

What is this desire? Reproductive decisions among women living with HIV/Aids from a psychoanalysis perspective¹

Que desejo é esse? Decisões reprodutivas entre mulheres vivendo com HIV/Aids sob o olhar da psicanálise

Karina Franco Zihlmann

Universidade Federal de São Paulo. Departamento de Gestão e Cuidado em Saúde. Santos, SP, Brasil.

E-mail: karina.zihlmann@unifesp.br

Augusta Thereza de Alvarenga

Universidade de São Paulo. Faculdade de Saúde Pública. Departamento de Saúde Materno-infantil. São Paulo, SP, Brasil.

Email: atal@usp.br

Abstract

We conducted a qualitative study to understand how women living with HIV/Aids realize their reproductive decisions and characterize their unconscious desire. In-depth interviews were conducted with 15 adult women, in an infectious diseases hospital and in a non-governmental organization. We constructed the interviewees' life trajectories following thematic type oral history. Moreover, in the psychoanalytic theoretical framework, we refer to the concepts of imaginary identification and symbolic identification to reveal aspects of unconscious desire. The interviewees' discourse showed contradictions and unconscious logic underlying their reproductive decisions, and pregnancy, in this context, is intended to restore narcissistic injuries, as their goal is to generate seronegative offspring. Another contradiction is that they evaluate the reproductive decisions of other HIV-positive women as "madness" or "irresponsibility" as they seek to justify their own desire and run away from responsibilities concerning reproductive decisions. Thus, a contribution of psychoanalysis to the public health field is the inclusion of the subject's idiosyncrasies and enabling the recovery of the singularity of the unconscious desire, besides allowing a reflection of these issues in comprehensive care, which, after all, can affect the complex needs of women living with HIV/Aids.

Keywords: HIV/Aids; Sexual and Reproductive Health; Lacanian Psychoanalysis; Public Health.

Correspondence

Karina Franco Zihlmann

Federal University of São Paulo. Baixada Santista Campus.

Management and Health Care Department.

Rua Silva Jardim, 136.

Santos, SP, Brazil. CEP 11015-020.

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Resumo

Realizou-se um estudo qualitativo para conhecer como mulheres vivendo com HIV/Aids atribuem sentido às suas decisões reprodutivas, bem como caracterizar seu desejo inconsciente. Foram realizadas entrevistas em profundidade com 15 mulheres adultas, atendidas em um hospital especializado em doenças infecciosas e em uma organização não-governamental. Foi construído um relato sobre a trajetória de vida das entrevistadas com base na técnica da história oral do tipo temática e na perspectiva teórica psicanalítica. Referiu-se aos conceitos de identificação imaginária e identificação simbólica para explicitar aspectos do desejo inconsciente. As falas das entrevistadas mostraram contradições e suas decisões reprodutivas são pautadas por uma lógica inconsciente, sendo que a gravidez, nesse contexto, tem a função de restauração narcísica cujo objetivo é gerar um rebento soronegativo. Outra contradição é que as entrevistadas avaliam as decisões reprodutivas de outras mulheres soropositivas como uma “loucura” ou “irresponsabilidade”, enquanto justificam suas próprias decisões procurando se desresponsabilizar por seu desejo inconsciente. Assim, uma contribuição da Psicanálise para o campo da saúde pública é a inclusão das idiosincrasias na relação do sujeito com o outro e, deste modo, viabilizar o resgate da singularidade do desejo inconsciente dos sujeitos, além de permitir uma reflexão sobre a interferência dessas questões no cuidado integral, o que, afinal, pode interferir no acolhimento das necessidades complexas de mulheres vivendo com HIV/Aids.

Palavras-Chave: HIV/Aids; Saúde Sexual e Reprodutiva; Psicanálise Lacaniana; Saúde Pública.

The research, its objectives and methodological procedures: the paths followed in discussing desire as an investigative issue

Following the HIV/Aids pandemic, it became possible to understand issues of sexuality and human reproduction as a complex problem deserving public policy specific actions and interventions (WHO, 2006; Kennedy et al., 2010; Gay et al., 2011).

Early on in the HIV/Aids epidemic, the few HIV infected women were discouraged from getting pregnant and, if they did so, were strongly censured by their health care team, often leading to abortion or abandoning medical treatment (Berer; Ray, 1997). Faced with the phenomenon of the feminization of the HIV/Aids epidemic, the focus of public health work has changed and these women's productive decisions have, thus, become crucial as a logical consequence of this is the risk of mother to child transmission (MTCT) and the expansion of the epidemic (Brasil, 2009; Myer; Morroni; El-Sadr, 2005; Gonçalves et al., 2009).

Numerous internationally recognized actions to deal with the epidemic have been established in Brazil (Barreto et al., 2011), for example, universal access to antiretroviral drugs for all HIV/Aids patients (Berkman et al., 2005), as well as protocols to decrease the risk of HIV MTCT (Brasil, 2009).

In spite of this favorable situation, certain studies have revealed health care teams violations of reproductive rights toward women living with HIV/Aids, for instance by facilitating access to sterilization (Hopkins et al., 2005), or even anti-family stigma that would explain a tendency on the part of the health care team to criticize patients who decide to have children (Oliveira; França-Junior, 2003). These studies reveal that this topic is still controversial among health care professionals and that these women's reproductive decisions may involve issues that had not been fully investigated.

