development. The desire for maternal perfection is rooted in the depressive anxiety relating to the disintegration of the loved object. By thinking of the loved object as perfect, the idea of it as subject to disintegration is disproved. The idealisation of the loved object is therefore necessary at the stage when the child's ego is not yet secure enough in its capacity to achieve the restoration

of the loved object. This task is reworked once more in the face of loss, and the mourner experiences great relief in recalling the lost person's good qualities, due to the reassurance received from preserving the loved object as an idealised one (Klein, 1940).

However, when extreme denial is operating under the influence of stigmatisation, a distortion of psychic reality occurs. Maintaining secrecy about the children's HIV status in the non-disclosed groups undermines the working-through of primitive narcissism and intensifies the splitting in the group, with the result that the idealised maternal imago (represented by the white therapist) functions to reinforce denial through enactments such as feeding the children and providing them with treats, and through manic attempts to control the contaminated, abject mother (represented by the HIV positive black facilitator), attempts that result in the continual collapse of the idealised mother into another of its opposites (the vengeful mother, represented by the 'racist' white therapist). Further, omnipotent and obsessive reparation continually come into play in the repeated attempt to undo the damage to the maternal imago that results from the manic defences. The outcome is two-pronged: unmetabolised, split-off grief reappears in the countertransference as hopelessness and burnout, on the one hand. On the other hand, the narcissistic defences are reorganised to institute the female black facilitator as a more functional, well, and therefore stable, maternal object by means of a manipulation of the transference, represented by the move, in K and S's groups, to a more directive way of working.

The following section describes the dynamics of the non-disclosed groups in which strong denial operates in concert with splitting and idealisation.

5.4 Keeping a secret

Reflecting on what has been most challenging about the work with the children, K says that it is the difficulty of doing group psychotherapy with children who have not been told that they are HIV-positive.

> What made it so hard, is that you're working while keeping a secret, and how much of it am I part of colluding, part of this whole, of keeping the group sick in that way, you know? Why not just say it? And I'd get very afraid of it myself, in that first group, very frightened of it. And it was interesting because the young facilitators that I was working with are so afraid of it coming up.

The reality of stigmatisation creates fear amongst the caregivers to disclose the child's status to him. Powerful taboos on 'speaking HIV' exist so that the group exercises a strong constraint on engaging with the reality of the condition. K speaks about how there is extreme anxiety and distress amongst the caregivers at the prospect of disclosing their children's status to them and a stifling silence amongst the HIV positive translators and facilitators about talking about their status. "It's a weird thing", she says, "you know it, and you're sitting in an HIV organisation, but you don't feel you can say, 'how you're doing with your status, what's your CD4 count like?' No-one ever talks like that so I feel like I collude in a way, I suppose." However, K also realises that the silence about 'speaking HIV' is maintained through a powerful group defence that cannot be cracked open by one individual: "I realise how hard it is actually. I think its something else – this is what we should be doing, but actually its quite a thing to negotiate".

The constraints on speaking about HIV that are exercised by the communities of which the caregivers and facilitators are a part, is duplicated in the groups with the children. K recounts

an early attempt to broach the subject of HIV in a group with four children who all knew they were HIV-positive. The reaction was extreme: two of the children crawled under cushions and regressed and a young teenager who was an HIV counsellor drew a picture with the message, 'AIDS will kill you'. None of the children returned for the next session and the group had to be disbanded after half the number of planned sessions. Speaking about the team of facilitators and translators, K says, "often the facilitators ask, 'what do we say if the child asks us if we're HIV positive?' So I ask, 'well, what would you say?' And they say, 'oh, no, I'm not telling them. It would freak me out. I would want to run away from this group'".

Similarly, S describes the powerful unconscious processes in the group that functioned to defend against an engagement with HIV. She explains that a central aspect of her countertransference during her work over a year with a group of six to eight year olds was a powerful irritation with the group's translator, a young HIV-positive woman who was ill (as a side-effect of the ARV's) throughout the group's duration. Her illness rendered her ineffective as a translator/facilitator and often she would fall asleep during sessions, arrive late or not at all. S's irritation with her grew to the point that she no longer wanted the translator in the group. Reflecting on it, S talks about how she became caught up in an enactment that evolved out of the group's defence against illness and death. S notes that the children "were quite happy when (the translator) fell asleep and didn't participate. They certainly didn't try to wake her or it didn't seem to upset them." She wonders whether the translator "did embody all the illnesses in the group with the children" and "perhaps they were afraid of her illness, because it represented death and things they were managing outside". S reflects on the possibility that her irritation with the translator also functioned to exclude the translator from the group and therefore to "push the illness completely out the group process".

S thinks of the translator's disengagement as representing the group's denial of pain and anxiety associated with the "broken family". She came to represent this dimension of the group's experience through being scapegoated as the recipient of the group's projections of aspects of their "experience around the parent" – "the ill partner, the absent father, the sleeping mother":

> All of these aspects of the children's experience around the parent seem to be, I think, must have been in some way projected into her, and she obviously took up that role, in addition to the fact that she was also very ill. So she did have the actual illness yet all those emotional actings out that parents in the real situation must have been doing anyway. And *that* she brought into the room.

S says that being in the presence of the translator's illness "really did feel like being inside HIV, right in the middle of it". Yet there were strong defences erected against a conscious engagement with HIV in the sessions. S says, "There was always an underlying feeling around (the children's) own vulnerability, but it couldn't be addressed (because) it felt like they would contaminate the space if they brought it in. It was a very special space and I think they didn't want to contaminate it with their own sickness".

The feeling that something precious could be contaminated by the children's sickness indicates that the scapegoating of the ill translator functioned to defend the group members against depressive anxiety. Depressive anxiety is anxiety lest the loved object and the ego should be destroyed by the bad objects and the child's greed and aggression (Klein, 1940; 1952). Depressive anxiety arises out of the action of the omnipotent defences that operate to defend against the frustration and pain of the real loss, in the external world, of the mother's breast during weaning. The baby feels that it is not only the breast and mother's milk that has been lost, but what the breast has come to stand for – nurturance, comfort, intimacy,

relationship, “love, goodness and security” (Klein, 1940, p.148). Further, the child feels that the loss of the breast is a result of her own greed. Depressive anxiety is heightened and compounded by the conflicts associated with the oedipal situation and the child’s ambivalence towards her siblings. Klein (1940) maintains that depressive anxiety is defended against by omnipotent and violent phantasies that attempt to control the bad object and to save and restore the good object; that is, by the use of manic defences. The operation of these defences is dependent on the action of splitting: this functions to constitute the objects as wholly good or wholly bad, and therefore as pre-ambivalent. In this respect, the secrecy around the children’s HIV positive status and the projection into the facilitator of the ‘bad’ mother is an illustration of denial and splitting, defensive manoeuvres designed to preserve the loved object from being injured or contaminated by the bad, vengeful objects, a pre-occupation that is closely associated with annihilation anxiety (Kauffman, 1994).

There is a sense, in S’s account, of a mutually negotiated projective identification. The translator submitted to the group’s projections of the ill and absent mother and behaved in accordance with the projection by absenting herself from the group through falling asleep and not arriving, while simultaneously being unmistakably present in her illness. She may therefore have functioned as a non-verbal expression of the illness and death that could not be spoken in the room, keeping alive that aspect of the children’s experience that was being strenuously defended against. At the same time her exclusion from the group provided an illusion of omnipotence over sickness and death. In her role as the absent, ill and unavailable mother who represented a feature of the children’s lives, she simultaneously became the excluded and negated mother.

The group was also replicating what the children's experiences were outside: when someone is ill because of AIDS, denial operates as a dysfunctional coping mechanism (Delius & Glaser, 2005; Reid & Walker, 2003). K talks about how silence surrounds an ill facilitator whose condition is made obvious by the volumes spoken at the level of her body:

> And what it means when you sit in a group with a caregiver-facilitator and she's so thin, because she's quite ill at the moment, and there she is sitting next to you, facilitating and she's got no weight on her at all, and you know that she's suffering and stuff's going on, and she's at the point of AIDS. (But no-one is taking about it).

According to Klein (1940), the maternal imago is split into its good and bad aspects when the ego is not robust enough to endure the pain of mourning. This regression to part-object relating in the face of loss is an attempt by the ego to sort the good from the bad, in order to facilitate idealisation of the good object, a necessary precursor for the child to gain more trust and belief in his real objects. Increased trust in the maternal object strengthens the child's ability to make reparation in phantasy to the good internal object, and thus to restore it after a loss is suffered in the external world; that is, to mourn the lost object (Klein, 1940). However, Klein (1940) maintains that denial must be partial and temporary, if this process is not to miscarry. A reconnection with the external world (in which the loved object is absent but other loving relationships are available) is primarily the means through which the loved object is constituted as ambivalent, and therefore reinstated in the ego as a whole object. However, a taboo on speaking about HIV in the groups introduces a distortion of reality that actively functions to deny the reality of loss, damages the relation with the maternal imago (and therefore the ego) and thus retards the work of mourning (Klein, 1956).

