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THE AURA OF SILENCE: A
PSYCHOSOCIAL ANALYSIS OF STIGMA
AMONGST STUDENTS WORKING IN
THE FIELD OF HIV AND AIDS AT THE
UNIVERSITY OF CAPE TOWN

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Abstract

Eleven white, well-educated students from the University of Cape Town, all actively involved in the field of HIV/AIDS, were interviewed through a free-associative-narrative method. This study sought to explore these students' perceptions of and associations with HIV/AIDS and those infected, in an attempt to assess the extent to which stigma may occur amongst these students. To the authors' knowledge, no other studies exploring HIV/AIDS-related stigma have been done on young adults who are actively engaging with, and highly educated on, issues around HIV and AIDS. The accounts revealed that underneath the overt denials of fear, the epidemic does seem to evoke various fears and anxieties for these students. Through their constructions of HIV/AIDS, the participants tend to 'other' the epidemic and those infected and thus distance themselves from a sense of threat. Such representations therefore appear to serve a protective function, enabling the participants to defend themselves from the anxieties they experience surrounding the epidemic. In line with psychosocial understandings of HIV/AIDS stigma, the results from this study indicate that this 'atypical' group of students may possess certain stigmatizing tendencies. This points to the fact that HIV/AIDS stigma may not be the product of a lack of education or 'faulty' thinking. There were however multiple, often contradictory and conflicting voices heard throughout the interviews. Many participants expressed an awareness of, and uneasiness with, their 'othering' and potentially stigmatizing tendencies. It is in this space, that the potential for change, and stigma reduction may exist. The findings from this study thus have both theoretical and practical implications for conceptualizing, and challenging HIV/AIDS stigma.

Bearing The Stigmata

I sit in the dark pew
abandoned
they shrink from me
fearing the cup we will share
stained with my blood
my diseased black body
despised
quietly condemned
leper of this age

place of condemnation
my Holy Mother
denying me my
birthright
I am
stoned again
for adultery
stoned for my race
for the sins of my brothers and sisters
my cross of shame
uncleaness...

(Govinden, from Rasebotsa, Samuelson & Thomas, 2004)

1. Introduction

1.1. Aims And Rationale

The HIV/AIDS epidemic has given rise to another pandemic, that of stigma and discrimination (Mann, 1987, as cited in Malcolm et al, 1998). From the onset of the epidemic, PLWHA worldwide have been stigmatized and ostracized. In South Africa, the now infamous cases of Nkosi Johnson, who was refused admission to school, and Gugu Dlamini who was murdered by a mob after publicly revealing her HIV-positive status, point to some of the horrors that

PLWHA face in South Africa (Finchilescu, 2002). Looking even closer to home, it was estimated that the prevalence of students at the University of Cape Town (UCT) living with HIV in 2005 was 9.5% (Kramer, 2003, as cited in Hall, 2006), and yet according to Sean Brown, the Project Officer at the HIV/AIDS Unit at UCT, to the unit's knowledge no student has *publicly* disclosed an HIV-positive status (S. Brown, personal communication, May 2, 2006). Furthermore, two projects that were funded by the Elton John AIDS Foundation that sought to address issues around stigma, mutually agreed to return the project funds due the difficulties they experienced in getting HIV-positive students to come forward and participate (S. Brown, personal communication, May 2, 2006). The challenges these projects faced, together with the immense secrecy and fear displayed by those few HIV-positive students that were involved anonymously, raises a number of questions around stigma at this university.

The problem of HIV/AIDS related stigma has however gained increased attention at UCT, in South Africa more generally, and internationally. In December 2000, Peter Piot, the executive director of UNAIDS, placed a "renewed effort to combat stigma" on the top of his list of "the five most pressing items on this agenda for the world community" (Piot, 2000 as cited in Parker and Aggleton, 2003: 14). Furthermore, the World AIDS Campaign chose stigma and discrimination for its theme in 2002-3, highlighting the pervasiveness of this issue (Parker and Aggleton, 2003). Ultimately, there have been worldwide calls to address and confront HIV-related stigma as it serves as one of the 'greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating impact' (Parker & Aggleton, 2002: 5).

Despite the continued concerns about the seriousness of HIV/AIDS related stigma, Parker and Aggleton (2003) argue that this issue is still poorly understood and inadequately researched. The authors emphasize that this inadequacy is linked to the particularly limited theoretical and methodological tools that exist (Parker and Aggleton, 2003). Similarly, Stein (2003) emphasizes that in South Africa, research on HIV/AIDS stigma has been extremely limited.

Thus, in an attempt to address the above research needs, and speak to the aura of silence and secrecy that seems to be surrounding students at UCT, this study sought to explore a group of UCT students' perceptions of and associations with the epidemic and those infected. By tapping into such understandings and constructions, the aim was to explore whether these 11 students, who are all

well-educated and actively involved in the field of HIV/AIDS, may possess certain stigmatizing tendencies.

1.2. Theoretical Issues In The HIV/AIDS-related Stigma Literature

By turning to the literature, there appears to be great controversy and variability around how to conceptualize and define HIV and AIDS-related stigma (Link & Phelan, 2001; Parker & Aggleton, 2003; Stein, 2003). It is clear that most understandings of HIV/AIDS related stigma take the now highly influential work of Erving Goffman, a pioneer in stigma research, as a starting point. Goffman (1963: 3) defined stigma as ‘an attribute that is deeply discrediting’ and that which reduces the stigmatized ‘from a whole and usual person to a tainted, discounted one’. According to Goffman (1963: 15), whether this ‘attribute’ is physical and/or non-physical, either way, ‘by definition we believe the person with a stigma is not quite human’. Although much of the theorizing on HIV/AIDS stigma shares Goffman’s definition as a point of departure, there tends to be a continuing polarization between the way it is read within the psychological domain on the one hand, and the sociological on the other (Deacon, 2005).

In terms of the psychological domain, given Goffman’s emphasis on a ‘discrediting attribute’, such theorizing has tended to understand stigma in highly individualistic terms, conceptualizing it as a characteristic or fixed attitude of individuals (Crocker & Lutsky; 1986; Deacon, 2005; Parker & Aggleton, 2003). For example, Herek (2002: 595) defines HIV/AIDS stigma as an ‘enduring characteristic that relegates an infected individual...to a negatively evaluated category’ (Herek, 2002: 595). The focus within the traditional psychological domain has thus been to identify and understand the nature of the beliefs and attitudes that come to be associated with ‘category members’ and the ‘category label’ (Crocker & Lutsky, 1986: 97). It is implied within this domain that HIV/AIDS stigmatization is a problem of individual ignorance and erroneous beliefs, and can thus be reduced with increased knowledge and education of HIV/AIDS (Deacon, 2005; Herek, Capitano, & Widaman, 2002; Shisana & Simbayi, 2002).

Such understandings of HIV/AIDS stigma have received much criticism within the sociological domain. In this domain, it is argued that Goffman emphasized

that stigma is a perspective that is attributed to a person within social relations, rather than being a static characteristic of an individual, as defined by dominant psychological theorizing. As Parker & Aggleton, (2003) and Link & Phelan (2001) point out, Goffman postulated that stigma is more than just a discrediting characteristic, ‘but should be seen that a language of relationships, not attributes, is needed’ (Goffman, 1963: 3). Thus, emphasizing the need to move away from the dominant individualistic understandings of stigma, such scholars have suggested instead that HIV/AIDS stigma is a complex socioeconomic and political process, directly linked to the wider notions of power and mechanisms of domination, exclusion and control (Campbell, Foulis, Maimane & Sibiyi, 2005; Link & Phelan, 2001; Parker & Aggleton, 2003; Stein, 2003). As Campbell et al. (2005: 808) argue, stigma ‘Serves to support systems of social inequality and social difference and to reinforce the interests of powerful social actors seeking to legitimize their dominant status’.

Now, various scholars have argued that both the dominant psychological and sociological theorizing are problematic in various ways (Deacon, 2005; Joffe, 1999). It is suggested that dominant psychological theorizing ignores the social processes that lie at the heart of stigmatization, but that the social control models, at the other end of the theoretical spectrum, focus purely on macro-structures failing to take heed of the individual who actually generates the responses (Deacon, 2005; Joffe, 1999). Furthermore, such sociological theorizing also runs into the problem of functionalism, defining stigma primarily in terms of its discriminatory effects (Deacon, 2005). Thus, it is argued that we need to pay attention to the interplay between individual and social processes, and how they intersect to give rise to HIV/AIDS stigmatization. As Deacon (2005: 4) argues,

‘We need to be able to explain the functions or effects of stigmatization without resorting to functionalism, and we need to be able to understand the role of the individual in stigmatization without resorting to individualism’.