The first studies into reproductive decisions of women living with HIV/Aids covered the decision whether to have children or not from the point of view of a stated desire, seeking to investigate whether these women wanted to have children. It

was observed that these women's serological status, or even having developed Aids, did not block them from getting pregnant or from wanting to have children (Sowell et al., 2002; Santos et al., 2002; Silva; Alvarenga; Ayres, 2006). The study by Sowell et al. (2002) reports that these women's reproductive decisions are based on various factors related to their circumstances, although it highlights that the women appear to have better guidance in adopting traditional gender roles. Santos et al. (2002) also observed a positive association between thinking of having children and motivation to fight for life and greater engagement with the treatment.

Faced with a diagnosis of HIV, the woman may feel certain constraints such as facing social or professional disapproval in case of pregnancy; or being unable to breastfeed as the first "symptom" revealing HIV status to others (Campos, 1998); and uncertainty whether the child(ren) produced will be infected (Tunala, 2002), among others. On the other hand both Campos (1998) and Knauth (1999) highlight that the status of being a mother appears to restore their identity to these women as "respectable women" or "victims of the epidemic".

Another study investigating the reproductive decisions of seropositive patients shows that, in contrast to other studies conducted in developing countries, the desire to have children was more common among men (Paiva et al., 2007), with the independently factors associated with the desire to have children as follows: being male, being of a younger age, not having children, living with one or two children and having a heterosexual partner (Paiva et al., 2003).

With advances in tackling the problem of MTCT it has become evident that the issue of desiring pregnancy and maternity among these women involves more than a considered, objective decision, i.e. such research have brought with them advances in approaching, albeit not doing away with this problem. Thus, a complex problem such as the issue of women living with HIV/Aids desiring pregnancy is more than an object for a field of knowledge, but rather involves a challenge of technical-practical articulations to which the field of public health has been called to respond (Alvarenga, 1994).

If, at first, research founded that women living

with HIV/Aids do, in fact, want to have children, a relevant issue that arises is what drives this desire and, finally, what is this desire? The essential question that arises is whether it is possible to equate the desire for pregnancy with the willingness to get pregnant.

There is a vast array of literature pertinent to the topic of sexual and reproductive health from the perspectives of gender, feminism or Social Psychology. Although recognizing the importance of this field, the research conducted proposes a different point of view. Thus, Psychoanalysis may contribute as it presents its own epistemological theory for understanding the issue of desire and, although there have been several studies on the issue of MTCT of HIV, there has been little investigation into the unconscious aspects in women faced with a reproductive decision in such a context. Taking this situation into consideration, the research objectives were defined. This report forms part of a broader investigation by Zihlmann (2005) and the study aims to discover how women living with HIV/Aids perceive and attribute meaning to their reproductive decisions, as well as characterizing the different ways in which this unconscious desire manifests itself, through Lacanian psychoanalysis.

In order to understand a complex decision such as having a child, especially in the particular condition of a woman living with HIV/Aids, a qualitative study was conducted with 15 HIV seropositive women, over 18, who were pregnant or who had had children after discovering they were HIV seropositive. They were women who were being monitored on an outpatient basis or in a hospital specialized in infectious diseases, as well as women who attended an Non-Governmental Organization (NGO) support group for HIV positive pregnancies, both institutions in the city of São Paulo, Brazil. In-depth interviews were conducted following a thematic script (Meihy; Holanda, 2011) and including questions on socio-demographic characterization, perceptions of the infection and disease and questions on sexuality and reproductive decisions. The interviewees were selected following the criteria of intentional convenience (Turato, 2003), in other words, they met the objectives of research irrespective of their clinic stage or socio-economic condition.

In order to analyze the data, reports were created about the life trajectory of each of the interviewees, using the thematic oral history technique (Meihy; Holanda, 2011). In addition, through explaining the concept of unconscious desire and femininity in the theoretical outline of psychoanalysis, reference is made to Zizek's (1992) contribution to the Lacanian theory of desire, seeking to recognize the concepts of **imaginary identification [i(a)]** and **symbolic identification [I(A)]** in the interviewees discourse as logical analysis operators. The study was approved by the Ethical Committees of the institutions involved and subjects signed an informed consent form which rigorously followed CNS Resolution 196/96.

The research subjects and their life trajectories

So as to characterize the women interviewed, table 1 presents a summary of the main data from each interview, illustrating the subjects' discourse. These discourses reveal that, in general, the women reorganize their personal life around pregnancy, received support from their family and other institutions, as well as the reception from the specialized care team.

As a general characterization of the group studied, we can state that the women interviewed were aged between 18 and 37 (mean 27) years old, the majority (60% of interviewees) reported being in a "stable relationship", although none of them reported being married. Only 13% of the interviewees reported being in a relationship of fewer than 12 months' duration, with the majority reporting relationships of between one and five years. Most of them (67%) were from the Southeast of Brazil and the predominant level of schooling was not having finished elementary school (40%). As for personal income, 33% stated that they had no income and another 33% reported an income of between one and three minimum wages. Only one of the interviewees reported having completed higher education. The remaining interviewees reported that they worked at home or autonomously.