Klein (1940) maintains that in the infantile depressive position, the ego is threatened by a dead or dying maternal imago which is defended against by splitting and by idealisation of the ideal maternal imago: “The idealised mother is the safeguard against a retaliating or a dead mother and against all bad objects, and therefore represents life and security itself” (Klein, 1940, p.157). The idealised mother is explored here as an illustration of how, under the powerful operation of the taboo on talking about HIV, defensive constellations (understood here via the countertransference) engender others that are a variation on and elaboration of a defensive theme, constituting a tightly knit network of refusals of and diversions from the work of mourning.

5.5 Too good a mother

The translator’s condition as dangerous and negated mother (what Kristeva (1982) calls ‘the abject’) is constructed in opposition to the idealised mother with “the perfect family of children”. “If I could exclude her by my irritation”, say S, “I could then have the perfect family of children”.

The close relationship between these two aspects of the countertransference (‘irritation with the translator’ and ‘wanting to create the perfect family’) illustrates the operation of splitting in the group process. S’s role as the idealised mother with the perfect family of children is linked with the translator’s role of the devalued, ill and abject mother; the construction of this binary illustrates the manic defences at play.

Speaking about what aspect of the work she found most challenging, S identifies, "the huge desire to give these children stability, and in some way to protect them from the very adult circumstances they were facing". S feels very strongly that children do not have the skills to manage when their mothers are ill or deceased, being instead, "very much at the mercy of the fall-out from such an illness" and "tossed around as things happened in the families". Her struggle to make sense of the injustice of children being born "with a death certificate" and having very little by way of psycho-social support led her to feel "hugely responsible for the children".

As a result, in the group S endeavoured to provide the children with a substitute family in which (she reflects in retrospect) she was "too good a mother - feeding them, giving them a safe space, interacting with them, bonding with them, allowing for some kind of family structure within the group". She understands her behaviour as being driven by a need for "a perfect, safe space for those children. My need was to make it as good an experience as I possibly could." She also understands the defensive function of this dynamic:

> And that was to keep the illness out. It really was a denial of it – it doesn't have to come into this space, this space is about nice things, this is a space around things being consistent and stable, every week having me there. No matter how disruptive their lives were, I was consistent in their lives. So it brought in another experience for them which they weren't experiencing outside, very often. And it set up a denial (pause) It did! I was setting it up.

Although here S considers herself responsible for setting herself up as an idealised mother in denial of illness and death in the group, it is also helpful to understand her contribution as the 'property' of the group (Foulkes, 1966). Foulkes' notion that the individual is transgressed by the action of group communications 'passing through' her (much like X-rays passing through a body), positions S as a nodal point on the group network and her behaviour as a

communication of the group unconscious. That her behaviour was a product of the group unconscious is illustrated by S's account of how the group's need for an idealised mother also emerged through the children's play. Early in the life of the group the children's artwork involved "creating these perfect environments, these perfect homes" that were populated with "mlungu[2] stuff" – TVs and stereos. Linked to this was the fantasy that S, as a white therapist, "came with a big house and a fancy car, a beautiful, nice home". Klein (1946) asserts, "While idealisation is the corollary of persecutory fear, it also springs from the power of the instinctual desires which aim at unlimited gratification and therefore create the picture of an inexhaustible and always bountiful breast – an ideal breast" (p.182).

Providing food and treats for the children every session fed into and, when viewed through a Foulksian lens, arose out of the group's need for an idealised mother as a defence against depressive anxiety and hence, the work of mourning. S reflects on how her weekly provision of food helped the group to stay in the fantasy that she came from a perfect home, uncontaminated by illness, loss and death. Similarly, K thinks about her strong need to provide the children with not just ordinary food but with sweet milk and other treats, as a need to, psychologically speaking, provide them with "chocolate breast milk" and how she "enjoyed giving that milk because they loved milk". Here K is acknowledging that the idea of the ideal breast that she was providing for the children was in some sense a caricature, and thus, a denial of psychic reality: feeding the children and giving them treats played into the denial of the pain and suffering associated with the children's bereavements and deprivation. In this regard, S wonders, while verbally distancing herself from this enactment, whether providing the children with food distracted from doing the necessary psychological work in the groups.

[2] White

"Because you were actually feeding them, you weren't left with a space of what is nurturing internally. It always got contaminated by feeding externally" and "once you start doing that you bring in another dynamic of is the space good enough without the actual food". Here, "good enough" may allude to the integration achieved when the good and bad aspects of the maternal imago are reconciled. However, when there is whole object relating, depressive anxiety arises, compelling the group to engage with the work of mourning, the pain of which is not tolerable under the powerful influences of stigmatisation. Thus, the group is deeply submerged in a powerful, defensive constellation against the reality of the children's deprivation, disrupted attachments and bereavements.

By feeding the children S understands herself as being in the role not only of the idealised mother, but also of an "emotional mother" who she contrasts with "the thinking mother", in Bion's (1962) sense of containing the child's projective identifications and bringing thought to bear on them rather than acting from them. S maintains that by being like a real mother to the children in the sessions through feeding them and meeting their need for physical holding she "became the mother in the transference, without it being a transference mother that the children could then take back as their own".

The unconscious quality of this dynamic in which part-object relationships are played out, stymie the thinking function as well as arise as a consequence of the group's inability to think. When thinking is undermined it fixes the group in part-object relating. The links that would enable communication between the different aspects and layers of the mind are weakened, limiting the group to repetitive behaviours, "endless rounds and futile wanderings" (Ogden, 2004). At the same time the generative aspects of complex processes of projective

identification and resonance construct a multiplicity of potential selves, thus providing an illusion of transcendence of the self (Ogden, 2004), as illustrated in the group idealisation of the "perfect mother" with the "perfect family of children".

Klein (1946) maintains that idealisation can perform an adaptive developmental function – it constructs a 'perfect' object in the real world so that the internal good object can be strengthened, thus strengthening the ego to cope with the pain of loss. Idealisation is the result of the defensive splitting of the good objects from the bad in order to protect the good object from being attacked, damaged and destroyed by the bad objects. In idealisation those characteristics that are felt to be good, vital and loved are put into an external object for safe-keeping, to be re-introjected at a later stage, intact and undamaged by the bad objects. However, defensive splitting is brought about through attacking and severing the mental links between different experiences and aspects of the personality (Bion,1962) in order to deny and annihilate a painful situation. Klein (1946) points out that "it is not only a situation and an object that are denied and annihilated – it is an object relation which suffers this fate, and therefore a part of the ego, from which the feelings towards the object emanate, is denied and annihilated as well" (p. 182). Because idealisation is driven by feelings of persecution, the idealised object is thus much less integrated in the ego (Klein, 1956). The presence of death in the room, in the form of the ill facilitator, provokes heightened fears of annihilation that overwhelm the confidence in the good object, necessitating the resort to renewed splitting, denial and idealisation, activities which further undermine the strength of the ego.

5.6 A mlungu holds the wellness

The taboo on speaking about HIV in the group is not just an idiosyncratic feature of the groups in which K and S were working; it exists as a powerful social sanction that exists in the group's unconscious, an unconscious that is profoundly social in nature (Foulkes, 1977). As a result, the life of the group is shaped by defensive dynamics that serve to maintain the taboo, thereby protecting the group from intolerable depressive anxiety. Part-objects are employed in a defensive repertoire and exist through and in opposition to one another. Thus the idealised mother finds an apt "hook" in the white, female therapist and is constructed in opposition to the ill, absent and devalued mother (the "hook" for which is provided by the ill, black facilitator) thereby functioning to defend against the intolerable pain of loss and bereavement.

A strong need for the preservation of wellness is also demonstrated in the groups. K and S both report that in the groups there was a lot of play with the doctor's set. The children in K's group spent a lot of time playing out feeling sick as a result of the medication and their experiences of coming to the hospital, without the group ever talking about the children's status. In S's group the play with the doctor's set was play about wellness. S recounts how at the beginning of every session the children would put on the stethoscope and check her heartbeat and look down her ears and throat to make sure she was well. She understands this as the group needing the wellness to be held in her, "and then they would feel alright, that we were not going to die, or that I was not going to die."