Thus, in an attempt to reconcile the psychological-sociological theoretical binary, from a psychosocial perspective, it is argued that HIV/AIDS stigma needs to be conceptualized as a social and emotional *process*. This process entails projecting risk for HIV-infection onto the ‘other’, in an attempt to distance the ‘self’ from the danger of HIV/AIDS (Joffe, 1998, 1999). This process is emotional, as it involves the psychological defence mechanism of ‘splitting’, linking the epidemic to ‘other’ groups, and associating it with

behaviours and characteristics of ‘the other’ (Crawford, 1994; Gilman 1988; Joffe, 1998, 1999). This stigmatizing process is also social as in externalizing the threat, people draw on existing social discourses, representations and ideologies that profoundly shape the way in which ‘the other’ is constructed (Deacon, 2005; Frosh, 1989; Joffe, 1998, 1999).

1.3. Methodological Issues In HIV/AIDS-related Stigma Research

In addition to disagreements surrounding conceptualizations of HIV/AIDS-related stigma, there also appears to be great controversies around how such stigma should be measured. Research on HIV/AIDS-related sigma internationally and locally has been predominantly quantitatively based, relying heavily on opinion polls, surveys and structured questionnaires (Deacon, 2005; Parker & Aggleton, 2003). Through such means, these studies have tended to investigate the attitudes and stereotypes people have towards PLWHA, in an attempt to measure context-specific amounts of stigma (Deacon, 2005; Parker & Aggleton, 2003; Stein, 2003).

For example, in South Africa, two recent quantitative national survey studies were conducted on issues around HIV/AIDS, including assessments of stigma within the general population. The first of these studies, conducted by the Human Sciences Research Council, was the first systematically sampled national community-based survey on HIV/AIDS in South Africa (Shisana & Simbayi, 2002). The second, commissioned by the Department of Health and conducted by the Centre for AIDS Development, Research and Evaluation (CADRE) assessed the responses to and knowledge about HIV/AIDS amongst public transport commuters in South Africa (Parker, Oyosi, Kelly, & Fox, 2002). In both studies, participants were asked to respond to statements such as ‘I will sleep in the same room as someone with HIV/AIDS’ and ‘I will talk to someone with HIV/AIDS’ in an attempt to assess the levels of stigma in South Africa (Shisana & Simbayi, 2002: 86). The findings from both studies pointed to relatively low levels of stigma in the general population of South Africa. For example, Shisana & Simbayi (2002) concluded from the results of their study that the majority of South Africans express attitudes of acceptance towards people living with AIDS, although a small minority have a clear tendency to stigmatize. From the results of their study, Parker et al. (2002:10) concluded that

‘The data suggests an encouraging degree of openness towards people with HIV/AIDS’.

Now, such dominant quantitative approaches to HIV/AIDS stigma research have been criticized in various ways. Firstly, by solely exploring people’s attitudes and beliefs, such studies fail to tap into the possible social, cultural and political forces that lie at the heart of HIV/AIDS related stigma (Link & Phelan, 2001; Parker & Aggleton, 2003; Stein, 2003). Secondly, various authors argue that there may be a number of limitations with the scales that are used to measure levels of HIV/AIDS stigmatization. Many scales fail to capture the complex and multidimensional nature of stigma and the varying forms in which it could manifest (Maughan-Brown, 2004; Stein, 2003). Finally, it is argued that given that overt forms of stigma are socially undesirable, it is questionable whether people’s self-reports should be taken at face value and whether more subtle and hidden forms of stigmatization are thereby captured (Stein, 2003). This contention is supported by the few qualitative studies that have been done on HIV/AIDS related stigma in South Africa. For example, in their qualitative study on students’ perceptions of, and attitudes towards, HIV/AIDS at UCT, Levine and Ross (2002) found that PLWHA tended to be constructed in highly derogatory terms, with sentiments of blame towards them being extremely pervasive. Such findings do cause one to wonder whether the more common, quantitative studies are in fact missing the new ‘dirty secret’ of HIV/AIDS stigma (Stein, 2003). It is therefore clear that HIV/AIDS-related stigma may be a more subtle and elusive object of research, and tapping into this phenomenon may be more difficult than commonly assumed.

2. Method

2.1. Participants

A purposive and ‘snowballing’ sampling approach was used to generate a sample of eleven white UCT students. Six of the participants were female, and five were male. The commonality between the participants was that they were all involved in some aspect of HIV/AIDS work, be it in the field of research, education, and/or awareness promotion. Therefore, they will be referred to as AIDS-workers throughout this paper. We knew most of the participants prior to the study, many of whom are colleagues and/ or friends of the first author. Thus,

some of the participants were recruited by the first author, with others being peers identified and contacted by those participants whom the first author knew directly. Participation was voluntary and informed, written consent was obtained from all of the participants. Furthermore, in line with ethical considerations surrounding confidentiality, the names of the participants in the study have been omitted, with participants being referred to numerically.

Due to the fact that all of the participants are actively involved in the field of HIV/AIDS, we took this to mean that they are exceedingly knowledgeable about HIV/AIDS. We wanted to explore whether even amongst these students, stigmatizing tendencies may still occur. The findings from this ‘atypical’ sample of students could shed light on what may be occurring amongst other, less educated young adults, as well as raise a number of questions about the role that education may play in HIV/AIDS stigma. To the authors’ knowledge, no other studies investigating HIV/AIDS-related stigma have been done on young adults who are actively engaging with, and highly educated on, issues around HIV and AIDS.

Table 1: Relevant personal details of study participants

<i>Respondent</i>	<i>Gender</i>	<i>Age*</i>	<i>Involvement in the field of HIV/AIDS</i>
Participant 1	Female	26	Conducting research in the field of HIV/AIDS and involved in coordinating an HIV/AIDS outreach programme
Participant 2	Male	21	HIV/AIDS peer educator
Participant 3	Female	22	HIV/AIDS peer educator
Participant 4	Male	27	HIV/AIDS NGO member
Participant 5	Female	22	Part-time research assistant in the field of HIV/AIDS
Participant 6	Male	24	HIV/AIDS peer educator and involved in organizing an HIV awareness campaign
Participant 7	Male	24	HIV/AIDS peer educator
Participant 8	Female	26	HIV/AIDS peer educator and part-time researcher in field of HIV/AIDS
Participant 9	Female	22	Part-time research assistant in the field of HIV/AIDS
Participant 10	Female	23	Part-time research assistant in the field of HIV/AIDS
Participant 11	Male	25	HIV/AIDS peer educator

* Note: At time of interview

2.2. Data Production And Analysis

In order to explore the possible stigmatizing tendencies these 11 AIDS-workers may possess, this study utilized Hollway and Jefferson's (2000) 'free associative narrative interview method' that involves turning questions into story-telling invitations. Thus, in-depth, individual interviews were conducted that aimed to elicit narratives surrounding the participants personal and social understandings and experiences of the epidemic, their thoughts, feelings and sense of HIV/AIDS, and their own and others experiences of risk and possible infection. In using this method, the researchers were able move away from the 'would you talk to an HIV-positive person' type survey research, and tap into the possibly more nuanced, complex and multidimensional dynamics at play. This is because the way in which stories are told, the emphases and links made, the morals drawn and the details, justifications and conclusions made, may shed light on certain subtleties, often beyond the storytellers' intent (Hollway & Jefferson, 2000; Radley & Billig, 1996). Furthermore, through the telling of stories and anecdotes, the participants were given the opportunity to choose how to address and converse with the topic, foregrounding their own subjective thoughts, experiences and meaning-frames surrounding the epidemic, rather than those imposed upon by the researchers (Hollway & Jefferson, 2000).

The participants' tendency to open up and provide rich and detailed stories was most certainly facilitated by their familiarity with the first author (Kvale, 1996). In many ways, the interviews embodied something like a social event, sitting around drinking coffee and chatting. The consequent emergence of open, unsolicited and everyday talk is highly advantageous as Willig (2001) emphasizes that discourse analysis should ideally analyze naturally occurring conversation, so as to reveal discursive strategies used in daily life, as opposed to those where the participant is positioned as *interviewee*.