Most of the interviewees (80%) had been aware of their HIV status for more than three years, 60% of them had started treatment at least three years previously. In 47% of cases, the partner was also

HIV positive, with 33% reporting that their partner was either unaware of their own status or had not yet, at the time of the interview, been tested. Four of the interviewees (27%) reported that their partner had died through Aids complications. Most of the women reported becoming infected through sexual contact with a companion or boyfriend (93%), with only one interviewee stating that she had become infected through a blood transfusion during one of her pregnancies.

Regarding number of children, two of the interviewees were pregnant; the majority (67%) had more than one child and one reported that one of her children had died at four months as Aids consequence. Most of the women interviewed (60%) did not discover their HIV status whilst pregnant (discovering it either before the pregnancy or between pregnancies). Five interviewees (33%) discovered they were HIV positive before becoming pregnant, and later became pregnant. Several of the interviewees (27%) already had children, found out they had HIV, and then decided to have more children. Some of them (20%) had HIV positive children, with the majority (73%) having access to MTCT prevention during all pregnancies (the pregnant interviewee had begun MTCT prevention monitoring during the second month of pregnancy).

Most of the interviewees reported that they did not use condoms consistently (67%), of whom only 20% adopted this behavior as a result of deciding to get pregnant. Some of the interviewees (20%) stated that they became pregnant *as a result of the condom splitting* and two (13%) said that they became pregnant because they used condoms only sporadically in their sexual relations.

Constructing a new view of the object of the investigation: the psychoanalytic concept of unconscious desire

We recognize that, in order to understand the psychoanalytical concepts involved in the issue of desire, a certain level of familiarity with this theory, more specifically, with the Lacanian psychoanalytical approach, is needed. We therefore refer readers

Table 1 - Summarized characterization of the interviews with women living with HIV/Aids. São Paulo, 2005

Interviewee*	Summarized characterization of the interviewee
Rita	Is 18 years old and has two children (a two-year-old and 11-month-old girl, both HIV-). She is a housewife and education up to the fourth year of elementary school, she discovered she had HIV during her first pregnancy, in the fifth month. Her partner is HIV- and she assumes she became infected in a previous relationship. The couple makes sporadic use of condoms, without much concern about the partner becoming infected. They do not use any method of contraception. If she gets pregnant again, she believes she will be stronger than the HIV.
Ângela	Is 33 years old in a stable relationship for the last year and a half and her partner has not been HIV tested. She has known her HIV status for five years. She works in a bank and graduated high school. She has triplets who are now three months old. Shortly after the birth she suffered a hemorrhage and needed a hysterectomy. With three young babies and having had a <i>struggle with death</i> , Ângela states that being HIV positive is a lesser problem compared with her other worries, as she feels lonely and overloaded, depending on support from her relatives.
Ana Carolina	Is 30 years old and separated. She found she had HIV in the 6 th month of pregnancy. Her companion does not have HIV. After discovering her HIV status the couple separated rancorously. She has a three year old boy, HIV-, who lives with his paternal grandparents. She states that because she is HIV positive she will not have any more children.
Flávia	She is 24 years old and is pregnant. She is a hairdresser and has finished high school. Her partner is also HIV positive and both have known their HIV status for four years. The pregnancy was unplanned and the couple makes sporadic use of condoms. They fear that the pregnancy will reveal their HIV status, which had been secret, will be revealed to their families. When she found out she was pregnant she thought about having an abortion, as she believed the child would be born HIV positive. The doctor told her that there was a low risk to the child if she used appropriate treatment and so the couple decided to go through with the pregnancy. If the risk of MTCT had been high, she said she would have chosen to have an abortion. For her, having a HIV negative child is a true mission to be accomplished.
Mariana	She is 23 years old. She became pregnant in 1998 and there was no HIV test. After the birth, the child fell ill and the family got tested and discovered that they were all HIV positive. The baby died aged four months. The partner (an intravenous drug user) died six months after the baby was born. She reported difficulties in forming new emotional bonds for fear of losing a loved one again and spoke of feelings of guilt about the child that died and, moreover, she considers the death of her child from HIV to be a personal failure.
Miriam	Is 33 years old, separated and lives in a refuge. She is an ex-sex worker and currently works in the refuge. She has a daughter from her first marriage (now aged 10 and HIV-). After separating, she returned to sex work and became pregnant from a client. She has known about her HIV for five years (having discovered after a previous abortion) and had not sought any treatment. She finally sought treatment because of the pregnancy and decided to keep the baby now a two-year-old boy, HIV-). She highlights the importance of institutional support and states that if it wasn't for her son <i>I would be dead, I didn't take care of myself and used drugs</i> .
Bianca	Is 33 years old, lives in a refuge and has left prostitution. She has two children from a previous relationship who live with her mother (an 18-year-old boy and a girl aged 13, both HIV-). She became pregnant from a client and intended to give the baby up for adoption. Two years after the birth of her daughter, Bianca fell ill and suspected she had HIV. She discovered she was HIV positive, and her daughter tested negative. Bianca states that <i>she tried not to become close to her daughter, as she was expecting her own death from Aids</i> . She says that she felt depressed and suffered, although the only positive thing in her life was the fact her daughter does not have HIV.
Dia	Is 29 years old and an artisan. She has a daughter (now aged five and HIV-) and during her second pregnancy her husband fell ill and was hospitalized, discovering he had HIV. The second child is three years old and HIV negative. Dia moved to São Paulo and lives with her grandparents. She was treated in a group with other pregnant women and recognizes the importance of group and individual psychological work, after her second pregnancy she was sterilized. She had planned to have four children but, because of the HIV, decided to get sterilized, fearing to have a HIV positive child, considering this as something unacceptable, a failure.
Sílvia	Is 22 and lives with her mother. She has a daughter (now aged nine months and HIV-). She discovered she had HIV when she was 16 and, although she thought she wouldn't be able to have children because of the HIV, had various relationships. She became pregnant from her boyfriend <i>as the condom split</i> . He didn't know she was HIV+ and is now threatening her. Before falling pregnant, Sílvia used drugs and did not look after herself. Nowadays she works, does not use drugs and looks after herself and her daughter, grateful for the institutional support she receives (from an NGO and specialized health care team).