S reflects on how her health became a feature of the idealised mother with the perfect family of children, constructed in opposition to the illness of the dangerous and devalued mother. The transference of the group to the therapist was that she was a parent who's "chances of dying were very slim", a parent who brought the children not only food and sweets from a perfect home, but also wellness, and with that, hope. At the same time the group worked to keep the translator, the dangerous and neglectful mother, on the periphery, thereby replicating their reality of belonging to broken families while negating and excluding her embodiment of illness in order to render it safe.

S notes how the fantasy of the perfect world was the "mlungu" world of abundance and privilege. In the same vein but on a different note, K says that a strong feature of her countertransference was the sense that her HIV negative status is somehow intimately *and* shamefully associated with her race: "It does make me feel more privileged. It adds to my whole package – I'm white, I live in the suburbs, I have a car, *and* I'm HIV negative, *and* I'm educated, you know".

When an attempt is made to crack the taboo and speak about HIV in the group, a powerful sense of guilt infuses the role of holding the wellness. With the stripping away of the protective denial, the idealised object seems to refuse the safe-keeping of the group's loved, valued and good parts. Instead it becomes a patronising white racist that keeps all the good for itself and where an HIV negative status is overlaid with other layers of white privilege. S says that through the group she "began to know that I was negative. You know, you don't think about it until you work in it and then suddenly, you are different. (I struggled) a lot

around my own feelings of being white and privileged, a huge amount of that." While K says of her attempt to broach the subject of the children's status in one of the groups:

> So I said, we are here because of HIV, everyone here has got HIV, and even saying that, there's always the feeling everyone's got HIV except me. And its such a - I suppose its that feeling of setting up that kind of patronising white person coming to help Africa, you know, and I hate that and I so don't want that to happen, and I hate the fact that I can't speak the language, you know.

And:

> Here I am, a white therapist who doesn't have HIV. And I think it just feeds into lots of feelings about being white in South Africa, for me. That's a lot of stuff I had to think about and work with, and still struggle with. I go in, and I leave, in my car, to the hospital. Everyone else gets R3 for transport or has to walk. And it's just the differences you have to face, even when it comes to HIV. I'm not saying that white people don't get HIV, they do, but in this kind of context, its black children, and lots of deprivation.

It seems that when cracks in the denial of illness and death appear in the group, there is a realisation that the idealised mother is founded on the group's denigration of the abject mother, a denigration that is associated with social stigma. The appearance of guilt therefore suggests that some integration of these split-off aspects of the maternal imago occurs, and as she is perceived as a whole object, a realisation of the damage done to her, and hence a sense of guilt, arises.

K says, speaking about a question posed to her by the facilitators about how to answer the child's enquiry about the facilitators' status, "I'd put it back. I wouldn't answer that kind of question as a therapist. I would explore with them, 'well, maybe you think…' But that's the thing – they all thought I wasn't, of course, because they'd made me into being something that wasn't, even if I was, because I was this idealised object." At the same time, K reflects on how the male facilitator also enjoys a relatively idealised position in the group, in contrast to the black female facilitator:

> He was cool, they liked him and they liked me. She was the one who took on the bad, the bad stuff. So its an interesting thing in terms of, I suppose, certainly white still has this thing that's kind of idealised, and something about men as well that's interesting. Something I suppose about the black woman who has the harder role. She had the tougher role. They would often not say her name, forget her in the circle, never forget me and never forget the male facilitator. And I think it was hard for her – she struggled with, she didn't know what to do with that.

Leclerc-Madlala (2002) illustrates that stigmatisation of HIV/AIDS in Southern Africa is founded on traditional conceptions of ritual pollution from African cosmology. Douglas (1966) asserts that death's power to threaten the stability of the conceptual grid gives rise to the association of illness, bereavement and mourning with pollution. These are thought of as "dirty" because they disrupt the orders of knowing and being. This disturbance of the conceptual order evokes the appearance of the pre-oedipal mother who is omnipotent and annihilating (abject), and thus pollution is intimately associated with women's bodies because the abject mother is pinned to women's anatomy, in an attempt to control it (Kristeva, 1982). Hence, in South African cosmology, women's bodies are the harbingers of death and disease unless pollution rituals are observed (Leclerc-Madlala, 2002). In the excerpt cited above, the operation of powerful projective identifications that are activated when the conceptual order is disturbed by the power of illness and death, renders the black mother as dangerous and contaminated and the white mother as good and abundant.

Being in the role of the idealised mother is experienced as tiring by K and S, not only because of the constant demands as a result of the group's projection into them of the "abundant breast", but also because the idealised mother is never far from the vengeful, persecuting mother, represented by the 'patronising' and 'privileged' white. K speaks of her strong desire for the splits between the idealised mother, the vengeful mother and the abject mother to be

healed through lending some of the good she holds for the group to the injured maternal imago and the vulnerable child self: “sometimes I wish I was positive because then I could sit in the group and talk about ‘us’, say ‘us’”, and “I suppose I would want to say I’m positive to give them hope or something”.

S reflects on her experience of being idealised in the group as a safeguard against the “retaliating or dead mother” (Klein, 1940, p.157) and how this is intimately bound up with her need to maintain a boundary between two worlds, that of poverty, illness and death, and that of white suburbia:

> The dynamic of the translator was that she would contaminate (the perfect mlungu environment), she would make the reality more, for them more of an awareness than it was. So they could stay in the fantasy, they could have this fantasy that I came from this other world with all these things.

And:

> I would have to go home after the group was over and I would need to have a bath, not a shower, but I needed a bath - trying to make some kind of adjustment to another world when you came back. So maybe the boundary was taking a bath, was my way of making a transition from one world into the other. I’ve always used a soaking bath when in emotional distress, so maybe that was my way of emotionally destressing. And if I couldn’t do that I was miserable, miserable as anything.

Ultimately, S reports that she burnt out as a result of the work and has stepped back from it, possibly because of the despair engendered by the failure of the healing of the split. K has continued to engage with the work and says, “lately I’ve been feeling more energised by the work, maybe because there’s more support, or it feels like the work’s doing more and its not just me having to take all the responsibility”. The project has moved towards a “directive creative arts approach” in which the facilitators are being skilled to run the groups within a theme-based framework. These groups are being run in conjunction with caregivers groups that function to promote disclosure to the children. A more directive way of working contains

the thanatropic anxieties that arise when the transference-countertransference is privileged in psychodynamic therapy, and also undermines maternal abjection by installing the black female facilitators as more functional, authoritative maternal representations. In this way, the good is not dominated by the white facilitators, as there is a greater equality between team members, as K alludes to in her wish that she could "speak about us". An engagement with disclosure to the children also indicates an increased receptivity to grief and thus a lessening of denial. The restoration of the good maternal imago strengthens the ego's capacity to tolerate the pain of grief, and in turn, the processing of grief strengthens maternal containment (Kauffman, 1994). K's desire to heal the split represents an act of reparation to the maternal imago and her sense of feeling more supported may therefore be an indication that the internal objects in the life of the team, and hence of the groups, are living more peacefully with one another and the self: "If greater security in the inner world is gradually regained, and feelings and inner objects are therefore allowed to come more to life again, re-creative processes can set in and hope return", says Klein (1940, p.162). However, there is also the possibility that a directive way of working will reinforce denial, and thus perpetuate the state of disenfranchised grief.

Kauffman (1994) refers to the stabilisation of self and object relations as "a proto-mourning process" (p.158) that is a precursor to mourning as well as at the crux of the mourning process proper. The stabilisation of the self and object relations involve the processing and transformation of primitive omnipotence and narcissism, actions that are central to the work of mourning and feature in the countertransference of all the participants.

The following section explores the feelings of persecution that are elicited in the participants in consequence to the narcissistic injury that is sustained in the face of loss.

5.7 Cruel and unfair

The presence of death renders us out of control and thus, helpless; an experience prefigured on the earliest experience of helplessness during infancy, a state that is one of total dependence on the maternal figure. Helplessness evokes frightening feelings of vulnerability and a resulting anxiety about the security and reliability of our good objects, particularly the parental imagos, and whether they are living peacefully and lovingly with each other and the self (Klein, 1940). The children's condition seems to defy the natural order and the law of consequences according to which reality is rendered not only meaningful, but also within the control of the ego. The confrontation with a disruption of the natural order through the inversion of conceptual binaries undermines confidence in the reliability of the good objects and destabilises the internal world. As a result, the internal world is felt to be dominated by capricious, hateful and persecuting objects that victimise the vulnerable, helpless child part of the self (Klein, 1940).