The interviews were transcribed verbatim and analyzed from a critical realist perspective advocating that there is a relationship between people's experiences of the world and the way in which such experiences are represented and expressed (Hollway & Jefferson, 2000). Such an approach emphasizes that there are material and social structures underlying discursive constructions of reality, and these discourses in turn have very real effects (Parker, 1992). Thus, proceeding from this orientation, our analysis was guided by Hollway and Jefferson's (2000) recommendations for analyzing data within a psychosocial paradigm, paying attention to emotional, social and discursive dynamics at play. The analysis was also informed by Potter and Wetherell's (1987) discursive

psychology approach to help identify the participants' clusters of ways of speaking or 'interpretative repertoires', as well as the three auxiliary criteria of Parker (1992) to locate such discourses within institutions, power and ideology.

3. Results

The results of the study will be presented in three parts. Firstly, we will show how underneath the participants denial of fear surrounding the epidemic, HIV/AIDS does seem to evoke various anxieties for them. Three of these fears will be explored. Secondly, we will demonstrate how through their constructions of, and associations with HIV/AIDS, the participants tend to 'other' the epidemic and those infected and thus distance themselves from a sense of threat. Finally, we will highlight how intermittently, some of the participants become aware of, and highly perturbed with, these 'othering' impulses.

3.1. Fear Surrounding HIV/AIDS

HIV Involves 'Social' And 'Sexual' Death...

Almost all of the participants claimed that the anti-retrovirals (ARV's) roll-out has eradicated the associations of HIV/AIDS with death, consequently diminishing much of the fears surrounding the epidemic. For example, when talking about his thoughts on the epidemic in South Africa at the moment, participant 11 remarked, in a bold and vehement manner,

... I think that HIV and AIDS has changed a lot since the government started making ARVs free to everyone who needs it. That must have been like in, what, the mid-late 1990s? ... You know like now AIDS is not a death sentence anymore. It really isn't... So there isn't so much despair surrounding it anymore...

Similarly, participant 1 said, when talking about her sense of HIV/AIDS in South Africa at the moment:

...knowing you can live with HIV has meant that people no longer get those horrible images of like people being sick and dying and stuff. So, it is not as scary as it used to be because you know that you can live a long and healthy life for many years now. I mean you could even die of old-age! So, I think people are not as worried and scared as they used to be, like when it first came out...

Beneath such ubiquitous choruses of life and hope however, through the stories and anecdotes the participants told, it became clear that the epidemic does evoke a number of anxieties for these participants. In the first instance, the participants appear to harbour great anxiety around the social and sexual demise it is seen to bring about. We thus catch glimpses of a terror of death, perhaps of a different kind of order. For example, when talking about some of the difficulties he would experience in disclosing an HIV-positive status, participant 6 said:

... it's all very well if I'm open-minded, but like a lot of people wouldn't want anything to do with you if you had AIDS... You don't want to be the person standing in the middle of the club, saying 'I have AIDS' and everyone doesn't want to know you... like that would be awful...

Similarly, participant 11 emphasized when imagining how he would feel if he himself received an HIV-positive diagnosis:

... It (AIDS) would completely redefine your relationships. How many people want to date someone who has AIDS or have sex with someone who is HIV-positive?... So, you probably going to be isolated... it's a scary thought in many ways...

This is the same participant quoted above who claimed that in South Africa, *'there isn't so much despair surrounding it (HIV/AIDS) anymore'*. It thus seems that when moving away from talking about the epidemic in the general sense, on a societal level, to thinking about it on a more intimate and personal level, very different sentiments seem to emerge. In a similar vein, participant 1, who as quoted earlier claimed that *'it (HIV/AIDS) is not as scary as it used to be'*, remarked when talking about how she would feel about telling her friends if she received an HIV-diagnosis:

...there still are so many stigmas surrounding the epidemic, like you'd be surprised how really liberal and open-minded people will still hold a lot of prejudices ...so like it's easy to say 'oh I would just be open about it'. I mean I would be terrified...um like you just don't know how people would react or like how they would be...

These painful accounts of being isolated, left alone and rejected mirror some of the powerful metaphors surrounding HIV/AIDS, that of social and sexual death (Gilmore & Somerville, 1994; Sontag, 1988). Fears of becoming *'an outsider'*, being *'pushed aside'*, and partners not *'sticking around'* tend to colour many of the participants' personal thoughts about HIV/AIDS. Similarly, many assertions were made such as *'like it would just be too scary to have sex'* and *'you couldn't*

expect your partner to have sex with you'. It thus seems that a fear surrounding HIV/AIDS for many of these participants may not be primarily that of biological death, but social and sexual dissolution. Such sentiments seem to be very salient in Sub-Saharan Africa, as indicated by Lorentzen and Morris (2003) in their thesis on HIV/AIDS-related stigma in Sub-Saharan Africa.

The Threat Of Contagion...

Besides the social and sexual demise HIV/AIDS is seen to bring about, there also appears to be great anxiety around the infectious nature of HIV/AIDS. For example, participant 3 remarked:

...somebody could pass out and you give them mouth-to-mouth and you both have cuts in your mouth and there's blood and then hey, you have AIDS. Or like, you drink out of my coffee mug, and then it cracks and there's blood. Or like, you knick something, or fall and cut yourself ... Or...

The list of examples continued for some time. We were taken aback by the urgent manner in which this young woman spoke. The constant flow of words and incoherent sentences provide a stark contrast to the well-articulated and calm manner in which this participant usually spoke. We were also struck by the repetitive use of the word '*blood*' and the perilous emotions it seemed to evoke. In a similar light, participant 7 remarked, when talking about someone he knew who was HIV-positive, beginning with a degree of caution,

...Like people would probably think I'm like discriminating against the guy, but I do feel nervous when we are together with my little sister. Like, you know, kids do fall all the time, and get cuts and nicks or... like bleed or whatever (laughs)...

The uneasy laughter at the end of this account, together with the reservations conveyed throughout this discussion, alerts one to the difficulties this participant has in expressing his fears, and yet one is made acutely aware of the anxiety that cuts, nicks and blood seem to evoke for him. In her analysis of purity and pollution, Douglas (1966) suggests that notions of danger tend to be directed towards bodily boundaries. That which threatens to perforate the body's margins, is likely to evoke immense fear. Thus, the bodily emissions that flow in and out of the body, in general tend stir up great anxiety, but particularly if possible infection is involved (Douglas, 1966). Amongst others, the two extracts above indicate the fears participants have around the permeability of the body, and the danger of HIV-contaminated blood flooding across fragile bodily

boundaries. This is further seen in a number of the participants' narratives about their concerns around receiving blood at hospitals. As participant 4 said:

...today they have ways of checking donated blood, but it's not foolproof, which is really scary. I mean, you could have an accident and need blood and then come out with AIDS. There's nothing you can do...

Similarly, participant 9 explained:

... My mom works for Grootte Schuur and she says that lots of blood passes through there that has not been tested. I mean, there was a time when the machine that tests the blood was broken for two weeks and they were just like, oh. So like that's one of the reasons why I will never, ever be operated at Grootte Schuur. It's just far too risky you know...

Thus, it seems that HIV/AIDS discourses buttress, and intensify, existing discourses of bodily invasion and pollution. The participants appear to fear the way in which HIV/AIDS is able to penetrate and infect the body via the exchange of blood, in instances over which they have limited control.

Intimacies Publicly Exposed...

A third and final fear surrounding the epidemic relates to the way in which it is seen to bring about public exposure of the most intimate and private behaviour: sex (Gilmore & Somerville, 1994). Sex, is almost unanimously constructed by the participants as something that should be confidential and hidden. For example, participant 7 said just before the interview ended,

...I must say, when you said to me on the phone that the interview would entail talking about sex I was a little apprehensive... I mean it is such a personal thing...

Similarly participant 5 remarked:

...it (sex) is between you and another person. No-one knows what you are like in the bedroom... You give this image of yourself to people, but when they know about your sex life, it can be like completely different to what they'd expect...

Besides representing sex as something personal and intimate, these excerpts also illustrate the strong sense of anxiety that surrounds having one's sexual activities known to other people. Such sentiments clearly reflect Elias's (1994) analysis of modernity and the Western 'civilizing process', and the way in which increasingly more instinctual human impulses and 'animalic human activities' became privatized, 'intimized' and forbidden from the scenes of

public social life (Elias, 1994: 365). Such standards of civilized conduct in turn also meant that everything pertaining to sexual life increasingly became submerged in secrecy, shame and discomfiture. This helps one understand the awkwardness surrounding participants' talk of their sexual activities. Elias's (1994) analysis also helps one understand why HIV/AIDS represent a serious threat for these AIDS-workers. When talking about whether he would tell people if he had AIDS participant 4 said:

... as soon as you say you have HIV, you open up the question of how you contracted it... And even if you can't pinpoint it, you just say 'oh I'm fairly confident I got it from sex'...its kind of like... being, um...being caught I suppose...