(continua)

Table 1 - Summarized characterization of the interviews with women living with HIV/Aids. São Paulo, 2005 (sequel)

Entrevistada*	Caracterização resumida das entrevistadas
Débora	Is 30 years old, a receptionist and has a child aged fourteen months (HIV-). She discovered she has HIV 10 years ago when her boyfriend fell ill and died. Six years ago she began a relationship with the father of her child (also HIV+) and he decided that they would have a child. She got pregnant and believed the child would be HIV+. After receiving medical guidance, she felt more confident, she had high hopes that her child would be <i>saved from HIV</i> . She separated from the father six months ago and began a new relationship.
Eliana	Is 30 years old and has been married for 16 years. She has three children, the first, a daughter, is 13 (HIV-), the second five (HIV+) and the youngest two (HIV-). She found out about the HIV when her second daughter fell ill and was hospitalized. The hospital verified that HIV had been found (on the child's medical records) and the family had not been notified. The couple was tested and both were HIV positive. She got pregnant a third time, <i>when the condom broke</i> , and underwent treatment to prevent MTCT. The couple has made a pact to keep silent and there are difficulties in the relationship. Eliana reports feeling guilt and worry about her HIV positive daughter.
Cátia	Is 33, a housewife and has five children: a daughter aged 12 (HIV-), a boy of 7 (HIV-), another boy aged 6 (HIV+) and five-month-old twins (HIV-). She discovered the HIV when her third child fell ill at three months. Her partner is not HIV+ and they assume she was infected from a blood transfusion during her second pregnancy. The last pregnancy was not planned (the couple do not use any form of contraception) and she reports that the relationship with her current partner is marked by conflict and violence. She says that <i>when she is pregnant he doesn't hurt her</i> .
Celina	At age 28 she has two children: her oldest son is aged 11 (whose father was killed when he was six months old) and the younger is seven months old. She found out about the HIV during her second pregnancy, when her partner was in prison and she was in her 3 rd month. He was released when she was reaching the end of the pregnancy. They have made a pact of silence, her partner (HIV and hepatitis C positive) is not receiving treatment and they make only sporadic use of condoms.
Márcia	Is 26 years old and has two children (a daughter aged 10, HIV-, and another aged six months, HIV-). She works in a bar. She found out about the HIV when she was five months pregnant, a few days after her first partner had died. She has had three partners: two died and one abandoned her while she was pregnant. She spoke of repeated experiences of losing partners and family and associating death with birth. She reported alcohol abuse. She did not want to become involved with another man, fearing more loss.
Maria	Maria has an 11 month old son (HIV-) and is pregnant again. She is 26 years old and is in a stable relationship with a HIV negative partner. She reported being an ex-drug user (crack and alcohol) and experiencing domestic violence, although she said her partner did not hit her while she was pregnant. Maria's attitude caused tension within the group she attended (there were complaints to hat she sold the milk she received from the NGO). The NGO intended to discontinue the service when she reported that she was pregnant again. Her report contained the signifier "hunger" countless times. Maria was triumphant to be pregnant again and laughingly stated that <i>I'll have as many children as I want. They can say what they want</i> .

* The names are fictitious.

to Lacan's work, especially in the 1957 - 1960 period when that author worked on the concept of Desire based on the Graph of desire, a complex development articulating various psychoanalytical concepts (Lacan, 1998, 1999).

In order to situate understanding the meaning of a HIV diagnosis, based on the psychoanalytical approach, it should be remembered that, in this

reading, this is a situation that could lead to raising the issue of castration, to the extent that the subject feels that something, i.e. being healthy, has been lost. It is a harrowing experience that may lead to feel that something is lacking and that they need to seek out something. We can, therefore, articulate the notion of desire as something that, in the end, they lack (Kaufmann, 1996).

For Psychoanalysis desire goes beyond the biological aspect and involves the field of relationships between humans. For Freud (1996)², we can translate desire as “desires” or as a specific particular desire focused on an empirical object. Lacan (1998), in turn, establishes a trilogy to explain that the human dimension goes beyond that of biology and is inserted within a system of relationships which, ultimately, concern Language. Lacanian theoretical construction, which aims to explain the difference between the notions of need, demand and desire, is essential for the process of introducing the subject into a relationship with the Unconscious. In this trilogy, the term demand is related to the level of the instinctive, lost forever in the speaking subject (i.e. inserted into the field of Language). The term want refers to the speaking subject who by demanding (asking) is faced with the “misunderstanding” of Language, and the subject therefore never obtains the object he longs for (complete satisfaction). Demanding, the subject comes face to face with the structural ambiguity of Language and the unconscious desire remains (and will remain) unsatisfied, as there will always be a “misunderstanding”, in so far as the speech will never encompass complete satisfaction.