This internal state is expressed by the participants as the strong feeling that the child's suffering is an injustice. "I suppose I can't make sense of it. It feels cruel for a child to have to deal with it, and everything else, and not have a mother", says K. Regression in the face of a loss reactivates the experience of the pre-oedipal maternal imago as vengeful (Kauffman, 1994), and this feeling arises out of angry attacks that are made on this object when she is

perceived as impotent and having failed to protect the vulnerable self from the pain of loss (Klein, 1940).

The sense of injustice about the children's condition is experienced on two levels: as an existential struggle and secondly, in connection with the recognition of social relationships of power and exclusion. In the former, the injustice of the seeming senselessness of a child being born with HIV is expressed by the therapists. J says, "I have to manage my feelings of how unfair it is for a little kid to have to deal with all this kind of stuff" and "that's one of the most unfair things, the hardest thing is to see a child who is terminally ill". Similarly, L says, "Why should a child have HIV, why should anyone have this HIV, but why should a child? They were all born with HIV. It just felt like they shouldn't".

The therapists also talk about the injustice of stigma and relationships of inequality between men and women in which women are infected by unfaithful partners. Speaking about stigmatisation, J says,

> A particular little girl told her friend (that she is HIV positive), who then told the rest of the school. Now nobody will play with her. It's a very, very real fear and that pushes my buttons because I want people to be understanding. That kind of stuff feels very, very unfair. It clashes with my kind of ideal, my idea of the world where: 'So you've got HIV, so you've got diabetes, it's the same thing'. But society sees it in such a different way.

Where stigma is operating, the stigmatised bear powerful social projections of what is abject and negated, terms of a binary that is constructed to guard the social order from the disruption of death. In this respect, Leclerc-Madlala (2002) discusses how the stigma of HIV/AIDS is constructed along the contours of Southern African beliefs about pollution rituals associated with sex, childbirth and menstruation; activities that are regarded as ambiguous

items that defy neat categorisation, and therefore possess a disruptive power in their role as occupiers of a liminal, or marginal zone in the conceptual taxonomy. Pollution rituals function to contain the dangerous power of these ambiguous phenomena, thereby protecting the social and cosmic order (Douglas, 1966). Within this belief system, HIV infection is considered a consequence of a failure to observe these rituals. Hence those with HIV and AIDS, as bearers of a terminal illness that is transmitted through 'liminal' activities such as sex and childbirth, are considered polluted, and therefore highly disruptive to the social and cosmic order. The stigmatised therefore bear 'a mark'[3] - that of pollution, ambiguity and danger, and stigmatisation functions as an attempt to maintain those with HIV and AIDS on the margins where they can in some way be 'known', thereby containing, at least to some degree, the danger they represent. From their position on the periphery, the stigmatised function as scapegoats for the social group's thanatropic anxieties (Kauffman, 1994).

However, in the therapy group there is some receptivity to and acceptance of the part-object relationship that has been projected into the child in his role of the bearer of what is abject and dangerous, and this partial lifting of denial of the power of death and the reality of mortality confronts the participants with anxiety about the security of their good objects. In experiencing the child's condition as cruel and unfair, the reality of mortality is perceived as retaliation by the parental imagos, as a result of displacing onto them impotence and grief in order to maintain the narcissistic defences (idealisation and omnipotence) against death (Klein, 1940). In this respect, L experiences the government as withholding treatment that

[3] The term 'stigma' derives from an ancient Greek word for a mark branded or tattoo'd on the skin of someone considered morally degenerate and therefore to be avoided. The contemporary meaning of stigma is defined by Goffman (1963, p.13) as "an attribute that is deeply discrediting". However, Goffman provides a significant qualifier: he asserts that stigma must be considered a quality of a relationship rather than a quality of a person.

could have prevented mother to child transmission, and therefore as inflicting a grave social injustice:

> I just want to take Thabo Mbeki to a place for one day for him to see how all these children were born with HIV and they didn't need to be. A lot of anger … How does one really deal with it? Well, it's just the reality, I can't say I fully accept it as it is, and that's alright. I don't think that it's alright, it feels like a fight, it feels like apartheid, like equating the struggle against apartheid, the struggle with HIV, it does feel a bit like that. It does feel like a struggle, it feels like something we should be able to contain.

L's anger suggests that she perceives, what is in reality government denial and ineptitude, as a retaliation (the deliberate withholding of treatment) by the parental (paternal) imago, an imago that is simultaneously impotent.

According to Klein (1940), it is faith in love that facilitates the work of mourning. Suffering becomes meaningful when love for the internalised good objects is felt to survive the perceived hatred and persecutory attacks of an internal world that feels bad, capricious and unfair. Through the work of mourning, the loved object is restored and reinstituted as alive and good in the ego. However, faith in love may be difficult to achieve when it is a perceived failure of love that has caused the child's suffering, for example, when the child's mother has been infected by her unfaithful husband. Faith in love is also difficult to achieve when the 'act of love' takes on a 'shadow' aspect through its role in transmitting the infection.

The struggle to restore faith in love can result in a profound despair (Klein, 1940). J says, "It's sad for me because this is not the way I think it should be. It's hard to make sense of it for yourself when you are in a place of despair". Despair may be defended against with a strong desire to rescue the child from suffering and even from death itself.

5.8 Rescuing the child

Working with children who have lost one or both of their parents evokes intense feelings of wanting to comfort, nurture and protect the child. "The patients I find most emotionally difficult to manage are the one's whose parents have died as well", says J. "I feel such a kind of affection for these children and a desire to take care of them and make it all better for them". L too speaks poignantly about her aching sadness at the children's "basic need to have a mother (which) they would express so clearly" and her realisation that she "couldn't be what they basically needed".

The children's obvious deprivation and their often unspoken sadness about their bereavements evoke powerful feelings in the therapists of wanting to rescue the children from poverty, protect them from stigma and provide them with maternal nurturance. "It's terrible if the mom is also sad", says J, because then the child has no-one to hold her, physically as well as emotionally. "When mum dies or dad does, or both of them die, where do you go?" asks, S. "You're shunted from gogo, to auntie, to another auntie, or……" Perhaps here it is the possibility of abandonment that is too painful to articulate.

The children's traumas and losses are played out in the groups, sometimes with the full intensity of the original experience. L describes a child survivor from the war in the Democratic Republic of the Congo who "would have a huge kind of trauma response to little things that might go wrong and she would just start screaming and crying and crying. She would not allow you near her to comfort her. You would just make her worse." Experiences like these were "very, very painful and very sad and very desperate" and left L "feeling really

desperate that these children need a mom". L says that it was in response to these painful feelings of helplessness that "fantasies of adopting" arose:

> I just felt that if I could be their actual mother. And it also seemed so possible. I would fantasise that I'm a young woman, I'm not a mother. I knew and I still know that I could, although it would be a cross-cultural situation, there's still no doubt that I could give them a whole lot better environment and nurturing, what they needed. If they were my child I could give them much more than they're getting in a children's home.

In the same vein, J speaks about how her sadness and sense of injustice regarding a child whose parents have died, elicit the desire to adopt the child "and take him away from this horrible, awful socio-economic circumstance and protect him and care for him. Because it's hard to explain why you love him for only one hour a week".

It is not only the children's unspoken expressions of grief and vulnerability that evoke rescuing in the therapists. Some of the children also "jump into" their hearts by actively seeking the therapists' love and attention. J says, "one or two of them push the boundaries. There's always, 'ah, can't I stay with you a bit longer?', and that plucks at my heartstrings, because shame, these poor little things." K says that at times when the children fought each other to claim her attention, what always struck her was the extent of their deprivation: "A desperate hunger. If you offer something, they all want everything and they want it all. And it's like a pack. They're like little puppies, they all get in and they want everything", "literally like puppies grabbing at the good breast". One little girl in her group tried desperately to claim a place in K's heart by leaving notes after the session telling K how much she loved her.

The children's neediness and vulnerability evoke strong maternal feelings in the therapist and fantasies of 'being their real mother". At the same time they induce a powerful identification

with the therapist's inner child. K recounts how she became strongly attached to a little boy in one of the groups and was overcome with the desire to adopt him when, on trying to comfort him one day by telling him she would ask his mother to tend to his painful rash, he replied that his mother was dead.

K speaks about how she responded most of all to his vulnerability in the group and felt very protective and maternal towards him. She says, "(I made) a very strong, I think more than I've even actually acknowledged, a strong connection with this little boy". But she also describes how her attachment to him was not only due to the fact that he does not have a mother. She had also made a powerful identification with him through relating to him via projective identification:

> Something in him was resonating in me. Just his struggle with being, just learning how to be. And I think in a way that did resonate with me. He just loved the arts as well, he just loved the opportunity to do what he was doing, and this was a safe space, and he could just be, to feel those feelings, and I think that also resonated with me.

