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POSITIVE DIAGNOSIS FOR HIV AND THE REORGANIZATION OF LIFE

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ABSTRACT

This article is the result of a qualitative study that aimed to understand how the lives of people living with HIV (PLHIV) were reorganized after at least one year of living with the disease. For this, interviews were conducted with some generating questions preceded by characterization of the subjects. The methodology chosen for the organization of the data was Collective Subject Discourse (CSD), having psychoanalysis and scientific productions related to the theme as a theoretical reference. The result refers to a thematic axis named "Subjective experience and adaptation from the disease", which constituted three discourses of the collective subject (CSD), these were named by the central ideas (ICS): (1) resignification from the disease, (2) biopsychological repercussions of the diagnosis; and (3) silence with self-protection. It was concluded that there is not only one way to reorganize life from the diagnosis, but it is correct to state that the stigma of the disease has a direct influence on all subjects.

Keywords: HIV infections. Psychoanalysis. Social Stigma. Patient Care.

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INTRODUCTION

HIV is an infectious disease caused by the human immunodeficiency virus, which is characterized by the suppression of T-cell-mediated immunity, leading to the development of AIDS. As it is considered a chronic disease after the development of antiretroviral treatment (ART), HIV/AIDS brings with it several challenges to care for health professionals, these challenges go beyond the control of the epidemic and advance to the importance of disseminating information and fighting against discrimination and social stigmas present in living with the disease (Fonseca, Santos & Araújo, 2020).

With the advancement of treatment and epidemic control, ways of adapting to HIV/AIDS called seroadaptive have emerged. These are shown to be ways of managing the adversities of being infected and being able to manage individual risks. Thus, the long experience with the virus and its time of existence, as well as resistance to condoms, and dissemination of knowledge about the treatment of pre-and post-exposure prophylaxis are associated with the increase in unprotected sex for HIV. In Brazil, another factor must be considered, such as the increase in conservatism, a fact present in recent times, in the face of false information that the AIDS epidemic would be controlled or even ended (Rios, 2021). However, a closer look at the epidemic is necessary, considering the increase in the number of AIDS cases, with this percentage being more evident in Brazil among the age group of young people aged 15-24 years, between 2007 and 2019 (Almeida; Ribeiro & Bastos, 2022).

It is necessary to consider the complexity of the issue, considering that HIV/AIDS has been associated over time with behaviors judged socially inappropriate, which has brought a character of culpability to people who have been infected with the virus. AIDS brings with it a double origin because it can be classified as cancer in the context of the microprocessor as an invasion. The second strand is related to transmissibility, generating meanings of an old metaphor related to pollution, equating to syphilis (Cazeiro, Silva & Souza, 2021).

The stigmas surrounding HIV related to risk groups were strengthened through the media, which at the time reinforced the distortion together with the stigmatization of AIDS as a disease with no cure and doomed to death. The result of this was a generalization of the feeling of rejection, fear, and stigmatization towards people living with HIV/AIDS, having a greater impact in Brazil on homosexuals and injecting drug users (Villarinho & Padilha, 2016).

In this sense, even today, to lesser degrees, we are faced with prejudices, fears, and taboos directed at certain risk groups, which have been stigmatized by behaviors not accepted in society (Villarinho & Padilha, 2016).

With the weight of stigma, research in the field of health shows how the diagnosis of HIV infection produces an impact and change of perspectives about the subject and the context experienced, with repercussions in the social and personal sphere and may affect the interpersonal relationships and self-esteem of these subjects (Sá & Santos, 2018).

Thus, considering the impact on subjectivity, sexuality, and life which can be found in the literature from the impact of the diagnosis, the present study aimed, through qualitative research, to understand how people living with HIV (PLHIV) reorganized themselves from a time of experience with the disease, articulating and interpreting based on the current literature on the subject and psychoanalysis.

METHODOLOGY

The present study is an axis of the results and discussions of a qualitative, descriptive, cross-sectional research, based on primary data collected in interviews with the target group, which was submitted to the Ethics Committee for Research with Human Beings and approved by opinion No. 4,371,174 for meeting the ethical requirements of the current legislation.