The main contribution of this theoretical dialogue is in explaining the complexity of the issue of desire in the subjects, i.e., in fact, stating they “want” something (as a synonym for conscious and objective will) is very different from “desiring” something (such as something unconscious) as, from the subject’s point of view, the problem of desire often causes real alienation in that he may not recognize himself in what he thinks he desires. In this sense, unconscious desire is based on the paradoxical status of the drive, responding to both the constructive (life drive), and destructive aspects (death drive). So we cannot establish a direct relationship between “desire to have children” with something positive or constructive, for what seems to be in question is the unconscious desire, which may jeopardize other factors beyond those morally accepted socially.

Desire to have children and feminine desire³: what does psychoanalysis have to say about this?

In Freud’s view, feminine desire itself cannot avoid passing through the issue of producing a “child-phallus”, an attempt at narcissistic restoration possible for women. It became clear then, for Freud, after a certain course as an analyst, that the issue of feminine sexuality was more than reproduction, highlighting it as an “enigma” (Prates, 2001).

Research based on gender theory also show that, for a HIV positive woman, maternity takes on a meaning of narcissistic reassurance, as well as the role of guaranteeing survival, making them dependent on the partner. Thus, the woman’s place in our society is still seen as “passive”, an object of another’s desire. It can still be observed today in the economy of symbolic exchange, women adopt an attitude of “consenting complicity” in relation to supposed male desire (Barbosa; Villela, 1996; Ventura-Filipe et al., 2000).

Without disregarding this approach and following another path of analysis, the Lacanian perspective emphasizes that “there is no such thing as a feminine essence”, meaning that there is no “natural instinct” that explained or justified the desire to have children. Lacan (1985) observed that women often “have a child” in an attempt to “hold on to the phallus”, as an “artifice” to deny castration and the lack of a final response to what “makes a woman” (Prates, 2001). If Freud came to the end of his life asking “what do women want?” it needs to be understood that he is not asking “what does a mother want?” as for him it is evident that a mother wants a child. Based on this question, Lacan moves forward and highlights that the issue of femininity imposes itself on the subjects as an unavoidable enigma and that, although women often try to respond to this enigma with pregnancy in the end the bigger issue - the issue of femininity - is more than just maternity (Prates, 2001).

2 Originally published in 1905.

3 We emphasize that we rely on the Lacanian psychoanalytic concept of the femininity, that is, from a specific point of view. We recognize that other relevant theories discussed femininity, women and feminism widely, but they are not part of the scope of this work.

To address desire in women living with HIV / Aids: desire as a response in relation to the other

Based on Zizek's (1992) reading of the Graph of Desire (Lacan, 1998), certain meanings stand out based on the interviewees' discourse on unconscious desire: femininity and the subject's constitution in the social bond. From this, we can see how the process of **imaginary identification [i(a)]** and **symbolic identification [I(A)]** occurs between these subjects (table 2).

In Zizek's (1992) reading of the process of **imaginary identification [i(a)]**, we have the descriptive traces representing the subject and that author comments that, schematically, this would be "how the subject sees himself". Imaginary identity is related to the ideal I, with the subject identifying himself with an image representing "what he would like to be". In this process of imaginary identification we imitate the other in the level of similarity, that is, we identify ourselves with the image of the other so as to "be like him" with an idealized function.

In the case of the interviewees, the image these women had of themselves indicated that they identified themselves with the image of women marked out by the revelation of their HIV diagnosis, meaning that appeared in the discourse of all the interviewees were "being HIV positive", "being a mother or being pregnant and lacking guidance", "needing care and support", among others. The interviewees revealed that their HIV diagnosis made them into "victims in need of support and guidance and feel-

ing guilty". A statement by Mariana illustrates this aspect: *being pregnant and having Aids is something that leaves us disoriented. We need support that we don't always get. I lost a child to Aids and I feel it was my fault.*

At this level of imaginary identification, the women take on the idealized role of the supposed "good patient" who, by adopting the health care team's recommendations without complaints or questions, would supposedly be welcomed and accepted. Such meanings can be seen in the statements from Flavia, Miriam, Bianca, Dia and Débora.

As for **symbolic identification [I(A)]**, Zizek (1992, p.107) refers to it as "the place in which the subject observes himself as worthy of being loved". This refers to the way the subject looks at the other which, in the end, indicates the way he looks at himself (Zizek exemplifies this process as "the being for the other is the being for itself"). **Symbolic identification [I(A)]** depends on the subject's relationship with the symbolic order, that is, the subject seeks a "attribute" that represents him, and in this sense, he takes on a "mission", that may be unconscious for the subject.