This participant did not finish his train of thought, but it seems that an HIV-infection would make him feel 'caught' in the act of *sex*, and all the shame that that would supposedly entail. Similarly, when imagining what it would feel like to have AIDS, participant 8 remarked:

...kind of like being naked. Exposed, in some way...

In a similar fashion, also when talking about how she would feel about telling her family if she received an HIV-diagnosis, participant 10 said:

...I know it sounds funny, but I would feel embarrassed (laughs)...well, not embarr (unfinished)...well, ja, people would be like 'what were you up to sort of thing' ...however ridiculous that sounds, it would feel a bit umm...humiliating...

It thus seems that HIV/AIDS may be frightening for many of these participants as it is seen to render that which supposedly must be kept most carefully veiled, open for all to see. Once again, we see how other discourses, in this case modernist discourses of civilized conduct, feed into the participants' discourses of HIV/AIDS. Such sentiments echo some of the feelings that people actually living with HIV have expressed. For example, HIV-positive Supreme Court of Appeal Justice, Edwin Cameron (2005: 71), explains that the infection leaves

'a print linking us back to an act so private, so intimate, so sacrosanct, so emotionally and spiritually unguarded- the moment of sexual coupling- that its external manifestation in an illness, its exposure to the world, is deeply embarrassing and therefore shameful'.

It is thus clear underneath the participants' blatant and overt claims about life, hope and diminished fear, they appear to express, in more subtle and covert ways, various fears and anxieties around the epidemic. This clearly reflects

Ratele and Shefer's (2002: 186) contention that the epidemic has induced an 'emotional context of fear, anxiety and panic'. The point of this analysis is not to evaluate the truth or falsity of these fears, nor to judge the rationality of the participants' anxieties. Most certainly, many of the fears these participants hold are anchored in some of the brutal realities of the AIDS pandemic. The point is however that despite their denials, on a personal level the epidemic seems to evoke very real fears and anxieties for these young men and women. What begins to unfold is that through the participants' constructions of, and associations with HIV/AIDS, they tend to 'other' the epidemic and those infected, and thus distance themselves from a sense of threat.

3.2. Defending Against The Anxiety Produced By HIV/AIDS

HIV Is The Outcome Of 'Others' Promiscuity...

The participants almost unanimously construct risk for HIV/AIDS infection as a result of promiscuity- behaviour that they rhetorically represent as different to, and outside the domain of, their own behaviour, and those that are close to them. For example, in describing someone that he knew, whom he thought could be at risk of contracting HIV, participant 7 said:

...He is extremely_promiscuous... he gets with completely random women, whoever they were and like just shags them...

Similarly, participant 10 remarked, when describing a friend who had recently gone for an HIV-test,

... he'd had lots of, lets call it 'high-risk' sex...within a week, he had slept with a considerable amount of girls... and he didn't even know them...

There were an abundance of narratives that cropped up again and again in the interviews describing people at risk 'screwing around', 'on a spree' and 'having lots of sex'. Thus, risk for HIV/AIDS infection is constructed as a result of promiscuity with 'random' people. The pervasive association of HIV/AIDS and promiscuity has been shown in a number of studies in different South African communities (See for example Levine & Ross, 2002; POLICY project, 2003; Ratele & Shefer, 2002; Strebel, 1997).

In direct contrast to the notions of promiscuity, participants tend to describe themselves as very *different*, having sex only within the terms of monogamous relationships. For example, participant 9 said, when asked if there had ever been a time when she thought that she might have been at risk:

No, I mean... for me, I have never really have one -night stands. I have only had serious relationships... it's just a personal thing...

Similarly, participant 6 explained when talking about a time when his girlfriend cheated on him:

...And like, we had been together for a heck of a long time ...Like we were really close and had the whole like 'I love you thing' (laughs)... I suppose that's how it always is for me...

Many participants shared these sentiments of monogamy being a '*personal thing*', as indicated by the ubiquitous representations of themselves as never having '*little flings*' or '*sex for the sake of it*' and only engaging in '*the simple stuff*'. Most certainly it is possible that the participants truly do not engage in such risk-laden behaviour. There were however occasions where participants would describe incidents that tended to position themselves within the supposedly 'high risk' domain of behaviour. On such occasions, these occurrences were framed as a '*once off incident*', or an '*exception*'. For example, participant 2 reassured me after describing a night when he had gone home with a 'random' girl from a club:

... It was the case of really excessive drinking and maybe a few drugs (laughs). I mean I was wasted. I would say I was even semi- comatose... I really wouldn't normally be like that... I wouldn't...

In other words, he had to be somewhat incapacitated to engage in behaviour so different from his supposedly normal, monogamous conduct. This participant's strong adamancy, and constant repetition, makes one feel that he is trying possibly too hard to retain his position outside 'the risky' domain. This quotation is illuminating as it sheds light on the fact that although many of the participants may be engaging in 'risky' behaviour, there seems to be a strong need to deny and/ or justify such behaviour. This clearly demonstrates the fact that the participants seem to construct a binary between the 'risky' promiscuity of others, and the safe monogamy of the self. Not only was there an apparent need to ensure that their own behaviour was read as the antithesis of the 'risky' behaviour, it also seemed necessary to position their friends apart from the 'risky' arena. For example, when asked if there ever was a time when she felt that any of her friends might have been at risk of HIV-infection, participant 5 said:

No...well, most of my friends aren't really sleeping around you see. And I'm not saying you know, whatever, it's only sleeping around that puts you at risk. But you know, it's just the context. They have like long-term boyfriends and whatever... like faithful relationships or at least perceived to be a faithful relationship (laughs)...

The need to distance their friends from a sense of risk becomes even more evident when participants describe circumstances when someone, possibly too close to them, had been engaging in 'risky' behaviour. Participants seem to deal with those incidents by distancing themselves from such individuals. For example, participant 11 concluded his story about his 'promiscuous' friend by saying:

... I kind of had to, well for my own sanity I kind of had to cut ties with him. I mean, it became difficult for us to relate to each other if you know what I mean...

Other participants had similar comments to this young man, making remarks about people that they knew or friends that were promiscuous, such as 'we were like worlds apart' or 'we kind of drifted apart' or 'we started moving in different circles' and 'I am not really friends with her anymore, I don't know, like we are very different people in many ways'. It is thus clear that through their talk, the participants construct a very distinct and specific image of what risk for HIV infection entails. The promiscuity of 'others' is constructed as what puts one at risk, behaviour that the participants represent as very different to their own, and their friends, monogamous behaviour.

The Promiscuous And Polluted Versus The Contained And Chaste...

Having made constructions of 'others' risky promiscuity and the safe monogamy of the 'self', such constructions also tend to become imbued with moral values. The risky and non-risky behaviour, and consequent subject positions they offer, are reduced to a further binary opposition: the good versus the bad; the virtuous versus the sinful and the polluted versus the pure. In the participants' narratives about the people whom they thought were at risk for contracting HIV, there were frequent comments such as 'like I tried to tell them that that this isn't, good or right for you' and 'I don't even think they were aware of how badly they were behaving' and 'her behaviour was beyond reckless'. Similarly, Participant 3 said, when describing someone's promiscuity:

...it just gets messy when you start getting involved with any number of different people...

In a similar fashion, participant 8 remarked when describing someone she knew who she thought was at risk:

...he used to work in this bar and like every weekend he would just pick up different girls...it was like that real skanky stuff...like having sex in the toilets at the club... or like going to his car or something like that...you know what I mean, just that a real seedy kind of vibe...

Thus, promiscuous sex of the 'other' is constructed as 'bad', 'seedy' and 'messy', as opposed to the 'good' and 'clean' 'nuclear, monogamous, heterosexual dyad' (Ratele & Shefer, 2002: 187) in which the participants position themselves. Such standards of decency reflect a number of scholars' contention that the HIV/AIDS epidemic has brought back an old-fashioned sexual morality rooted in Judaic-Christian discourse (Treichler, 1989; Watney, 1989; Weeks, 1989). The central moral framework of familial ideology, prescribing monogamy, fidelity and sexual restraint is increasingly informing constructions of acceptable sexual behaviour (Wilton & Aggleton, 1991). As the above quotations illustrate, such norms feed directly into the participants' HIV/AIDS discourses. Constructing promiscuity, deemed to be putting one at risk of HIV, as a turn away from what is right, and an indulgence in what is wrong, seems to be a common tendency in HIV/AIDS discourses (for example Goldin, 1994; Joffe, 1995; Nelkin & Gilman, 1988).