The qualitative methodology is defined as the development of concepts through facts, ideas, and opinions, as well as the understanding and interpretations attributed to the data collected linked to the research problem. That is, qualitative research is linked to the experiences and their interpretations of the social phenomena studied (Soares, 2019).

The research was carried out at a Day Hospital Unit for infectious and parasitic diseases (UDIP). The study sample was configured as a non-probabilistic convenience sample. The inclusion criteria used were: people of both sexes, over 18 years of age, who had been followed up at the Day Hospital for at least one year. The exclusion criteria were people with cognitive deficits and Indigenous villagers.

Data collection took place between July 15 and 30, 2021, The process took place in three stages: (1) identification by the Day Hospital team of the participants who fit the inclusion criteria for the first contact; (2) presentation of the research, its objectives, benefits and risks, and invitation to participate in the research, whose agreement was registered through the signing of the Informed Consent Form (ICF); (3) recording of the participant's characterization data followed by a semi-structured interview with guiding questions.

Regarding the records, authorization for audio recording was requested for later transcription of the data. The interviews took place in the Psychological Care Room of the Day Hospital, with secrecy and confidentiality being guaranteed, with an air-conditioned environment being provided, with adequate tables and chairs, privacy, and free from interference.

To organize the data from the interviews, the methodology of the Collective Subject Discourse (CSD) (Lefèvre & Lefèvre, 2005) was adopted, which is characterized as "a systematic description of reality and reconstruction of collective thought as a scientific product" (Lefèvre & Lefèvre, 2014, p.504).

The data are organized from six stages in the CSD: (1) analyze issues in isolation; (2) identify and underline key expressions, central ideas, and anchorages; (3) identification of central ideas; (4) identify and group central ideas of the same meaning; (5) to carry out groupings to name a central idea that better encompasses meaning; (6) construction of the DSC (Lefèvre & Lefèvre, 2005).

The analysis and interpretation of the data occurred from the theoretical contribution of psychoanalysis with the scientific production of the theme.

RESULTS AND DISCUSSION

The study sample consisted of 20 random participants, men (14) and women (6). The characterization of the participants served as a subsidiary to the discussion given the identification of possible variables and is better illustrated in Table 1:

Table 1 - Characterization of the research participants according to demographic and social variables.

Variables	No.	%
Sex		
-Male	14	70
-Female	6	30
Age (in years)		
- 24-33	7	35
- 34-43	4	20
- 44-53	5	25
- 54-63	1	5
- 64 and over	3	15
Sexual orientation		
-heterosexual	14	70
-gay	6	30
Religion		
-Catholic	7	35

-Evangelical	7	35
-Christian	2	10
- Umbanda	1	5
- Does not have	3	15
Schooling		
- Incomplete elementary school	8	40
- Complete elementary school	1	5
- incomplete high school	1	5
- Complete high school	5	25
- incomplete higher education	2	10
- complete higher education	3	15
Length of experience (in years)		
- 1-5	6	30
- 6-10	2	10
- 11-15	5	25
-16-20	3	15
- 21-25	4	20

The sample was composed of 14 men (70%) and 6 women (30%), this data can be related to the distribution by sex of people living with HIV/AIDS contained in the 2021 Epidemiological Bulletin (June 2007 to June 2021), in which all regions have a higher incidence of the disease in men, with the number of 1789 cases in men for and 643 cases in women in the Midwest (Brazil, 2021). Gender issues can be taken into account in these data, considering that men are more restricted to self-care due to cultural issues, such as machismo (what it is to be a man and the notions of virility), the conception of the use of condoms only as prevention of pregnancy, and decreased pleasure from using condoms, important factors to consider.

The age group with the highest number of participants was 24-33 years, with a total of 7 participants (35%), followed by 44-53 years (25%) and 34-43 years (20%). According to the Epidemiological Bulletin (2021), it can be observed that the age group with the highest rate of HIV infection corresponds to 20-34 years (52.9%) (Brasil, 2021).