At the level of **symbolic identification [I(A)]**, we observe that the women interviewed saw HIV positive women who decide to have children as being "crazy" or "irresponsible". When evaluating their own decision to have a child, however, a contradictory understanding appears, as they justify their own reproductive decisions by placing the responsibility on another. In their discourse, their pregnancies were "an accident", "it was my husband

Table 2 - Schema presenting the results of the research concerning imaginary and symbolic identification in the women interviewed. São Paulo, 2005

Concept	Point of reference	Results observed in the interviewees' discourse
Imaginary identification [i(a)]	"how the subject sees himself"	- Signifiers: pregnant women, victims, vulnerable, disoriented, needing support. - Identifying with the profile of a "good patient"
Symbolic identification [I(A)]	"the place in which the subject observed himself as worthy of being loved" or "the being for the other is the being for itself"	- Observations on the pregnancies of HIV positive women as "crazy" and "irresponsible" - Observations of their own pregnancy as justified: "it was an accident"; "my husband wanted it" - Fundamental attribute: avoiding responsibility for their own desire

who wanted it”, “all women want children and I didn’t want to be any different”, “it was carelessness”. The attribute that characterizes them is their subjective position of avoiding responsibility when faced with the desire, as they try to blame someone else. They try to justify their acts based on the “imposition” of another, as a “mission” they take on in the attempt to be accepted for the other.

We observed, however, that the women interviewed clung to the imaginary identification, taking on an identity of “victim” in an attempt to be accepted (loved) by the other, but this strategy does not allow them to avoid the question of castration as a persistent “reminder” presenting itself in the dimension of desire. Desire in this way takes the subject outside of the comfort of the imaginary identification and, by trying to correspond to what he “supposes to be the desire of the other”, the subject comes up against an unsolvable enigma (the enigma of femininity, which is not limited to the issue of maternity) and, thus, in anguish, they resort to artifice to deal with the dissatisfaction: the subject offers himself to the other, as the object of his desire. The “mission” related by the interviewees is a type of sacrifice in which the subject offers himself to the other’s supposed desire and, therefore, having a child transforms becomes a trial the objective of which is to generate a HIV negative offspring. This aspect is explained in the statements by Rita, Flávia, Mariana, Bianca, Dia and Débora.

But why could having a child be a narcissistic rescue? The answer is that women living with HIV/Aids experience narcissistic damage and the act of producing a “healthy” (HIV negative) child gives them a fleeting sensation of completion and negates

the lack, as, by producing healthy offspring, she accomplishes her “mission” and rescues the damaged narcissism. However, the statements of the women interviewed show that getting pregnant is not enough: even when the child they “produce” is HIV negative, there is still the issue of their own HIV status, representative of the subject’s confusion when faced with a lack which is, after all, structural. When the child is HIV positive the sacrifice, rather than dampening the lack, brutally uncovers the problem of HIV infection in all of its anguish and structural lack (table 3).

The women’s position of avoiding responsibility appears in the conjugal and affective relationships and tends to be repeated in the relationship with the health care team. This means that the way they treat the disease varies according to what the team presents to them as a reference in a mirrored and imaginary relationship. The health care professionals come to be the “other to be blamed or take responsibility” and, when the situation of pregnancy is distressing there is the risk of acting out. This appears in situations in which patients abandon or adhere poorly to treatment, or even fail to follow medical recommendations, creating great discomfort for the health care team. It is worth remembering, then, that it is important for the health care teams to be aware of and to understand that when the HIV positive women become pregnant, she engages in a type of mission and has expectations - concerning the pregnancy as well as her relationship with partners and with the health care team itself - expectations that are not always clear to the women themselves, as they are unconscious issues.

We should also clarify that when we state that the

Table 3 - Schematic table of the unconscious desire to have a child and the underlying unconscious expectations among the women interviewed. São Paulo, 2005

Mission	Status	Result	Emotional consequences	Signifiers
Sacrifice/trial: HIV positive woman should produce a HIV negative child Objective: operation aiming at the subject’s narcissistic recovery	Mission accomplished	HIV negative child	Narcissistic recovery	victory salvation plenitude peace
	Mission failed	HIV positive child	Suffering because of having to deal with HIV (in herself and in child)	penalty guilt punishment

women “avoid responsibility” for their unconscious desire, we are not making any kind of moral judgment, we are not saying the women are “irresponsible”. The concept of desire as unconscious allows to be understood that these issues and dynamics of women living with HIV/Aids are not conscious and may directly or indirectly affect the relationship with the team and, consequently, concretely affect health care.

Psychoanalysis contributions to the field of public health: after all, what is this desire?

Contributions from the field of Psychoanalysis become possible when we place the field of desire in a different register from the natural and/or biological environment, placing it in the symbolic field. We can thus state that being a mother is different from being a woman. Psychoanalysis does not aim to characterize a HIV positive woman’s desire as “a natural desire to have children”, nor does it characterize maternity and pregnancy as the insignia of being feminine. It is, then, not important whether the subject will have children or otherwise, Psychoanalysis concerns itself with knowing the position the subject occupies in relation to the unconscious desire.

The interviewees’ statements show contradictions, anguish and idiosyncrasies, showing that their reproductive decisions are based on a particular subconscious logic placing them, in their singularity, face to face with the possibility of getting pregnant, without necessarily being conscious of these contradictions as it is, evidently, something unconscious. We can state that pregnancy in a HIV positive woman is an attempt at narcissistic restoration and, when pregnancy occurs, it becomes a trial the objective of which is to generate a HIV negative offspring.