Similarly, J says that it is her "vulnerable child" part that is elicited in the work with the children.

> Working with these kids brings out your vulnerable child, in a big way. So that you can't avoid it. Especially the ones who've lost parents, who've lost so much stuff, and they're just this little vulnerable person in a horrible big, ugly world, and you're sometimes the only kind of anchor, consistent caretaker.

What can perhaps be seen operating here in the countertransference is what Deutsch (in Lasky, 1993) refers to as a "double identification" and Racker (1957) refers to as "concordant" and "complimentary" identifications. The therapists identify with the children's significant internal object (the mother), as well as with the children's self representations. Further, the

children actively enact the role of the vulnerable and needy child in an attempt to elicit maternal behaviour from the therapists. The participants also bring their own unresolved unconscious difficulties to this relationship, providing a "valence" for the children's projective identifications, while the children's subjectivities are also partly negated through the operation of the therapists' projective identifications. The third subjectivity that is experienced by the therapists contains aspects of two subjectivities – the helpless vulnerable child and the powerful "real" mother. It is through the acts and fantasies of rescuing the child that the therapist becomes the "real" mother in the analytic third. Yet in the third, the child's appropriation of the therapist's power and the therapist's subjugation to the vulnerable child also creates a potential subjectivity in which the child transcends the role of victim and the therapist discovers a new strength in vulnerability. This is discussed in more detail in the latter part of this chapter.

Greenson (in Bolognini, 2004) maintains that identification is a defensive manoeuvre designed to avoid painful feelings. The double identification made by the therapist gives rise to fantasies of rescuing the child, fantasies that remain in the mind of the therapist as ruminations about adoption, and also play out in the sessions as "doing too much". Doing too much springs from the desire to "make a difference", "create a perfect family", "protect the child from the very adult circumstances they were facing" and "wishing I could make it be okay for them". Perhaps what are being avoided by resorting to fantasies of rescue are the desperately painful feelings associated with the children's bereavements. Kauffman (1994) maintains that the therapist's denial of death or intolerance of helplessness can mobilise rescue fantasies (a wish to save the bereaved from the pain of loss), undervaluing the bereaved's need to suffer the pain of loss and helplessness, resulting in an engagement of

compulsive defences that jettison feelings of loss, helplessness and the reality of death: "Our yearning for closure, our subtle denials, our whispers of self-assurance, our urges to fly from the agonising emptiness, our dread and numbness, our aching for release of tensions, and our passion to cure the helplessness of those we care for must be recognised as signals" (Kauffman, 1994, pg. 166).

L recognises that her feelings of wanting to 'save' the children arise as a response to her sadness about their suffering: "I think my feeling response to those children, before even working with them, is that it was profoundly sad, you know. Where their lives had ended up and yet so needing to hold that, and I guess a part of that was to try and save children from that place". Kleinian theory helps us to understand that L brings her own personal history to the relationship and is also trying to save her internal child from a deep sadness. This realisation is expressed succinctly by J as follows:

> And in terms of just managing, being the vulnerable child in a world that wants to be taken care of - that puts me in touch with things in my past where I was vulnerable and I wasn't taken care of, and the desire now from my big, strong therapist point of view is to take care, is to be the one to take care where I think I was missing it, kind of when I was a small kid.

And C:

> I think my own fears, the anxiety that was around, very primitive stuff like mom not being available, mom not being there or being around, and you know the way these children, a lot of them are forced to become very precocious and independent, and I think I was like that. So there's something that reminds me of myself … in a way it's the 'me' I'm trying to mother, to nurture, my own internal child in these little children.

The identification with the 'vulnerable child' reactivates conflicts in the participants relating to their own 'vulnerable child part' and initially an attempt is made to manage these conflicts

through projective identification of the internal vulnerable child into those children in the groups that have a "valence" (Gabbard, 1995) for this. Hence, fantasies of rescue act to magically transport the internal child away from suffering (through adoption fantasies, for example), and to omnipotently effect a restoration to the wounded child by offering the ego as a replacement for the dead or dying mother.

The enactment by the therapists of the omnipotent mother in the analytic third operates in concert with the subjugating of the vulnerable child as a helpless victim. Note how S's language denotes omnipotence (italicised) while simultaneously constructing the children as helpless: "And I've always queried work with children when you're working with this kind of level of any abuse, any deprivation, the difficult situation where these children come from. Is it ok to give the children a space that's different and hopeful and then *put them back* into such a dire situation?" A similar sense of omnipotence and helplessness comes through when J speaks about her response to her colleague's denigration of her work with HIV positive patients:

> These people, the work here feels really important, they don't have other resources. If we're not here, there's nobody here, and nobody will take care of them, whereas other people have a medical aid or they can afford to go to a session or they can get their stuff looked after. It's one of my resentments as well, kind of, hello, I'm saving people who are poor and cannot do it for themselves.

Omnipotent fantasies of rescue thus continually damage the internal vulnerable child who must be constructed as powerless to maintain the equilibrium in the binary impotent/omnipotent. Reflecting on this, L says, "(I) kind of had to work with (trying to save the children), and not to be the saviour, and not to imagine these children were sad all the

time, because of course they weren't", and C: "I think that's very much my own stuff, the pull to, in a sense not trust their vulnerability, to feel the need to make it better."

The double identification that constitutes the analytic third sets up a dynamic that deflects from the work of mourning until such time as the pain of loss can be sufficiently contained by the intersubjective ego. Thus the poles of helplessness and omnipotence continually collapse into their opposites as they are constituted in and through each other. Kauffman (1994) maintains that helplessness and omnipotence are present everywhere in the group as it struggles to do its work. He states that they are opposite sides of the same coin. Omnipotence serves to transform death into its opposite, and helplessness "is the presence of death within omnipotence" (p.155). This splitting happens as a defence against the "primitive narcissistic anxieties of helplessness, abandonment, being overwhelmed, loss of control and rage" (p.157) that are elicited in the face of object loss and annihilation anxiety. As primitive omnipotence and helplessness are gradually worked through, a greater differentiation of container/contained occurs, making possible a greater tolerance of the pain of loss, and hence, movement towards an acceptance of reality (Kauffman, 1994).

While helplessness is being defended against with omnipotent fantasies of rescuing the child, reality nevertheless continually bursts through the omnipotent defences. A last-ditch attempt to ward off the reality of helplessness in the face of loss is resorted to through expressions of anger, while despair is never far off. At an unconscious level, this is anger at the parental imagos who have failed to protect, who abandon, who are unavailable, worthless and powerless (Klein, 1940). In the participants' accounts, anger therefore finds expression

towards authority figures such as the medical establishment, funders, the administrators of the mission home, the government and even God.

5.9 Raging and blaming

L says, “I think I have found a lot of anger about it, at who, or what, or why, I don’t really know. Maybe God”. At times the participants attempt to modulate the painful feelings of vulnerability, helplessness and persecution relating to the ‘injustice’ of “children being born with a death certificate”, through expressions of anger. The following comment from J illustrates that the painful feeling of helplessness in the face of suffering and death is experienced as persecutory and defended against with anger: “It makes me angry, but in a global sense. I’m not angry with a particular woman who slept with a particular man and got HIV. There’s more a feeling that the world is unfair and I don’t like the way it is and there’s nothing I can do about it.”

L talks about how she tried to deal with her feelings of sorrow for and desperation about the children by becoming “kind of an activist in the mission home. I would become quite angry. So I wasn’t always heard.” Similarly, C expresses her rage “against the medical system” in response to the helplessness and despair she felt while witnessing the emotional and physical suffering of a dying six year old who had been virtually abandoned in the hospital by her mother.

> I've got one patient that died where I did feel a lot of rage, but it was rage against the medical system, it was, ‘how could they?’ She was just treated so badly at the end. I wanted to just let her die. Stop trying to feed her with a

> tube down her throat, she doesn't want it, and she's throwing up and she's not going to survive, so let her eat sweets and drink Coke, as much as she wants!

S expresses her anger towards the funders' for their insistence that the project prioritise a short-term, directive group intervention over long-term psychodynamic group therapy:

> I became very angry towards the funders. Because it is *really* driven by the funders, it's not driven by anyone else. And their focus is to get as many children through the system as possible. Whereas maybe you could make a difference in 6 children's lives, really make a difference. Was that not better than trying to push a whole load of children through a program?

Directly prior to this passage, S had got in touch with her profound feelings of despair and hopelessness at not being able to make a difference in the children's lives: "Hopelessness and despair – that came with the children, and that came specifically because I knew I was putting them back into the same situation. I wasn't changing the situation".