Sexual orientation was another piece of data obtained, which was contrary to what was stated in the aforementioned Epidemiological Bulletin and stigma, in the research 14 participants (70%) declared themselves heterosexual and 6 participants homosexual (30%), and in the data of the bulletin 52.1% of the cases were due to homosexual and bisexual exposure in men and 86.8% of the cases in heterosexuals in women (Brasil, 2021). The stigma of the disease carried by Men who have Sex with Men (MSM) makes them responsible for the largest amount of seroadaptive practices and consumption of biomedical content (Rios, 2021).

Regarding education, most participants had incomplete elementary education 8 (40%), followed by complete high school 5 (25%) and complete higher education 3 (15%). According to the Epidemiological Bulletin, there was a high percentage of unreported schooling, preventing an assessment of this variable, with the reported schooling being mostly people with complete high school education (21.5%) (Brasil, 2021). It is important to emphasize that the level of education is an important factor within the treatment of HIV and its coping, as demonstrated by this research, and it can present interferences according to how the subject understands and elaborates on the impact of the diagnosis, with the healthiest ways of coping based on the understanding of the functioning of the disease, providing better adherence and reducing the chances of abandonment of treatment.

The length of experience with the disease ranged from 1 to 25 years, with the highest rate being 1-5 years, 6 participants (30%), then 11-15 years, 5 participants (25%) and 21-25 years, 4 participants (20%). Data from the literature indicate that people who live longer with HIV are prone to better acceptance and adaptation to the disease, resulting in better adherence to treatments (Oliveira et al., 2015; Foresto, et al. 2017; Hipólito et al., 2017).

The results of the interviews were grouped in the Collective Subject Discourse (CSD), following the methodological steps: identification of key expressions and similar semantic contents, giving rise to central ideas. These central ideas, in turn, consisted of a word or expression that encompasses the discursive content, and later the grouping of key expressions corresponding to each central idea occurred, thus forming the CSD.

Thus, the present article corresponds to a thematic axis of the research called Subjective experience and adaptation from the disease, which covers three main central ideas discussed below from the DCS: (1) Resignification from the disease; (2) Biopsychological repercussions of the diagnosis; and (3) Silence as self-protection. These three discourses represent in the expressed contents different ways of dealing with the diagnosis after experiencing the disease.

RESIGNIFICATION FROM THE DISEASE

This central idea is based on the impact of the diagnosis, the construction of acceptance of the collective disease (psychic elaboration of the fact), and the resignification of sexuality (the form of relationship with oneself and others), which resulted in a change of meanings in the face of the experience with the disease, as the CSD discusses:

> I had to accept it, do what? I was very shaken and today, like this, I accept. Today I am, already... with this thing. Either he wants me or he doesn't. If you like me, you will accept me the way I am. I put it in my head. It was difficult, it was difficult at first, yes.
>
> Because no way doesn't mess with you, right? I try to live a normal life, just like I say I try to live a normal life, I only remember that when I go to take medicine and when I come here alone, I don't think during the day, I don't think at all, you know. So like, after I started to have this attitude, I realized that I started to have a better relationship, even with myself, you know, internally, you know.
>
> From the moment I started the treatment and I started to understand myself more, to accept myself more, I allowed myself to kind of love myself more, regardless of the diagnosis ... There is evil that comes for good, right? Nowadays as a person of emotional stability, I think I'm very confident, you know? Very well decided. After my security came, I was able to relate to other people, and I started to feel beautiful again, to take care of myself more.
>
> I understood all this, I saw how it is, and then this issue of sexuality became calmer like this. For me... for me it was for the better, I started to love myself more, it's... I don't say in terms of aesthetics or anything, but in this matter... is... with whom I relate, in a matter of... to select friendship, to filter the family.
>
> Today I feel like a safer person, more equal I said happy, I live the day, something that has changed a lot all these years, before I found out the diagnosis of our I... I had no sensitivity, I noticed that after these problems happened to me, I changed my view of the world, and of life for changed completely.
>
> It changed the meaning of life and everything. You start to have a different outlook on life and you start to... to value things more, value things more! I was changing, today I am a changed person, transformed ... life is not over... This is my motto, life is not over, it is not for nothing that you have to live, it is the same as I say like this, I live... I live the day today. And show your strength to someone else, pass it on to someone who needs a word, because sometimes the person feels so small, so I don't know, mediocre with this disease, there had to be this thing that someone passes on something positive, "guys, life is not over, let's go.
>
> That was part of me, but it wasn't what defined me. That's how I went back to doing the things I liked to do, I went back to spending more time with my friends. (P03, P05, P06, P10, P16, P18).