These women’s discourses contains a contradiction: they evaluate the reproductive decisions of other HIV positive women as “crazy” or “irresponsible”, whereas they seek to avoid responsibility for their own reproductive decisions. From the point of view of psychoanalysis, when we say that the

interviewees avoid responsibility for their desire we are not making any kind of moral judgment. Psychoanalysis allows it to be understood that, when these women act thus, they do it for “a good reason”. The issue of unconscious desire is something that imposes on the subject in an unavoidable way and often, the more they try to escape it, the more they are faced with the structural lack and with the unsatisfied desire. In attempting to deal with lack and with castration, the interviewees appear to engage themselves in an uncontrolled project that, in the end, does not protect them from experiencing distress. The pregnancy, then, can become something that explains a acting out (Kaufmann, 1996) not permitting the elaboration of the anguish but rather explaining it. When the subject tries to avoid responsibility towards the desire, psychoanalysis takes into consideration that this has consequences and, in the case of the interviewees, one can observe the anguish of castration made explicit in their discourse. It is also worth remembering that, on becoming mothers, they are far from answering or elaborating the question of the enigma of femininity. These data may be articulated with the results of research by Paiva et al. (2007) reporting that the desire to have children was more expressive in men living with HIV/Aids. The gender approach contributes to this issue by placing the focus on the man-woman relationship in the social context (Scott, 1989). In this sense, psychoanalytical and gender readings come together, as the statements by the interviewees allow us to understand that the women tend to take on the desire of the other - in this case, the man - as their own, something that presents itself as the structuring of subconscious desire itself. Moreover, they establish complicity with their partners and trick themselves in the project of having a child in order to cushion their loss. This relationship produces a type of bond with the partner that does not necessarily involve the issue of affection, nor is it conscious, which may explain the so-called “classical unplanned” pregnancies.

We observed that this position of avoiding responsibility is also evident in the conjugal-emotional relationships and tends to be repeated in the relationship with the health care team. The women’s discourse shows that their behavior is not

necessarily determined by the guidance received from the team but it was possible to identify the need to show themselves to be “good patients”, adhering to treatment and, above all, grateful for the institutional support received. Moreover, as Campos (1998) and Knauth (1999) also point out, being pregnant appears to require (currently, as there have been advances in attaining the rights of individuals living with HIV/Aids) special reception on the part of the team, beyond providing them with access to certain benefits for themselves and the baby (such as, for example, facilitated access to ante-natal appointments in institutions prepared to deal with their reality, receiving formula milk to substitute breast feeding, in some cases receiving clothing, being able to participate in support groups, among others). The interviewees revealed that through the pregnancy they could join (or rejoin) groups and obtain help and support, both objective and subjective. This relation even occurred with the participants of the group itself, in the form of a bond in which information and experiences were exchanged helping them to construct (or even reconstruct) professional training as well as citizenship.

Although we have seen great advances in recent decades in terms of access and rights for these patients, we see that there are often conflicts in the doctor-patient relationship, in other words, the behavior of these women when trying to show themselves as “grateful” and “good patients” often serves as a shield against a series of subconscious conflicts that could damage their health care itself. It was observed that the confusion of the (mis)match between health care professionals and patients reveals a need for a more in-depth understanding of these phenomena. A view based on Psychoanalysis is, in this context, an invitation for the subject to become aware of his idiosyncrasies, and thus take a position of being responsible for his behavior. Similarly, psychoanalysis can contribute to the field of public health, based on including the subjects’ idiosyncrasies. Thus the rescue of the singularity of the subject’s unconscious desire is possible, and allows reflection on how these issues affect comprehensive care, which, after all, can interfere with the reception of the complex needs of women living with HIV / Aids.

References

- ALVARENGA, A. T. A saúde pública como campo de investigação interdisciplinar e a questão metodológica. *Saúde e Sociedade*, São Paulo, v. 3, n. 2, p. 22-41, 1994.
- BARBOSA, R. M.; VILLELA, W. A trajetória feminina da Aids. In: PARKER, R.; GALVÃO, J. (Org). *Quebrando o silêncio: mulheres e Aids no Brasil*. Rio de Janeiro: Relume-Dumará, 1996. p. 17-32.
- BARRETO, M. et al. Successes and failures in the control of infectious diseases in Brazil: social and environmental context, policies, interventions, and research needs. *Lancet*, London, v. 377, n. 9780, p. 1877-1889, 2011.
- BERER, M.; RAY, S. *Mulheres e HIV/Aids: um livro sobre recursos internacionais: informação, ação e recursos relativos às mulheres HIV/Aids, saúde reprodutiva e relações sexuais*. São Paulo: Brasiliense, 1997.
- BERKMAN, A. et al. A critical analysis of the Brazilian response to HIV/Aids: lessons for controlling and mitigating the epidemic in developing countries. *American Journal of Public Health*, Washington, DC, v. 95, n. 7, p. 1162-1172, 2005.
- BRASIL. Ministério da Saúde. Secretaria de Vigilância em Saúde. *Programa Nacional de DST/Aids. Recomendações para a profilaxia da transmissão vertical do HIV e terapia anti-retroviral em gestantes*. Brasília, DF, 2009. Disponível em: <<http://bvsms.saude.gov.br/bvs/publicacoes/gestante2.pdf>>. Acesso em: 15 abr. 2013.
- CAMPOS, R. Aids: trajetórias afetivo-sexuais das mulheres. In: BRUSCHINI, C. *Horizontes plúrais: novos estudos de gênero no Brasil*. São Paulo: Editora 34, 1998. p. 85-109.
- FREUD, S. As teorias sexuais infantis. In: _____. *Obras completas*. Rio de Janeiro: Imago, 1996. v. 9, p. 117-229.
- GAY, J. et al. What works to meet the sexual and reproductive health needs of women living with HIV/Aids. *Journal of the International Aids Society*, Geneve, v. 14, n. 56, p. 1-10, 2011.