The 'helpless rage' of which the participants speak is also felt to be the children's projective identification. K speaks of a little boy who had been disclosed to a few weeks previously and came to his first group session in a rage, ostensibly at the 'stupidity' of a group where he had no friends and would not be playing soccer. Similarly, C talks about how she held "a lot of (a dying child's) helpless rage at the world" and says of this experience:

> (It was) very painful, there was a lot of rage. I think there's a lot of her stuff you end up holding. I think her emotions, and I think in those cases, that is your role. You're the therapist; you're there to take and contain all that uncontrollable, un-containable stuff. The word 'stuff' keeps coming out and I think there are no names for that kind of emotion right in the beginning you know, when these children are so young and dealing with something so huge like that. And so I think you hold a lot of it, it does bring up a lot of the unfairness of life.

Attempts to modulate the pain of mourning through expressions of anger can also have a destructive effect that intensifies painful feelings. When projective mechanisms can no longer protect the loved object from attack, there are painful consequences to the self. C speaks about how the children's refusal to take their medication can represent an attempt to angrily deny loss and punish the vulnerable, unwell self:

> We talk about how horrible it is to take the medication, how some of them will not take medication, that they feel angry that they have to have this illness. 'Yes it is, it's unfair and you feel really angry', and you explore other ways of feeling angry rather than punishing the self. It's like the internal, sick, vulnerable child they're trying to kill off, you know. In a sense it's like a denial.

Anger about the unfairness of a child being born with HIV is an indication of a struggle with helplessness in the face of loss and death (Kauffman, 1994). Helplessness evokes powerful fears of annihilation anxiety and anger may be employed in an attempt to fortify the ego to increase its capacity to tolerate the pain of loss. By projecting the anger onto authority figures in the external environment, the loved object is also temporarily protected from internal persecutory attacks (Klein, 1940). However, the search for meaning can be made more difficult if anger is excessive because anger can inflame the internal world, resulting in painful attacks on the loved objects, in particular the parental imagos, and because the ego is identified with these, this results in painful attacks on the self, thereby intensifying the pain of loss, evoking despair and meaninglessness and delaying the work of mourning (Klein, 1940).

5.10 Despair, hopelessness and meaninglessness

At times a sense of despair, hopelessness and meaninglessness permeates the work of the participants. C says, "It brings up a lot of despair. There are times when I think that spoils it

completely and I hope I never have children. It sounds terrible, and it has that sort of effect on you. I think it can sometimes make your own relationships meaningless, your own life seem meaningless". Suicidality in the children is the ultimate expression of hopeless despair and provokes a corresponding attack in C on her internal vulnerable child (note her use of "you" to denote verbal distancing, with the result that there is slippage between the first and third person in "*you* would be better off dead"). Responding to the question about what is the most difficult aspect of the work, C says:

> I would say suicidality in these children. To talk about that is very hard. That I think is a button for me as well, it's my button, in terms of people dying. And my related sort of responsibility includes everyone, you know, the responsibility, my omnipotence. It's a difficult button. Sometimes with these kids you do have a feeling where you would be better off dead. You know, sometimes there is that feeling with these children where they are so abused, so neglected, just so completely left that you just think whew …

And:

> You just think, My God, if I was you, I would have killed myself a long time ago

Klein (1940) asserts that omnipotence is closely bound up with sadism in the unconscious, giving rise to the feeling that the part of the self identified with the vulnerable child is repeatedly injured. In identifying with an omnipotent maternal imago (rescuing), the vulnerable parts of the self are harmed through the act of subjugating the internal child as weak and helpless, sometimes to the extent that it is felt to be "better off dead". In this regard, C's comment is an expression of profound despair about the ego's ability to love the vulnerable parts of the self, as well as to make reparation to the good object. As Klein (1940) has shown, when manic defences are in play, the good object, and hence the self, are experienced as being repeatedly injured by the manic attempts to possess, control and master.

When omnipotent fantasies of rescue are in play, the reality of human limitation (helplessness) is experienced as impotence. Thus, the participants report that feelings of hopelessness arise out of "the feeling of not being able to do enough" (impotence). L says, "I felt it would never be enough, and not only for those children, but when one looks at the amount of children living with HIV, it's just a drop in the ocean. It will never be enough". Similarly, S says, "Boy, did I struggle with understanding that what you do is good enough".

The despair that arises when rescuing fails is illustrated by S: "Hopelessness and despair came with the children, and that came specifically because I knew I was putting them back into the same situation. I wasn't changing the situation". J says, "It makes me sad in a very helpless way. I feel I do damage control a lot of the time. I'm containing and catching stuff without necessarily being able to make a difference at the end of the day."

5.11 Conclusion

In normal mourning, "the poignancy of the actual loss of a loved person is greatly increased by the mourner's unconscious phantasies of having lost his internal good objects as well. He then feels that his internal 'bad' objects predominate and his inner world is in danger of disruption" (Klein, 1940, p.156). This threat is experienced at the primitive narcissistic level of the personality and the defences that arise are thus manic in character. Helplessness is experienced as the threat of annihilation, and denial, splitting, idealisation and aggression come into play. Depressive anxiety also emerges at times when the maternal object is more integrated, but is defended against with omnipotence fantasies of rescue. These defences play an adaptive role but also have a destructive effect on object relations and thus on the

ego. Hence, despair and meaninglessness continually arise and provide an impetus for repeated attempts to work through primitive narcissism, integrate the split imagos and make reparation to the good objects so that they can be installed as whole and vital in the ego. The following section explores how the installation of the good object facilitates containment, and thus an engagement with the work of mourning.

5.12 Engaging with the work of mourning

5.12.1 Relinquishing omnipotence

"In the regression of early group and at nodal points in group history, we witness a stirring, sometimes a turbulence, of primitive anxieties. In these group events, the symbolic mother-group object is a pre-oedipal mother who is rejecting and overprotective, omnipotent and helpless, compelling submission and opposition and representing a wish to annihilate and bring back to life" (Kauffman, 1994, p.159). Omnipotence is a primitive state that functions to stabilise the object and the self in order for the ego to overcome the internal persecutors to some extent and "assert itself against a slavish and perilous dependence upon its loved objects" (Klein, 1940, p.151). However, maternal omnipotence must be mourned in order for the internalised object world of the group to develop: "Only through losing mother-group as a primitive pre-object presence, is she constituted ambivalently in group-object space." (Kauffman, 1994, p.158).

In the previous section, maternal omnipotence has been demonstrated through the participants' desire to rescue the child, and the resulting subjugation of the vulnerable child in

the analytic third as weak and impotent. However, there are points in the narratives of the participants where they recognise that the desire to rescue the child is an omnipotent fantasy that constructs the child as powerless and establishes a relationship of dependency that gratifies the group wish for the revivification of the preoedipal mother. J says, “so it's around my omnipotent process: oh gosh, I need to save them and rescue them and make everything absolutely perfect. And that is a wish, but gee, I can't”. Similarly, L says, “ I think the need to be a kind of saviour was, and I was kind of conscious of that, was what one would like to steer away from really. I wouldn’t be there to kind of save anyone from anything.” When omnipotence is relinquished, whole object relating becomes possible and there is a tolerance of the child as vulnerable, wounded and suffering. This facilitates a recognition that the child is also resilient, coping and playful. This represents whole-object relating which allows the painful reality of the children’s bereavements to be confronted, without omnipotence. In this regard C says, “(it’s been) a psychological education for myself in terms of sitting with the pain, and sitting with the stuff that’s ugly and not nice and there is no way you can make it better. That’s just how it is.”

5.12.2 Awareness of fusion

A reflective engagement with their work with the children, privately or in supervision, facilitates containment of the therapists’ archaic object relations that are activated in the groups. The utilisation of the witnessing function (Britton, 2004), a reflexive third position from which it is possible to think about, rather than act from one’s internal experiences, allows the participants to become aware of how they relate to the children via projective

identification, and bring conscious thought to the interventions they make in the sessions. C says, “I want to teach them to intellectualise, you know. Cope like I coped.” She goes on:

> I became a very over-achieving child, to cope with the feelings (associated with her depressed and suicidal mother). It was a way of almost, perfectionism as a means to bind my own anxieties, and so very much I think there is a pull for me to do that in the group

Reflecting on her tendency to fuse with one of the children in the group around the child’s experience of bereavement, L says, “I suppose a lot of it is about unravelling what’s your’s and what’s their’s”:

> A child kind of draws a picture of their mother in the session. And their mother had died, which is (pause). I mean I would be almost consumed by sadness. The child would be drawing away and not necessarily expressing that, and I would need to make a choice – how much was mine and how much was their’s? What would I do with that? Would I give voice to my feelings or would I not? And those kinds of choices. I spent a lot of time wondering what do I give voice to (pause). All those people who work in the field, one encounters a lot of one’s own feelings

The fusion that occurs as a result of the projective identifications that constitute the analytic third are also expressed by J: “It's hard for me to distinguish where I want the group to go from where they want the group to go. Whose expectations are we working with here?” Yet J also reflects on how the child is constructed as powerless in the analytic third through J’s projective identifications:

> I wonder how much of my feeling that the kids are overwhelmed is my feeling of being overwhelmed and also sort of putting myself in their situation, which is not really feasible. I imagine, oh my God, if that were me, I'd be totally screwed (laughter). But I'm not there and I don't know what it's like really, really, if you see what I'm saying. So it's my feeling overwhelmed by the process as well.