It is possible to observe through the CSD the resignification of the experiences from the disease, which in turn brought a dose of psychic suffering, crossing a path of psychic elaboration and new meanings.

The processes of signification and resignification of health and disease produce subjectivation, thus presenting subjectivity as plurality, which is anchored in the various relationships between peers for its construction (Selli et al., 2008).

Illness is not only limited to the medical attributions of the diagnosis, it involves suffering the disease, as well as the meanings attributed by each biography, by each singularity, enabling the individual to go through an integral process of meanings based on this (Ávila, 2012).

In this way, it is possible to identify in the discourse and in the literature that the HIV-positive person experiences negative ideas of the diagnosis at this first moment, moving on to stability in the way of living with the chronic disease, mediated by the feeling of hope (Gomes et al., 2021).

In another study regarding quality of life, it was evidenced that PLHIV had a good quality of life in the physical and psychological areas, with deficits located in the family and social fields. Another factor refers to people who had less than two years of experience with the disease and had a lower quality of life score, which was attributed to adaptation to the new condition (Santos, França Júnior & Lopes, 2007).

A study carried out in the northeast region of Brazil, referring to the quality of life of PLHIV, obtained good scores in most of the domains surveyed, with emphasis on psychological (67.9) and spirituality, religiosity, and personal beliefs (65.7). The areas with a deficit were related to the environment (59.2) and level of independence (55.1), and this deficit was reinforced by other Brazilian and international studies (Oliveira et al., 2015).

The advancement of HIV treatment was responsible for the increase in the quality of life of PLHIV (Moura et al*.,* 2021). Thus, correct medication adherence is the main factor for this increase in quality of life (Souza et al., 2019). According to these authors, the main components of this adherence are environmental, psychological, and physical.

People with a longer time since diagnosis and also a higher TCD4 cell count have a higher rate of adherence to ART treatment, ratified by other studies (Foresto et al., 2017).

Based on the CSD, it is observed that experiencing HIV as a chronic disease from the longer time of diagnosis enabled acceptance, adaptation, and compliance with the disease. This allows PLHIV to devise projects, have greater social inclusion improve affective and sexual relationships, and increase treatment adherence. Thus, the resignification and normalization of HIV come from the acceptance and subjective elaboration resulting from time and the transformation of the impact of the disease (Oliveira et al., 2015; Hipólito et al., 2017).

It follows the perspective of time from the psychoanalytic point of view. In psychoanalysis, time does not modify the unconscious contents, or there is no chronological order or representation of time. Freudian theory states that there is no linear in the unconscious, just as we socially organize in the line of consciousness of past/present/future, these have no connection with psychic functioning. This "timelessness" of the unconscious has led to a new conception of time, since "the psychic transit between different eras transforms the arrow of time not only by the possibility of inversion of meaning but also by circularity, which allows several times to coexist simultaneously (Libermann, 2014).

Thus, the CSD of resignification can be analyzed from the Lacanian perspective of logical time. For Lacan, there are constitutive instances of time, divided into three instants: the instant of looking, the time of understanding, and the time of concluding (Garcez & Cohen, 2011).

For Lacan, logical time is a theoretical resource used to deal with the temporal modulation of the logical process, in which the subject is included and shown to be inherent to every psychic process. In this way, time is related to mental processes, or even the subject's time (Jungk, 2018).

It is observed that in CSD, initially, the discourse collides with the reality of the disease, in psychic suffering in elaborating and integrating the experience with the disease. This first moment can be identified as the first Lacanian logical time, the instant of looking, encountering the fact, but not with its understanding. To be endured, the disease at this first moment must be forgotten, looked at, but not elaborated, so that one can live with one's suffering.

In the first moment, the instant of seeing, the subject remains captured in his ignorance in the face of the occasion, being unable to perceive his condition. At this point, the subject places his attention on others, aiming to visualize something authentic emitted by the other of himself. This is associated with the imaginary, since through it the ego is structured in unity during the mirror stage, or rather, if it looks from the other's gaze, which constitutes a mirror (Jungk, 2018).