At the same time as constructing promiscuity as 'bad' and 'wrong', those people who engage in such behaviour also seem to be constructed as polluted, and lacking sufficient moral fibre. As participant 10 explained when talking about someone who was sleeping around and consequently whom she thought was at risk of contracting HIV:

...she was completely thoughtless...she just didn't care or give a shit...

Participant 4 remarked when describing a similar circumstance:

...he seemed oblivious to reality. Just a complete sense of apathy...

Similarly, participant 1 said when talking about her 'promiscuous' friend:

...like she had no real values, well at least when it came to that kind of thing...like, sex meant nothing to her, it just didn't affect her in any way... I kept telling her that she is being so irresponsible. You know like, not only

irresponsible in terms of, umm, safety, but it's also irresponsible in terms of like her heart...

Another example of the negative construction of the promiscuous 'other' emerges in the following quotation whereby participant 5 describes someone she knew whom she thought was vulnerable to HIV infection:

... 'cause like she was involved with these dodgy guys. Wow, they were like dodgy, dodgy motherfuckers... Like they bring a new dimension to the word 'promiscuous'... Ja, dodgy, dodgy motherfuckers...

The strong sentiments of deviance and filth are clearly revealed in this repetitive, and emotionally charged account, that emphasizes again and again the supposedly 'dodgy' and 'motherfucker' person who is at risk for HIV. Similarly, participant 9 said, when describing an incident when she asked her friend if he had been for an HIV-test:

... he got so offended. He acted as if I was implying that he was like manky or something...like I wasn't insinuating that he was like a bad person or anything (laughs). I mean obviously I wasn't. Obviously...

The overly reassuring nature of this excerpt, repetitively making claims to the supposed 'obvious', makes one feel that it is perhaps a case of protesting too much. One is thus left with a sense that this participant may be projecting onto her friend, some of her own associations of HIV/AIDS with 'badness' and 'mankiness'. Dirt and pollution have been some of the dominant constructions of PLWHA (for example, Crawford, 1994; Gilmore and Somerville, 1994; Green & Sobo, 2000; Ratele & Shefer, 2002). The participants' tendency to construct people at risk for HIV as dodgy and dirty, devoid of the qualities that supposedly make one a responsible and assiduous person, reflects Douglas's (1966: 35) notion of dirt being an anomaly or 'matter out of place'. That which is not in its proper place, which transgresses boundaries and taboos is labeled as 'dirty' and 'polluting'. Given the participants' moralistic constructions of acceptable sexual conduct, people who are deemed at risk of HIV are seen to have violated the moral order. They are consequently designated as polluted and 'dirty'. As Douglas (1966: 113) emphasizes, 'A polluting person is always in the wrong. He (sic) has developed some wrong condition or simply crossed some line which should not have been crossed'.

The Particularly Polluted Woman...

Constructions of the tainted, promiscuous 'other' also seem to take on a distinctly gendered dimension. The promiscuous woman is constructed as exemplary of pollution and contamination. This seems to have emerged out of the ways in which the participants' constructions of risk and promiscuity were deeply entangled with social constructions of gendered sexuality. Men predominantly were constructed as possessing an inherent sexual force. As participant 1 said, when talking about a male friend she knew whom she thought might be at risk of HIV:

... Not that he was all that different from other guys. I mean, guys just like to shag...they just like that...

This familiar biologically determinist discourse has been identified and labeled by Hollway (1984, 1989) as the 'male sexual drive discourse'. The key tenet of this discourse is that men have a biological drive for sex, and is frequently used as a justification for why it is more morally appropriate for men to be more sexually active (Shefer & Foster, 2001). In direct contrast, the participants' representations of women's sexuality tend to correspond with Hollway's (1984, 1989), 'have/hold' discourse in which women's sexuality is constructed as 'naturally' enmeshed with love and relationships. As participant 4 said:

... this girl has slept with about 13 men... And, she was dating none of them...She has never had a relationship with any of them. I mean I find that amazing...

In other words, it was impossible for this young man to imagine a girl having, or desiring sex outside of a relationship and the dominant sex-love conflation. Similarly, there were a number of phrases scattered within the participants' narratives, such as 'you see, a lot of girls associate sex with love' and 'she does sleep around quite a bit, particularly for a girl'. This tendency to construct women's sexuality as naturally passive, bound up with love and meaningful relationships, has been shown in studies both internationally (for example Holland & Ramazanoglu, 1992; Juhasz, 1990; Nack, 2002) and in South Africa (for example Shefer & Foster, 2001; Wood & Foster, 1995).

These gendered constructions of sexuality play a major role in shaping how the 'promiscuous other' is constructed. Given the assumption of indisputable difference, although the participants did, to some extent, view men's promiscuity unfavourably, such behaviour was seen as somewhat more

understandable. As participant 7 remarked when describing his 'promiscuous' male friend:

...He definitely was being stupid, but I suppose well, you know. It's just that, as a guy, well, I don't know...

This participant did not finish his train of thought, but his vacillation about the inappropriateness of this young man's conduct is clearly conveyed. In direct contrast, given that women are constructed as innately asexual, those women who are deemed as engaging in risky promiscuous behaviour are thoroughly debased. For example, participant 3 said when describing a girl friend of hers who was sleeping around:

... She was like, um, a complete nympho-maniac (laughs)... I mean, well like, she was terrible when it came to that kind of thing (laugh)...

The stuttering of words, together with the nervous laughter accompanying this account sheds light on the somewhat involuntary unease this participant seems to experience when talking about a promiscuous woman in this way. Nonetheless, her value judgments are explicitly conveyed. Similarly, participant 5 remarked about a girl friend of hers who went through a very promiscuous stage:

...But, like it was only really in her High School days that she was doing that kind of thing...like we even tease her now about what a slut she was at school (laughs)...we sometimes call her porno- _____ (laughs)...seriously though, when I think back now, she really was putting herself in danger...

In similar fashion, when describing a girl that one of his friends had been dating, participant 11 remarked:

...he had been with some easy girls before, but this reached a new dimension...I mean, she had slept with so many guys...I'm sure she'd even lost track...she wasn't just a slag, she was also really bitching...anyway, so I was really worried about my friend as I don't know if they were using protection...

Other highly disparaging labels given to women who were sleeping around included 'skanky girl' and 'somewhat of a whore'. It seems that those women who are seen to have departed from the socially prescribed behaviour of female sexuality are given extremely dehumanizing labels. It is not uncommon for women who actively seek out sex with different partners to be represented in such ways (for example Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1990; Lawless, Kippax & Crawford, 1996; Richardson, 1996). Furthermore, one participant portrayed a woman who seemed to have sexual agency as potentially

hazardous. For example, when describing an incident when a woman tried to pick him up in a backpackers hostel, participant 2 said:

...I was just sitting on the bed and this girl sort of looked at me from across the room. And the next thing I knew, she was coming towards me and just started kissing me... and wanted to sleep with me... it was scary...

This construction of a sexually active woman as scary and dangerous, being able to arouse fear and panic in others resonates with a long-standing history of constructing female sexuality and desires as potentially dangerous and out of control (Ussher, 1991). It thus seems that in constructing women, who are deemed to be at risk for HIV, the participants draw on a coalescence of repressive discourses on women's sexuality. Furthermore, the general moralistic binary of sexuality the participants construct is far more stringently applied to women, whereby the age-old Madonna/whore binary is drawn upon (Ussher, 1991). In this dichotomy, women who are seen as promiscuous and highly sexual are given dehumanizing labels such as 'whore' or 'slag' (Ussher, 1991). This reflects Soskolne's (2003) contention that the fear surrounding the AIDS epidemic has resulted in an even greater polarization in the Madonna/whore split. Patriarchal ideologies thus seem to feed into both male and female participants' HIV/AIDS discourses. Consequently, although the 'promiscuous other' is denigrated in general, the promiscuous woman, who is deemed at risk of HIV, is constructed as far more dirty and far more morally degenerate. Such gendered differentiation was also found by Ratele and Shefer (2002) in their focus group discussions with South African-based communities.