- GONÇALVES, T. R. et al. Vida reprodutiva de pessoas vivendo com HIV/Aids: revisando a literatura. *Psicologia & Sociedade*, Belo Horizonte, v. 21, n. 2, p. 223-232, 2009.
- HOPKINS, K. et al. The impact of health care providers on female sterilization among HIV-positive women in Brazil. *Social Science & Medicine*, Oxford, v. 61, n. 3, p. 541-554, 2005.
- KAUFMANN, P. *Dicionário enciclopédico de psicanálise: o legado de Freud e Lacan*. Rio de Janeiro: Jorge Zahar, 1996.
- KNAUTH, D. R. Subjetividade feminina e soropositividade. In: BARBOSA, R.; PARKER, R. (Org). *Sexualidades brasileiras: direitos, identidades e poder*. São Paulo: Editora 34, 1999. p. 121-136.
- KENNEDY, C. E. et al. Linking sexual and reproductive health and HIV interventions: a systematic review. *Journal of the International Aids Society*, Geneve, v. 13, n. 26, p. 1-10, 2010.
- LACAN, J. Subversão do sujeito e dialética do desejo no inconsciente freudiano. In: _____. *Escritos*. Rio de Janeiro: Zahar, 1998. p. 807-842.
- LACAN, J. *O seminário: livro 5 - as formações do inconsciente*. Rio de Janeiro: Zahar, 1999.
- LACAN, J. *O seminário: livro 20 - mais, ainda*. Rio de Janeiro: Zahar, 1985.
- MEIHY, J. C. S. B.; HOLANDA, F. *História oral: como fazer, como pensar*. São Paulo: Contexto, 2011.
- MYER, L.; MORRONI, C.; EL-SADR, W. M. Reproductive decisions in HIV-infected individuals. *The Lancet*, Oxford, v. 366, n. 9487, p. 698-700, 2005.
- OLIVEIRA, L.; FRANÇA-JUNIOR, I. Reproductive demands and health care for people living with HIV/Aids: limits and possibilities within the context of specialized health care. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 19, p. 315-323, 2003. Supplement 2.
- PAIVA, V. et al. Desire to have children: gender and reproductive rights of men and women living with HIV: a challenge to health care in Brazil. *Aids Patient care and STDs*, Larchmont, v. 21, n. 4, p. 268-277, 2007.
- PAIVA, V. et al. The right to love: the desire for parenthood among men living with HIV. *Reproductive Health Matters*, Londres, v. 11, n. 22, p. 91-100, 2003.
- PRATES, A. L. *Feminilidade e experiência psicanalítica*. São Paulo: Hacker, 2001.
- SANTOS, N. J. S. et al. Mulheres HIV positivas, reprodução e sexualidade. *Revista de Saúde Pública*, São Paulo, v. 36, p. 4-11, 2002. Suplemento 4.
- SCOTT, J. *Gender: a useful category of historical analyses: gender and the politics of history*. New York: Columbia University, 1989. Disponível em: <<http://www.direito.mppr.mp.br/arquivos/File/SCOTTJoanGenero.pdf>>. Acesso em: 1 nov. 2013
- SILVA, N. E. K.; ALVARENGA, A. T.; AYRES, J. R. C. M. Aids e gravidez: os sentidos do risco e o desafio do cuidado. *Revista de Saúde Pública*, São Paulo, v. 40, n. 3, p. 474-481, 2006.
- SOWELL, R. L. et al. Factors influencing intent to get pregnant in HIV-infected women living in the southern USA. *Aids Care*, London, v. 14; n. 2, p. 181-191, 2002.
- TUNALA, L. Fontes cotidianas de estresse entre mulheres portadoras do HIV. *Revista de Saúde Pública*, São Paulo, v. 36, p. 24-31, 2002. Suplemento 4.
- TURATO, E. R. *Tratado de metodologia da pesquisa clínico-qualitativa: construção teórico-epistemológica, discussão comparada e aplicação nas áreas da saúde e humanas*. Petrópolis: Vozes, 2003.
- VENTURA-FILIPPE, E. M. et al. Risk perception and counseling among HIV-positive women in São Paulo, Brazil. *International Journal of STD & Aids*, Thousand Oaks, v. 11, n. 2, p. 112-114, 2000.

WHO - WORLD HEALTH ORGANIZATION. *Sexual and reproductive health of women living with HIV/Aids: guidelines on care, treatment and support for women living with HIV/Aids and their children in resource-constrained settings*. Geneva, 2006. Disponível em: <<http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf>> Acesso em: 10 ago. 2013.

ZIHLMANN, K. F. *A questão do desejo da gravidez e da maternidade em mulheres vivendo com HIV/Aids, na perspectiva psicanalítica*. 2005. Dissertação (Mestrado em Saúde Pública) - Faculdade de Saúde Pública da Universidade de São Paulo, São Paulo, 2005.

ZIZEK, S. *Eles não sabem o que fazem: o sublime objeto da ideologia*. Rio de Janeiro: Jorge Zahar, 1992.

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