This is clear in the first moment of the discourse, in which it is equivalent to the instant of looking, in which the process does not involve reasoning or subjectivization, but only the confirmation of what can be observed (Garcez & Cohen, 2011). The fact is remembered when thinking about leading a "normal life" and daily care about medication adherence. The association of normal life is also highlighted in the discourse, with the concept of normality being antagonistic to HIV.

In a second moment in the discourse, equating with the moment of understanding, it can be observed that from understanding the subject's vision in the discourse is modified. It is in the time of understanding that logical relationships take place, which favor the understanding of what is not known and that does not encompass direct perception (Junke, 2018). Furthermore, the important episodes of life play a valuable role in the experiences of the subjects, which can mean an opportunity to confront the past, this provides a better interpretation of this same past, which can be more inclusive, with less repression, and enables resignification, finding itself free from the single path of repetition (Libermann, 2014).

Sexuality gains prominence in this second moment, it is present again through the understanding of the experience with the diagnosis, given this, there were changes in the perception of self-love, related to narcissism, through which the subject of the discourse alters not only his object relations, but also the way he apprehends the world and experiences the present. PLHIV manifests lower self-esteem about other people who have other comorbidities (De Carvalho & Souza, 2021), this statement can be related to the results of the interviews, in which, in a total of 20 participants, only six presented discourses related to the resignification of life. Thus, the reconstruction of self-esteem becomes an element of great importance for resignification based on the impact of the diagnosis.

The relevance of self-esteem in CSD is considered a way of protecting against social issues that accompany infection, which shows that intercessions in the social, individual, therapeutic, spiritual, and family fields are fundamental as a positive restoration of the same (De Carvalho & Souza, 2021).

The third moment, the moment of concluding, is defined by the haste, from which each subject will use his capacity for generalization to reach what concerns his truth, or even the truth that can be reached through his capacity to elaborate synthetic consciousness, this concomitant with what is achieved of his psychic reality and the characteristics that build it (Garcez & Cohen, 2011; Jungk, 2018).

At this moment, two important factors are identified in the discourse, the first being the approximation with death, which brings the urgency of concluding and rethinking life. For Antunes, Rosa, and Brêtas (2016), it is from the possibility of death that the diagnosis carries that people can make new reflections and rethink life. The second factor is social support in the face of living with the disease. Strengthening this support is shown to be an important element for treatment adherence, as well as coping with the feelings of exclusion and rejection associated with the diagnosis (Caixeta et al., 2011).

It is possible to identify in the CSD the entire process of Lacanian logical time so that a resignification can be achieved after the impact of HIV, in this way, there is what is of each subject's own time, not obeying a logic of chronological time, and also, other themes can be initiated for elaboration based on this moment. Time is discontinuous, integrated by pauses, described by Lacan as suspensive scansions (Nominé, 2021).

The identification of the subject is configured as a logical and collective process and in it, the subjects must take themselves into account. To identify oneself is to find one's place in a collective (Nominé, 2021). The subject of the discourse, therefore, concludes with the issues involving HIV, facing the feeling of "mediocrity" of the disease, detaching himself from this identification with the stigma of the disease, of which he can carry a definition himself.

BIOPSYCHOLOGICAL REPERCUSSIONS OF THE DIAGNOSIS

The following central idea, named "Biopsychological repercussions of diagnosis" demonstrates a different path taken, illustrated by the following CSD:

> It was terrible. I did a blood test, I was diagnosed and I had a psychotic break, which is said, it was horrible, I lost my appetite... Until then I didn't have any symptoms, after I found out that I had several. I had sleep loss, it's... intense heat at night, you know? Horrible things, nightmares, insomnia, insomnia was more frequent, I couldn't sleep.
> At the moment I excluded myself, I did like this, I didn't want to believe, I didn't want to. I tried to hide the truth. Then it started there with the people who started to come that... It was in 2009... Then they came after me and talked. Then you get a little grounded, bitch with whom I contracted, with whom I contracted. Then at that moment, I didn't go to seek treatment, but then I started to prevent myself from doing something I had, I didn't want someone else to have.
> It was that acceptance and denial. It was difficult to accept, until one day I managed to accept, today I'm super well, today I accept, you know? It's not easy to live with this, every day we remember because of the medication. I at least think "Oh, I have it", so I take the medication. But is it difficult to accept? Yes, but it has... Unfortunately, it's the reality, right? And it hasn't been easy. It's not easy to accept, wow! To this day I lose sleep a lot, you know? I wake up and think "Oh, I do!
> It's different, it seems like it's psychological, I take a dipyrone pill and put it in my hand here so I take it normally, it's... these HIV medicines just by getting them like my stomach already... My mouth starts like this, it seems that I've even tried to take it out of the bottle, and put it in another bottle, but there was no way.
> The issue of anxiety, it's clear, you know? Many times I... My blood pressure changes, because of this, this diagnosis. And I can't control it, but there's always been altered data, you know? It turns out that where the weekend because of anxiety, and nervousness I ended up eating more.
> And that's how it is, because of this diagnosis I stopped my life. I stopped, I did several things at the same time. And today I have no reason for anything, I have been looking for religion, you know, and God has been the basis for me, you know. And a lot of things I could, I could have avoided if I continued, even the issue of this diagnosis today, I could have avoided it if I continued in the church, for various reasons they made me leave the church and I ended up having fun, right? Out there, as we say. I ended up distancing myself from religion, and that's where I got stuck, and ended my life, this diagnosis made me... It made you feel bad, you know?
> At first I didn't like to look in the mirror, I didn't like to be touched, I didn't like to be too close, I didn't like... I didn't take care of myself, I cut my hair because I had to. I think it was harder... It was easier than myself, I accepted myself, I think. Yes, I think it's more the question of... how can I say... of the expectation that I created, I...

> anxiety, negative rejection even of the same fact, of letting go of yourself, of not being accepted. More along this negative line.
> And I was very stressed when I found out, because I was always stressed, but when I found out I started to be more boring, unbearable. Because I started to get bad with everyone, people came close to me, I treated them badly, and I kicked them. Regarding relating to other people, it's a little complicated for me because I'm having a lot of anxiety crises, I'm getting nervous, so I end up mistreating them unintentionally. Oh, I don't know how to explain it, because out of nowhere it changes, the person gets close and I get stressed, you know? I get a lot, I even get bad, I can't explain why. (P01, P02, P05, P06, P10, P12, P18).

The CSD evidences the anguish of the diagnosis, this anguish, in turn, may be the result of the fantasy of feeling helpless for the Other, revealing a mark. In this way, the diagnosis of HIV can be presented as something in the field of trauma, with the levels of this trauma being supported by the conditions of each subject. Furthermore, receiving the diagnosis is a way to face the vulnerability of the essential support characteristics of the self (Castellani & Moretto, 2016).

The impact of the diagnosis influences the libidinal device of the subjects, which results in an important inhibition in different fields of life. According to Freud, inhibition is characterized as a "functional limitation of the Self", occurring due to "excessive eroticization of the organs required for these functions" (Freud, 2010, p. 17-18). In this way, all libidinal investments end up turning to the Self, resulting in a distancing of the libido, considered pure inhibition (Medeiros & Calazans, 2021).

In Lacanian theory, inhibition is related to the imaginary, described as "an Imaginary identification with the Real Other, an identification with the desire of the Other, which Freud places as a constitutive identification of the masses" (Capanema & Vorcaro, 2017, p.400). Thus, the trauma that originated in the diagnosis generates several inhibitions, such as the first moment the lack of appetite, intensified insomnia, and physical symptoms. These libidinal inhibitions and retractions, in turn, directed to narcissism, are accentuated by the Imaginary and the consolidated image of what the desire of the Other is. How, what does it mean to be HIV-positive? What images do I unify and incorporate that are in accord with the Other? And what do I do in the field of subjectivity? These questions resulted in this exit via anguish from the Real to the Imaginary sense.

From the inhibitions, the subject of the CSD moves towards restrictions in the field of relationships: social isolation, change about oneself (self-prescription), moving towards the formation of symptoms, such as mood changes to depression and a position of aggressiveness towards the other.