Britton (2004) maintains that the “reflective third position” is an oedipal position in which self and object are differentiated. The primary form of relating in this position is not projective

identification that results in a blurring of ego boundaries and a fusion between self and object representations, but whole object relating in which the other is perceived as separate and independent. Concomitant with this, the ego is able to adopt an external, non-fused position and is strengthened in its capacity to provide containment and to gain a realistic perception of the external object and the self. In this regard, J's awareness of her "enmeshment" with the child brings her into contact with reality, and therefore with the child's strength, agency and resilience. She also comes into contact with a realistic perception of herself in which she is whole, with limitations to her love as well as her hatred:

> It's comforting to know that they are strong enough to manage but I also don't think that I'm that important. I, for them, am not going to make or break. I can't save them. I also, by the same token, can't damage them completely and break them into small pieces, because I'm just the therapist, I'm the lady that they come to talk to once a week and we talk and they feel cared for and it's nice.

5.12 .3 Tolerating the feelings

The participant's awareness of the subjugation of their subjectivities in the analytic third is a result of containment: the ability to bring thought to bear on what is being enacted in the groups. Kauffman (1994) maintains that the process of mourning the preoedipal omnipotent mother allows for a greater differentiation of container/contained. The presence of the preoedipal mother in the group signifies the activation of the primitive fusion of self and object, and hence, of container/contained. This is the state of the infant prior to the stabilisation of object relations. The preoedipal mother, in her omnipotence, also contains within her death, through her power to annihilate the self by means of engulfment. The fusion of container/contained thus represents the regressive horizon of the group, a state of extreme instability.

The participants' awareness of their limitations and the regressive function of rescuing represents a relinquishment of the role of omnipotent mother, and thus a greater differentiation of container/contained. In their function as differentiated maternal containers, the participants' mature ego functions become available and they speak about the importance of tolerating the painful feelings that arise relating to the children's bereavements, rather than acting on them under the influence of subjugation in the analytic third. L speaks about this differentiation as "keeping some kind of space, there as a kind of individual, not to be emotional, because I can be very emotional, not all consumed, but to remain as the someone who would be the container as well". Similarly, J says, in response to the question, "how do you manage (the work with the children), how do you make sense of it?":

> I don't know if I do (laughs). I talk about it a lot, I think about it, I write about it, I take it to supervision (pause). Just the language of it makes a difference, just to language it, to express it, to think about it in a meaningful way. And sometimes I bring it back to the kids, not to say, "Ah, I'm feeling terrible", but "It's quite hard to sit here and be scared of what the future holds". And that's also pretty much what I feel and what I'm picking up from the kid as well.

C's awareness of her tendency to relate to the children via her own projective identifications, facilitates a sense of internal space in which she can hold her painful feelings of loss that arise in the group, rather than defend against them by changing the subject. Her greater receptivity to her own grief facilitates receptivity to the expression of grief in the group. Narrating an experience in one of the groups in which the children had spoken without inhibition about the deaths of their parents, an issue of painful personal significance for C, she speaks of her awareness of her "urge to end it, because what if it's too much for them". While "ending it" refers to ending the therapy session, the allusion to suicide is telling. C talks about how understanding her avoidance of the pain of the children's bereavements as a defence against painful childhood experiences of her depressed and suicidal mother, helped her to

tolerate painful feelings arising in the groups, by bringing awareness to her internal state during these moments:

> I think (pause) working with them, there's a sense that I have to be more vigilant for my stuff. Because I know that there's such a lot of it and there's so much that hooks (pause) and it's very much a case of with these children (pause) the feeling in the room can get very heavy. And then for me there's a pull, and this is where I know my own stuff is to move away.

And:

> These little kids (pause), and I think that's very much my own stuff, the pull to, ja, in a sense not trust their vulnerability, to feel the need to make it better. And for me it's been a complete education, I mean a psychological education for myself in terms of sitting with the pain, and sitting with the stuff that's ugly and not nice and there is no way you can make it better.

Kleinian theory emphasises that the result of projective identification is the blurring of ego boundaries and a weakening of the ego, giving rise to the feeling that the ego cannot protect the loved objects from attack. The thinking function, as maternal containment, enables a renewed contact with reality and an experience of reconnecting with the good mother. These experiences strengthen the ego which increases its capacity to tolerate the painful feelings of loss, and hence, to mourn. Pines (1994) expresses this as follows: "benign cycles of introjection replace the evacuative projections" (p.146).

5.12.4 A new conception of strength

With the relinquishment of omnipotence, the participants demonstrate an acceptance of limitations, their own, other's and that of the human condition (mortality). C says, "My okayness came a lot later, and an ability to make sense rationally of a world where children die, and how it was okay, you know." J says, speaking of her own limitations, "It's nice for me to be able to build a relationship with a kid, not to save, not to do anything, but to be there, to

talk what needs to be spoken. And I don't have any illusions that I've made the biggest difference in the whole world (pause). You know, because J is here (pause). Not like that at all". The following remark from L demonstrates that thinking about her countertransference facilitates an acceptance of reality as a place where suffering can be endured so as to effect constructive change in the internal and external world:

> It was very overwhelming, the awareness, the feelings….. it was difficult to make sense of it. But obviously, working as a therapist, one is constantly processing all of those feelings and I mean I feel okay (pause)…. I guess I found a place of being, of acceptance, that it's not something that does sit comfortably, nor I think will ever sit comfortably, it doesn't feel right. I think that is part of the impetus in the work, to kind of continue on. I guess I do feel that I'm part of some, a minute part, but a part nonetheless, of some kind of struggle against it, of trying to contain, trying to kind of manage it, trying to be part of a response to this thing of HIV and how it's affecting us in South Africa.

In this regard, the following quote from Klein (1940) is relevant: "In mourning, suffering can become productive. We know that painful experiences of all kinds sometimes stimulate sublimations, or even bring out quite new gifts in some people…Others become more productive in a different way – more capable of appreciating people and things, more tolerant in their relation to others – they become wiser (p.164).

With the relinquishment of omnipotence, helplessness is not devalued as impotence, but embraced as a positive state of receptivity to the emergence of "the unknown" unconscious material that exists in the group. C says, "It's very much this idea of venturing into the unknown with this patient, there's that feeling about it. And getting to a place where I can be comfortable with death". L offers a moving account of how she experiences being "left on the edge there in terms of life and death, those sorts of major archetypal questions" when a group of three little girls 'crucified' her in the session, and how important it was to tolerate the experience, so as to contain it for the children:

> It felt overwhelming, thinking whooo, and feeling, how does one deal with this now we're in heaven and being crucified? Wondering, where's the line going to come and where's the ending for this story which was the big question. How will this end? (pause). But at the same time being able to reflect as we were going through the play, how valuable it might be for them to actually walk this path, you know, and not having them be the one who's sick and dying. I was left having to contain that experience for them and they were very watchful actually to see how I was managing it.

The relinquishment of omnipotence brings about a sense of humility and tolerating pain and uncertainty is accompanied by a renewed receptivity to "the tender, intimate and vulnerable links to the object world" (Kauffman, 1994, p. 168). C says, speaking about the sense of "vulnerable strength" that she experiences when she allows herself to sit with "the stuff that's ugly", says, "I think that is a very difficult thing to kind of hold in your head, where sometimes strength is a defence and sometimes it's okay to be strong and not face those scary, horrible feelings. And sometimes it's important to be there and be vulnerable and not cope. And it's that constant balance and movement".

5.12.5 A space to be

Ogden (2004) maintains that the analytic third has generative potential for an enriched subjectivity in which the limits of the self are transcended. Therefore, it is not only the omnipotent mother and powerless child that are constructed in the analytic third, but when the manic defences relax as a result of the benign and self/object differentiating effects of containment, the projective identifications lessen and the participants become aware of being enriched through their work with the children. In this regard, C says of her work with the children:

> It's partly my journey as well in this process. I would say they help to make my world more meaningful. They can find those little things where the illness and the suffering has some kind of meaning. And I think that is the reason I stayed there and have not burnt out completely. I'm not despairing altogether, but it's holding the both. I think there is something about the beauty and the both, suffering and strength, you know, the vulnerability and the strength, the humanity that you see in these specific people.