The Middle-class Only Have Themselves To Blame For HIV/AIDS Infection...

The participants' constructions of risk for HIV/AIDS not only make distinctions based on gender, but also on class. What begins to unfold is that if the polluted and promiscuous 'other' (particularly women) is middle-class, an HIV-infection for 'them' is constructed as their own fault. Thus, not only are they denigrated and demonized, the middle-class, promiscuous 'other' is also condemned. The rationale behind such blame seems to emerge from the connections the participants make between promiscuity and risk, education and personal choice. When talking about some of the HIV/AIDS prevention campaigns in South Africa, participant 8 said:

...so, yes, if you've had enough education, you know what measures or behaviours you must cut out...like people like us, as I said, we've been schooled

in this stuff...like 'HIV loves promiscuous sex'. So, just don't sleep around...so I mean, in the end, you need to choose to protect yourself... It's purely up to you...

Similarly, participant 10 said:

...none of us can say that we didn't know. I mean, we've been so lucky to have had so much education about it, like...so many less privileged people haven't been exposed to what we have... But for us, it's about making a conscious decision not to put oneself at risk...

It is clear from these excerpts that if one is educated, and knowledgeable about HIV/AIDS, protection or risk is constructed as primarily a matter of personal choice and responsibility. This rhetoric of personal agency and individual responsibility has been the dominant ideology underlying most of the HIV/AIDS education and prevention campaigns locally and internationally (for example Campbell, 2004; Wilton, 1997). Focusing centrally and pivotally on sex, such campaigns draw on the discourses of individuality, autonomy, freedom and choice, now so characteristic of contemporary, liberal democracies (Rose, 1996). Responsibility is placed on individuals who are 'free' to make rational choices for their own protection. It thus seems that such discourses have played a significant role in shaping how these participants construct risk for HIV/AIDS, which is understandable given that they are educated and well-informed students. Drawing on such liberal discourses of 'choice' in relation to HIV/AIDS, seems to be a common tendency among other young adults (for example Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1990, 1992; Joffe and Bettega, 2003; Strebel & Lindegger, 1998). The irony with the 'supposed' freedom and agency of such liberal discourses is however, as Rose (1996: 17) argues, individuals are 'not merely free to choose, but obliged to be free, to understand and enact their lives in terms of choice'. Individuals are impelled to make certain choices that fit with certain prescribed norms and demands (Rose, 1996).

In terms of the participants, it seems that those individuals who are privileged enough to have received education in South Africa, and still 'choose' to put themselves at risk by 'indulging' in promiscuous behaviour, a resultant HIV infection is seen as their own fault. They are thus blamed and condemned for inexcusably imposing risk upon themselves. For example, in explaining why he would have difficulty feeling sorry for his 'promiscuous' friend if he received an HIV-diagnosis participant 2 said:

...if you are privileged enough to know what the risks are, and you still choose to go out there and sleep with random people, well then how can I really feel sorry for you?... you only have yourself to blame. It's like taking a revolver, putting it to your head, and shooting...

This rather angry and aggressive account clearly reflect Green and Sobo's (2000) and Goldin's (1994) argument that PLWHA frequently suffer from some of the most harrowing forms of blame due to the construction of HIV/AIDS as a calamity one brings upon oneself. Similarly, participant 9 said when responding to how she would feel if her 'promiscuous' friend received an HIV-positive diagnosis:

... at the back of my mind I would kind of think she deser (unfinished). Well, not that she deserved it, but like she knew that sleeping around with whoever is stupid so like, in a way it would kind of be her own fault (laughs)...

In a similar light, having described a friend who had been engaging in risky behaviour, participant 3 was then asked how she would feel if later she found out her friend had contracted HIV. She replied:

...I would be devastated. I mean obviously I would give her all the support she needs...(long pause)...But, well, I suppose, well I don't know...in some sense, well, ja.

After encouraging her to finish what she was saying, this participant went on to say:

Well, in some sense, I would also lack sympathy. Like, obviously I would never say it to her, but like I probably would feel like you know. Like this is what happens when you reckless. Like as I was saying earlier, you shouldn't be sleeping around and mean obviously I shouldn't really judge people because, like, well, you know. But like she is pretty guilty in some sense...

The incomplete words and laughter, together with the overall tentative manner in which both these last two participants speak, makes us once again aware of the difficulties and reservations many of the participants seem to have when talking about PLWHA in a negative light. Nonetheless, although submerged in awkwardness and discomfort, when referring to educated people, many of the participants' constructions of promiscuity and pollution tend to become tied to the rhetoric of blame and condemnation so characteristic of many HIV prevention campaigns. It is important to mention that such findings do point to a possible tension that may thus exist between HIV/AIDS prevention campaigns and anti-stigma initiatives (Joffe, 1995; Stein, 2003; Wilton, 1997). By

generating the message that risk and safety are purely matters of individual responsibility, besides ignoring the many social and structural factors that affect people's ability to protect themselves, (Campbell, 2004) such prevention campaigns also foster a climate of blame (Joffe, 1995; Stein, 2003; Wilton, 1997). Buttressed in a 'you get what you deserve ethos' these campaigns produce, and exacerbate the blame and condemnation so many infected individuals experience (Joffe, 1995: 4), as indicated by the sentiments of many of the participants in this study. Addressing the tension that thus may exist between HIV/AIDS prevention campaigns and anti-stigma initiatives is not an easy task, as individual behaviour change is essential if the spread of HIV/AIDS in South Africa is to be curbed.

The Poor And Black Should Not Be Blamed, But Saved From Their 'Cultural' Limitations...

Having constructed prevention (and risk) for HIV/AIDS as being a matter of informed and educated personal choice, this logic is followed to explain why poor black people are particularly vulnerable, but cannot be blamed for this susceptibility. Explicit references to race are rare, but by constantly referring to '*the townships*' and '*informal settlements*', the racial implications are evident. As participant 7 said:

...I mean, we can't expect people to protect themselves if they aren't educated ... Like, in the rural areas, people haven't been exposed to nearly the kind of education and awareness that we have... so like we can't deny the fact that they are a lot more vulnerable...and its not their fault...

Many of the participants' discussions relating to poor black people tend to begin with similar sentiments to this participant, describing their lack of education and consequent 'blameless' vulnerability. As the conversation continues however, other reasons for their supposed irreproachable susceptibility begin to shape the conversation. What starts unfolding is that such groups cannot be blamed because in addition to, and probably as a consequence of, a lack of education, they possess certain cultural beliefs, traditions and practices that make them *innately* susceptible. Thus, certain racial and class stereotypes seem to feed into the participants' 'othering' tendencies. For example, participant 1 said, after describing the great need for more HIV/AIDS education programmes in '*rural areas*':

...But, well, it's not so simple. Like there are certain cultural beliefs that are like deeply entrenched you know ...Like the whole dry sex thing... And like, there are strong cultural reservations to wearing condoms...

Similarly, participant 4 remarked,

...there are very different cultural norms in many informal settlements...like often being a 'real' man means that one cannot wear condoms...and one should have lots of sexual partners... I mean, like they, well, there are real patriarchal structures there... So like how do you change those attitudes?...its really difficult but it's those kinds of things that make them so much more susceptible to infection...

By reifying and essentializing 'culture', these participants imply that people 'in rural areas' and 'informal settlements' hold certain intrinsic and ahistorical beliefs that make them inevitably vulnerable and somewhat devoid of 'choice' when it comes to protecting themselves. Similarly, other participants tend to make subtle links between black people and promiscuity. For example, when talking about why the lack of education makes 'poor communities' so much more vulnerable, participant 8 went on to say:

... But also, well, I suppose, in poor communities, well, like just culturally, there are also just very different attitudes, towards sex ...like, having a lot of sexual partners is often accepted, encouraged even in many cases... So, at the end of the day, one can completely understand why AIDS is just spreading so much there...

Similarly, when talking about why HIV/AIDS is so much more 'rife' in the 'townships', participant 11 remarked:

.....but, for me, it's about the culture, more than anything else. Like, the ladies I was talking about that work in the kitchen at the restaurant that I work, well they've got, like, well for example, the one lady has got two children with one guy, another kid with another guy, she's having an affair with this other guy and she talks about how she wants to sleep with one of the cooks at the restaurant (laughs). It's like they just, um, (pause), they just do things differently you know...I mean there is just story after story after story like that in the kitchen that I work...