PLHIV experiences " the fear of losing the support of social relationships as a whole, often leading to the non-disclosure of their condition", driven by prejudice, stigma, and discrimination, resulting in a social impact of AIDS (Gomes et al. 2021).

The central effect identified in the CSD was anguish, called anxiety, experienced in the body, through arterial alterations, and increased libido directed to oral drive, such as increased food consumption to make up for the lack of anguish. For psychoanalytic theory, anguish is considered an effect, not a symptom, so it is not possible to repress it, which makes it go aimlessly (Benia, Celes & Chaterlard, 2016).

In the field of aggressiveness, named by the CSD as "stress" with another, it can be categorized as a depressive subjective position. There is a loss of the capacity for self-criticism in this position, humor is transformed into a feeling of irremediable loss about the past and future, which drives a new effect against the Self: aggressiveness, which results from the idea of loving abandonment (Dunker, 2021).

Thus, depression is an essential symptom associated with narcissistic pathologies, that is, it is the only reference (Dunker, 2021). There is a lot of affections experienced during the illness, which are removed from objects and directed to the Self. In this way, after the cure, the libido may be confused in its paths, causing the symbolic world to be invested in the pain of each subject (Lacan, 2009).

It is concluded that the CSD evidence that the trauma in the face of the non-symbolized diagnosis mobilized a depressive state as a symptom, bringing into play inhibition, anguish, and aggressiveness. These, in turn, are potentiated by stigma, prejudice, and social discourse around HIV/AIDS fixed in the Imaginary alter the experience of the disease with the experience of illness.

SILENCE AS SELF-PROTECTION

The CI "Silence as self-protection" highlights the experience of the confidentiality of the diagnosis about the social environment as a way to protect oneself from the stigma and prejudices surrounding the disease:

> I didn't want to go home anymore. I didn't want to go back, I didn't want to look at anyone's face. I didn't tell anyone, absolutely no one. And so, I don't feel that... security in being able to vent to someone.
> It was a bit of a complicated process because I did it kind of alone with him, you know? Without medical help, a specialist, someone who could help me was an infectious disease specialist, of course, who I talked to, but in my little head, it was just me. I had to deal with... I always followed in anonymity, family... I concluded that

> the more you talked, the more you could be playing the poor thing or people looking at you like a poor thing.
> So you end up... having an embarrassment, thank God I managed to keep myself not easy. It's something that inside here (beats her chest) I fight with her, right, but it's easier than you leaving is... Talking trying to help, a word of consolation right? So usually in all the cases that I know about that people opened up, they suffered a lot psychologically, right, because of the contempt, the abandonment, you know.
> I was sad to regret not having protected myself the way I should, yes... like "Oh, why is this happening to me?", but... is... I wasn't so sad that I felt "Oh! That I needed to kill myself" or that I needed to put an end to it, it was a process that was very slow, but it was important to be able to relate to other people. It was a moment when I started to do a little poorly in college and now that I'm doing it like this because I didn't feel like studying, I didn't have... No... is... I thought "Well, I'm going to graduate, but I'm going to be a person alone, I'm always going to be alone with my friends, what projection or future would I have?
> I saw that with cancer it's easier, you can talk. ... as cancer has evolved of improvements, today people already notice that cancer no longer kills, people do not impact, if I talk about cancer it is one thing and if I talk about HIV it seems that it is something else, you know. There is a trial, in cancer there is not. In cancer, there is only one pull!
> Why don't you hear about HIV treatment like that, about it naturally, you know? You don't... in... in my family or people of close friends because of prejudice, you know, then you don't say, "No, my aunt has HIV and everything is fine, good, wonderful and such... my uncle doesn't, everything healthy", no! People hide that I think it's the big problem, like... It's a problem of you I think of... society is like this at the same time that you prevent prejudice by secrecy, right, by a right to... from... Because not everyone has an emotional condition for you to get stoned in the face, right? As if that were it.
> So this way I can live socially, in society, like... I put everything in its place. Look ahead and know what is the solution? It happened, it happened, oops! Let's go, so instead of discussing how it happened, let's see what we can do so that... to have a better quality of life. So that's it, I seek a quality of life today.
> Because for me HIV is like a characteristic of mine, you know? The color of my eyes, what I like, I don't like. It's something I know, and it's up to me to say it or not to someone else, but like this... I don't comment on anyone.
> So it's... I prefer... I played soccer, I stopped playing soccer a short time ago for fear of getting hurt, of bleeding, you know... That's why... This ends up being a... one for us... is... It ends up being you don't reveal, right, what you have, ends up being just yours, right?
> It ends up being a... that one seems to be just for us, it's... But the important thing is that... the treatment does me good and... My life is normal... It's not a problem, HIV doesn't kill you, but it leaves you... reserved, right? Reserved. So I only hide it because of that issue of people looking at me differently, because I'm not afraid. To get that face oh what a poor thing. (P01, P02, P05, P06, P07, P08, P09, P10, P13, P14, P16, P17, P18, P20)