Simultaneously, the participants experience the child, not as a powerless victim, but as strong, resilient, unique and autonomous. K says:

> And then, at the same time, just children's enormous resilience and love of life. And they get a cold and they get flu, but they still so want to play and be there. So its not all just, "Oh God, this is terrible". It's also an amazing sense of life. When I think of that little boy who I so wanted to bring home and adopt, ja, he could also just run around and play with a ball, he just wanted to be an ordinary little kid.

Similarly, J says, "I think kids are profoundly resilient as well. It's phenomenal what they can take on and manage".

When the child is perceived as whole, her uniqueness is appreciated. Relating to the child as a whole object also has important implications for the interventions the participants make in the sessions. Promoting the child's autonomy, rather than attempting to rescue, becomes a primary focus when the child can be perceived as separate and independent. L says:

> more and more I kind of gave it over to them to kind of lead sessions, you know, have a lot of choice, to have a kind of open session where the child would lead. Generally the sessions would take the path that they did when the child led, and at the end there was always a strong focus on kind of containing.

With renewed faith in their ability to contain the painful feelings associated with bereavement, the participants demonstrate greater receptivity to these feelings in the sessions. As a result,

the child's expression is encouraged. C says, "for her to find a voice in the group is so important, and I think that, when you link it back to her family and what's happening there, I don't think she has much of a voice there". L says, "I felt like in the therapy space they were able to kind of share a lot of their experiences and feelings in a very intimate way,...and I would try to make this space where they could really express things that would not necessarily be heard elsewhere".

Ultimately, there is a recognition that the child is engaged in her own process of mourning her losses. L says, "I wouldn't be there to kind of save anyone from anything, I'd really be someone to be with them, to kind of walk down the road with them and support them and give them kind of their own journey, understanding their HIV, their loss of a parent".

CHAPTER SIX: CONCLUSION

6.1 Summary and Findings of the study

The countertransference responses of the participants in group psychotherapy with HIV positive children have been understood to indicate a site of mourning. It is not just the children's health, longevity and social acceptance that has been lost, but many of the children have also lost one or both parents and other members of their family to AIDS. In turn, the children's bereavements elicit depressive anxieties in the participants who embark on a process which is at times intertwined with and at other times runs parallel to the children's journey of mourning their losses.

The reactivation of the participants' earliest losses occurs as a result of the subjugation of their subjectivities to the analytic third, an intermediate area in which the participants receive the projective identifications of the children for the purpose of experiencing, and ultimately transcending the limits of their selves. In the analytic third, the participants identify with the vulnerable and wounded child who is struggling with bereavement, as well as his own mortality. The disturbing power of death is imaged in the HIV positive child and the participants are thrust into a liminal zone in which the conceptual order is disturbed. This is also the area of decentred group unconscious, a concept similar to that of Ogden's "analytic third": the space where the individual is simultaneously I and not I, where subjectivity is continually negated and reappropriated and other potential subjectivities generated.

Through their participation in the group matrix, the participants are confronted with their own earliest losses. Fundamentally, this is the loss of the mother's breast, and with it, the feeling that all that is good, nurturing and comforting has also been lost. The parental imagos thus become temporarily unreliable and a frightening sense of persecution by bad objects arises. The activation of these primitive conflicts occur as a result of the disturbing power of death that is imaged in the HIV positive children, and in the context of the powerful social projections that they carry as a result of stigmatisation. Further, these primitive conflicts are highly personal to the participants and their countertransference responses can at times be seen clearly as driven by their unique personal histories.

The subjugation of the participants' subjectivities to the children's projective identifications activates complimentary and concordant identifications in the therapists, based on their personal histories. These identifications are interdependent and are constructed through and in relationship to one another. Thus, a concordant identification with the vulnerable, helpless child occurs in relationship with a complimentary preoedipal maternal identification. Hence, the participants enact the role of the omnipotent mother who desires to rescue the child part of the self from suffering the bereavement. This is expressed in the countertransference as fantasies of adoption, a magical transportation away of the child, not just from poverty, neglect and abuse, but also from the seemingly intolerable pain of loss. However, the identifications function as a defence against the frightening feelings of helplessness and persecution that arise as a consequence of the reactivation of early losses and thus continually enlist manic mechanisms that negate the need to suffer and mourn what has been lost in order for the good object to be reinstated in the ego. As a result, the good parental imagos as well as the vulnerable child part of the self are continually injured by the controlling,

engulfing and sadistic aspects of the preoedipal maternal object, calling for repeated attempts to make good the damage done. Further, the desire to enact the role of the omnipotent, pre-oedipal mother is continually frustrated by the intrusion of reality: that of the participants' limitations and human mortality.

These frustrations and the pain resulting from the damage done to the good objects and the vulnerable self lead at times to a profound sense of hopelessness and despair, states of mind that drive the participants to seek containment in supervision or their own personal therapies. Containment allows for reflection on the defensive function of trying to rescue the children from their grief. This brings about an awareness in the participants of their immersion in the third space of the group unconscious, variously referred to by them as 'enmeshment' and 'fusion'. Containment thus allows for the participants to re-appropriate subjectivity. However, the participants' subjectivities undergo a transformation as a result of the appropriation, through identification, of the children's vulnerabilities. This transformation is represented by a greater tolerance for grief and sadness, the desire to "be comfortable with death", an acceptance of limitations, experienced now not as impotence, but as humility, and a new conception of vulnerability as a form of strength. These expressions of the countertransference are indicative of the work of mourning and evidence of the survival of the good object and its reinstatement in the ego. Within the analytic third, the maternal object is more whole and there is evidence of the vulnerable child subjectivity having appropriated some of the good represented by the oedipal mother: the child is no longer a helpless victim, but is resilient, playful and strong in her vulnerability. The recognition of the child as whole and separate is demonstrated in the interventions the participants make in the groups. For a time, rescue attempts recede in to the background and focus is maintained on "walking with"

the child in her grief, and on providing opportunities for the child to exercise her autonomy, find her voice and express her uniqueness. As Kauffman (1994) has asserted, in the bereavement group an engagement with the work of mourning exists alongside defensive manoeuvres against the pain of bereavement. The work of the group is thus characterised by an alternation between tolerating grief, sadness, guilt and helplessness and reversion to the defences of denial, idealisation, rage and omnipotence.

The countertransference responses of those participants who are conducting groups with children who do not know their status differ in a number of significant ways from the responses of the other participants. The secrecy that characterises these groups functions to deny the reality of the children's bereavements. As a result, there are powerful group defences against engaging with the subject of HIV. These defences play out as the idealisation of the white therapists and the 'invisibilising' of the black, HIV positive female facilitators. A dual outcome results: Hopelessness, despair and burnout, on the one hand, and on the other, a manipulation of the transference through the move to a more directive way of working. Working directively may function to contain the groups' thanatropic anxieties by installing the black female facilitators as more functional, well maternal objects, lessening the need for the idealisation of the white facilitators. However, until the self and object representations have been initially differentiated and stabilised to some extent, the group will not be able to tolerate or contain the affects that are elicited by the work of mourning and a continuation of denial, splitting and idealisation will occur, with the potential for integration, as well as the potential for fixation in pre-oedipal object relations.

The findings of this study have application for therapists working individually and in groups with HIV positive children. By understanding the fundamental dynamic in psychotherapy with these children to be the alternation between engaging with and defending against the work of mourning, powerful countertransference responses that include a sense of strangeness and displacement, rage, the desire to rescue the child, impotence, despair and meaninglessness can be understood as defensive responses against the grief, guilt and profound sadness that are elicited as a result of bereavement. Remaining receptive to understanding these feelings as indicating a site of mourning facilitates containment, and thus greater tolerance of the painful affects associated with grief. Ultimately this results in the strengthening and enrichment of the child's ego.

6.2 Limitations of the study and suggestions for further research

Due to limitations on time and resources, measures to ensure the validity of the findings, such as triangulation, were not performed. Hence, the credibility of the findings was not evaluated by participant feedback about the degree to which the findings did or did not resonate with their experiences of working with the children. Further, owing to the small sample size, saturation of categories was not achieved and in this respect it is likely that additional data may have yielded findings that confirm or contradict the conclusions that have been drawn from this study. Lastly, the data in this study is derived from one-on-one interviews and access to the group consciousness is therefore compromised by virtue of this data collection procedure. Future research on countertransference responses in group work may therefore benefit from employing focus groups as the method of data collection.

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