In a similar vein, when talking about why the prevalence of HIV/AIDS is so much higher in South Africa than in other countries, participant 3 said:

...like the other day I was watching this documentary on TV and this guy had interviewed various people, mainly men... in one of the townships in South

Africa...I'm not sure which one. Anyway, I was just so struck by the...um...behaviour of many of these guys... Like, with a disease where the greatest form of transmission is through heterosexual sex, it's crazy the amount of sexual partners these guys had. Like, many of them described having four or five girlfriends...it's just madness... Like, maybe it's due to the migrant labour-system, but I also just think that sexual relations for them...um...well, is like different to how maybe you or me would be or like...um how we'd think about those kinds of things...

Despite the clear reservations these participants convey when talking about people in 'poor communities', through the rhetoric of 'culture' they tend to draw on the common associations of blackness and promiscuity. African people generally, and specifically within HIV/AIDS discourses, commonly are constructed as more promiscuous (for example Crewe & Aggleton, 2003; Sabatier, 1988). These modern descriptions of course come out of a long history of European writings about Africa, particularly in the colonial era. Colonial discourse repeatedly constructed African people as possessing uninhibited sexual desires (McClintock, 1995; Crewe & Aggleton, 2003). Thus, there is a tendency to echo such colonial sexualization of African people, possibly in a less overt and blatant manner, by constructing black people in the 'townships' as more sexual and thus innately vulnerable to HIV infection.

Other class, cultural and racial stereotypes besides promiscuity are also drawn upon to account for poor black people's supposed inherent vulnerability and 'blamelessness'. For example, when talking about why many HIV/AIDS prevention campaigns are unsuccessful, participant 2 said:

...you see the people that the epidemic is affecting the most...like the poorer communities... you can't be telling them that they need to be thinking long term. Because like, when you are poor, you only live from day to day. That's all you can afford to do. So, for someone to come along and tell you to think 2010, it's ridiculous. I mean, if you think long term, you are a lot more likely to fear AIDS and take the necessary steps. But, when you think short-term, which seems to be an epidemic of people who are struggling to survive (laughs)..., then it's just at the bottom of your priority list. It's like if I can survive till next week, that's great, you know...

Similarly, participant 5 said:

... I'm part of the _____ project...and we go into Khayelitsha once a week, and the kids we meet there have no ambition, at all... Like kids in that, um... kind of culture sort of thing, um, seem to have so little sense of self, or sense of

worth, or sense of what they want to be. So, like its almost impossible for them to even think about being cautious...

Although expressed with a degree of trepidation, listening to this comment, one cannot help but think of the colonial trope of the 'primitive' African people, lacking self-determination and agency (Comaroff, 1993). In order to 'address' these supposedly innate 'cultural ways' that supposedly make poor, black South Africans more vulnerable to HIV-infection, many participants emphasize a strong need for such groups to be educated. For example, having spent much time talking about the 'cultural ways' so prevalent in 'the townships', participant 9 concludes:

...so, we need to get education in there...Like, somehow, and its very difficult, but we need to address these cultural (pause) cultural obstacles...or else they not going to even have a culture left.

Similarly, participant 10 remarked:

...although there are a lot of HIV/AIDS billboards in the townships, there really is not enough getting done in those areas. Like, the government needs to put a lot more funds into making people aware of AIDS in those areas and educating them about how they can protect themselves...like that's the only way we can hope to even begin to change their behaviours...

Such sentiments display further remnants of the colonial legacy, embodying goals that come close to colonial civilizing missions that sought to 'instill in the native inmates 'moral backbone', the wherewithal to live 'clean and healthy' lives' (Comaroff, 1993: 232). Through education and 'knowledge, it is implied that poor, black South African's will be redeemed, and their culture saved. Thus, the participants draw on a number of class and racial stereotypes to construct poor black people as possessing certain innate characteristics that make them far more vulnerable to infection. Such stereotypes are also drawn upon to emphasize that such groups need not be blame nor condemned for their increased vulnerability, but educated and saved. The contradictory nature of their representation as supposedly 'blameless' infected poor black people is therefore quite evident.

3.3. Awareness Of, And Discontent With The 'Othering' Impulses

Appearing intermittently amongst the participants' 'othering' discourses, we see glimpses of an awareness of, and uneasiness with, such discourses. As we saw, many participants in subtle, often unconscious ways exhibit a degree of discomfort with their 'othering' impulses. In other instances however, the participants express their ambivalence in a much more audacious manner. For example, participant 10 said, whilst describing some of the work she does in relation to HIV/AIDS:

...you know, at _____ I preach about how people mustn't be afraid of HIV...but if I'm honest with myself, it does terrify me (long pause)... It forces us to be very honest with ourselves, about so many things and in many ways, we can't bring ourselves to do that. It's too painful (another long pause). However much I hate to admit it, I tend to push it away, to disassociate with it and see it as something over there...

In this extremely painful account, this participant attempts to sit with the anxiety. Rather than instinctively defending herself against this fear, she seems to immerse herself in it and engage with her need to push it away. In a similar light, when talking about someone she knew who she thought could be at risk for HIV/AIDS, participant 3 said:

...like, he's an absolute sleaze... (long pause). Um, sorry, I lost my train of thought (laughs, long pause). You see, there I go again... That's what I do (laughs). I'm such a hypocrite...Like, I just immediately assume, oh he's sleazy or oh, he's promiscuous, or oh he's black and so he must be at risk. He must have AIDS (laughs)...My God, what is wrong with me? ...It's completely bizarre, but I still do this stuff...

In mid-sentence, this participant becomes deeply distressed with the way in which she tends to 'other' the epidemic, seeing it as something that affects only 'sleazy' people or promiscuous people or black people. We are made aware of the tension she seems to experience with her need to position herself 'not at risk' and the uneasiness such a position evokes. Similarly, participant 4 remarks:

...it's funny but I do think that deep down, I think that I believe that HIV/AIDS is something that affects 'other' people (laughs). Like, it goes against everything that I stand for...but I never really associate it (HIV/AIDS) with people that are like me, like that have gone to my school and mix in my circles...I know its crazy...like maybe I just don't want to think about those kinds of thoughts...

Once again, this participant becomes aware of his tendency to ‘other’ the epidemic, and engages with the fact that bringing a sense of risk closer to home, may have difficult emotional consequences. Other participants express a discrepancy and tension between their social identities and personal concerns. For example, at the end of the interview, participant 1 said:

... there seems to be like a split between the social and the personal you know. There’s like _____ the individual who thinks about AIDS in one way, and then there’s _____ the social, like the South African as part of the society, who thinks about it differently. And you can combine those two lives, I suppose. The personal and the social. At the moment though, I would say I am like socially aware of it and involved in it, but not personally concerned about it. How profound hey (laughs).

Similarly, participant 11 remarks:

...In many ways, it’s easier to preach from a distance...to become part of AIDS activism, than to get involved with one’s own hang -ups and personal fears about it...

It is thus clear that some of the participants seem to become aware of the discrepancies and contradictions in their thoughts and feelings. They seem to grapple with the very real fears they experience on a personal level, and the social identities they hold that seem to be incompatible with such feelings. Furthermore, the realization of their somewhat ‘reflex’ reactions to ‘other’ the epidemic and push it away seems to place them in a position of emotional and discursive ambivalence that is difficult to sit with, let alone reconcile. It is in this space however, engaging with the complexities, contradictions and fluidities between their social and personal identities that the potential for change may exist.

4. Discussion

Using a ‘free associative narrative interview method’ that involved eliciting participants’ narratives and stories related to the HIV/AIDS epidemic, this study explored how a group of well-educated students, that are actively involved in issues around HIV/AIDS, feel, think, experience and talk about HIV and AIDS. The aim was to explore whether these 11 AIDS-workers may possess certain stigmatizing tendencies.

What emerged from this study is that beneath the participants' overt claims that the fear surrounding the epidemic has declined, they appear to harbour certain very real fears and anxieties surrounding HIV/AIDS. They seem to fear the way in which the virus is able to penetrate and invade the somewhat permeable body, render that which is supposedly most personal and private open for all to see, and bring about social and sexual death. The participants' adamant denials of fear surrounding the epidemic alludes one to the fact admittance of such fears may be seen by these AIDS-workers as incompatible with the social identities they hold.