In the CSD, it is possible to identify a subject who is affected by the diagnosis, but who mobilizes another form of coping through anonymity, anchored in the fear of the reactions of others. The fear of moral judgment and culpability becomes present, considering that the diagnosis is directly related to sexuality, due to being a disease that is one of the means of sexual transmission. In psychoanalysis, the feeling of guilt is characterized as a consequence of conflicts between internal and external cultural demands, reaffirmed by moralistic thoughts of civilization (Gellis & Hamud, 2011).

Thus, guilt is shown to be an important factor throughout the discourse for the choice of secrecy as a confrontation, as well as the defense of the position of "poor thing", of the stigmatizing gaze of the other. The stigmatized person carries a marked and deteriorated identity, associated with attributes that lead to discredit (Almeida & Labroniei, 2007). Furthermore, stigmatization is equivalent to rejection and marginalization, which results in suffering, guilt, and shame in those who experience it and pity or contempt in those on the other side (Eiguer, 2019).

Thus, secrecy and solitude as a path present itself not only as a defense of social judgment but also of one's identification with stigma. In psychoanalysis, stigma is considered between the logic of the biological and psychological by way of identification, embodying in the inhabited body the trace of the object (Nunes Júnior, 2016). It is observed that there is an identification of the subject with whom he rejects, which reaches the ego and the bond with another (Eiguer, 2019).

Throughout the discourse, it is perceived that although time is considered slow by the subject, it is important, emphasizing once again the issue previously discussed in another axis referring to time, and it is throughout it that the relationships with the other happen again in the face of the guilt experienced and shaken perspectives for the future. Guilt is present as something present in PLHIV, according to studies, being accentuated when the infection happened due to unprotected sex, with the most common feelings being guilt, shame, self-discrimination, and inferiority (Patricio et al., 2019).

Due to stigma, and prejudice, the decision not to tell is prioritized as a strategy for these subjects, as a way to avoid discriminatory situations and moral judgments. Thus, in secrecy, the situation of the disease is faced alone, which can lead to difficulties in coping positively with the circumstances of the disease (Gomes et al., 2021).

Finally, in the discourse, the way of coping follows the affirmation of life against the struggle of guilt, focusing on the quality of life, and the choice to live better as a way out of the conflict between guilt HIV, and loneliness. Thus, knowledge about the epidemic is an important tool for the elaboration of the subject. This elaboration can be anchored in scientific knowledge, in social relations, so becoming aware of an alarming problem, makes society think about the future not only from the perspective of prevention but also of care (Silva & Takahashi, 2008). It is noteworthy that the discourse was formed by 14 participants, with varying periods of experience with the disease (1 to 25 years), showing how the stigma related to HIV is still strong and impacts people.

CONCLUSION

It is concluded that there are several ways to deal with and adapt to the disease, not having a specific time, being characterized as a process, this is anchored in aspects such as fear, loneliness, depression, anguish, hope, resignification, and newly acquired meanings.

Above all, it can be stated that the stigmas crystallized by the disease reach and influence all subjects, passing at first through the deconstruction of self-prejudice for ways of coping.

The work also found the relevance of access to information and understanding of the functioning of the disease as tools for adherence to treatment, increased quality of life, and deconstruction of stigma.

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