In light of the presence such fears, it seems that the participants construct HIV/AIDS and those infected in ways that enable them to manage and defend themselves from such anxieties. In order to distance themselves from a sense of threat, the participants appear to 'other' the epidemic and those infected. Beginning very broadly by constructing HIV/AIDS infection as the result of 'others' promiscuity and constructing themselves and those that are close to them as the antithesis, the AIDS-workers begin to distance themselves from a sense of personal risk and vulnerability, being left with somewhat of an illusion of safety (Deacon, 2005; Green & Sobo, 2000; Strebel, 1997). The participants distance themselves further from the threat of HIV/AIDS by imbuing promiscuity with notions of dirt, and pathologizing those 'others', particularly 'other' women, who engage in such behaviour. By demonizing the 'other', the distance and difference between 'them' and 'me' is enhanced, as a clear barrier is placed between the polluted and wrong 'other' and 'pure' and righteous 'self' (for example, Gilman, 1988; Joffe, 1998, 1999).

Furthermore, it seems that blaming middle-class people, who occupy similar discursive positionings to the AIDS-workers, enables the participants to separate themselves from such people (Nelkin & Gilman, 1988). As Joffe (1995: 2) argues, placing blame 'renders the world controllable by locating mass threats and thereby circumscribing them, allowing those who do not hold blamed identities to distance themselves from the threat'. Finally, it seems that by constructing poor black people as *innately* susceptible and thus most vulnerable, and simultaneously positioning the 'self' as educator, the participants own threat of HIV/AIDS is placed even beyond the horizons of perceivable thought. It is the *inherently* different poor black people that ultimately waver on the edge of dissolution.

Thus, the participants' associations with, and representations of HIV/AIDS seem to serve a protective and defensive function. Their method of defence can be

characterized somewhat like a protective discursive chain, consisting of a sequence of interrelated and connected links. These links tend to metamorphosize as new connections flow out of, and build upon previous 'links' in the chain. These 'links' combine however to form an integrated and interdependent distancing and protective function for the participants.

As highlighted at the beginning of this paper, there is much disagreement and controversies surrounding how to conceptualize and define HIV/AIDS stigma, and thus assessing such an elusive phenomenon is not a simple matter. From a psychosocial perspective, HIV/AIDS stigma can be conceptualized as a social and emotional *process* in which people distance themselves from the danger of HIV/AIDS by projecting risk onto the 'other' (Joffe, 1998, 1999). The theory advocates that the roots of this stigmatizing process lie in Melanie Klein's psychodynamic notion of 'splitting' (Joffe, 1999). In infancy, the child experiences great anxiety when it begins to recognize the distinctiveness between the mother and self (Frosh, 1989). One of the ways in which the child manages this anxiety is through the process of splitting, by viewing the world in highly polarized terms. This entails projecting or pushing out all that the infant wishes to distance from the 'self', onto 'the other', in an attempt to produce a sense of security (Frosh, 1989; Joffe, 1999).

In later stages of life, when faced with a potential threat, such as HIV/AIDS, people frequently resort back to such infantile patterns of representation (Joffe, 1999). Thus, fear and anxiety are conceptualized as fundamental foundations of HIV/AIDS stigma (Deacon, 2005; Joffe, 1999; Lorentzen & Morris, 2003; Malcolm et al, 1998). In order to allay the anxiety of HIV/AIDS, the splitting tendency is re-awakened, whereby the epidemic is linked to 'other' groups, and associated with behaviours and characteristics of 'the other' (Crawford, 1994; Gilman 1988; Joffe, 1998, 1999). Furthermore, the 'other' that is associated with HIV/AIDS is frequently disparaged. This strengthens the binary between the 'good and protected self', and the 'bad and vulnerable other', enabling the self to forge a pure and protected identity (Gilman, 1988; Joffe, 1999).

Thus, situated within a psychosocial framework, the evidence from this study points to the fact that these 11 AIDS-workers may in fact possess certain stigmatizing tendencies towards the epidemic and those infected. By 'othering' and denigrating HIV/AIDS and those infected through the construction of a discursive, protective chain, the participants seem to partake in the defensive *process* of stigmatization. A psychosocial conceptualization of HIV/AIDS stigma emphasizes further that although the psychological defense of 'othering'

and distancing the epidemic has its roots in a series of emotions experienced within, the mechanisms of splitting and projection are mediated by a number of social, cultural and political forces 'out there' (Crawford, 1994). There is an inherent 'social contribution to such mental events' (Frosh, 1989: 58). In externalizing the threat, people draw on existing social discourses, representations and ideologies that profoundly shape the way in 'the other' is constructed (Frosh, 1989; Joffe, 1998, 1999). Consequently, other deep-seated forms of prejudice and social inequalities frequently feed into the defensive process, and buttress HIV/AIDS stigmatization.

In distancing themselves from the disease, the AIDS-workers invest in discourses that fit into existing ideologies and power relations, and reflect wider social interests and privilege. Dominant familial ideologies, as well as liberal ideologies of individualism and capitalism were incorporated and reproduced. The participants also drew upon a number of sexist discourses, and class and racial stereotypes. Thus, as reflected in the dominant sociological literature on HIV/AIDS stigma, in employing an eclectic range of discourses, the participants perpetuate and reinforce some of the prevalent forms of social and structural inequality and oppression in South Africa (for example Parker & Aggleton, 2003; Soskolne, 2003 and Campbell et al, 2005). This paper however would argue in line with Stein's (2003: 10) contention that 'this function of stigma is operationalised through...the psychological defence processes implicated in denial'. It is through the process of distancing themselves from, and 'othering' the epidemic, that such wider, macro processes co-occur.

It is important to emphasize that the discourses the participants employ are not necessarily 'false' constructions born out of fear. Many of such discourses and associations are embedded in some of the brutal realities of the epidemic in South Africa. For example it has been shown that HIV/AIDS in South Africa is disproportionately distributed along racial lines, with more black than white people being infected (Sabatier, 1988; Sunter & Whiteside, 2000). Such realities however seem to become coloured with negative connotations and moral values. Thus, many of the discourses in which the participants invest are a blurring of some of the harsh realities of the epidemic, with potentially denigrating and derogatory protective discursive constructions. This clearly reflects Treichler's (1989: 42) contention, when talking about AIDS as an 'epidemic of signification', that 'AIDS is a nexus where multiple meanings, stories, and discourses intersect and overlap, reinforce and subvert one another'.

This is not to say that this group of young adults is without nuance. The evidence from this study also sheds light on the multifaceted identities they hold, and the presence of multiple, often contradictory and conflicting voices. Intermittently, in the cracks between the links in the discursive chain, we see attempts to unravel, and break free from the protective chain. Many participants expressed an awareness of, and uneasiness with, their ‘othering’ and potentially stigmatizing tendencies. From a psychodynamic perspective, this emotional and discursive space has been termed a ‘depressive position’ (Frosh, 1989; Hollway & Jefferson, 2000; Joffe, 1999). Rather than impulsively launching into defensive representations, occupying such a position entails holding onto the often very frightening and painful feelings. Instead of representing the world in a rigidly polarized and split manner, in such a position, one attempts to tolerate ambivalence, understand ‘gray areas’ and engage with complexities, contradictions and fluidities (Frosh, 1989; Joffe, 1999). This is a very fragile and difficult space to occupy when faced with the overwhelming threat HIV/AIDS seems to impose. It is in this ‘depressive’ space however, becoming consciously aware of one’s ‘own hang-ups and personal fears’ that the links of the chain, and the HIV/AIDS stigmatizing process, begins to crumble.

5. Conclusion

This study has been an exploration into how a group of UCT students understand and construct issues around HIV/AIDS in an attempt to assess the extent to which these well-educated students working in the arena of HIV/AIDS may possess certain stigmatizing tendencies. The results from this study showed that the *process* of HIV/AIDS stigmatization did appear to occur amongst this particular group of young adults. Most certainly the principle findings emerged out of the ‘data’, but this reading was framed within and informed by a psychosocial theoretical paradigm. The ‘data’ and ‘theory’ became inextricably interrelated and thus if viewed within an alternative theoretical framework, a very different reading may have emerged.

The findings from this particular study are however illuminating in various respects. Firstly, most certainly the usual concerns about generalizing from a small sample and the fact that discourse analysis ultimately does not seek generalizability, do apply to this study (Kvale, 1996). But, if the HIV/AIDS stigmatizing process was shown to occur amongst this somewhat unusual group of socio-politically conscious and progressive white students, it does say, at least

something, about what may be occurring amongst other students at UCT (See Schofield, 2000, for generalizing from the unusual to the typical).

Secondly, the results from this study have theoretical implications. These highly informed and educated students tended to ‘other’ the epidemic, and associate HIV/AIDS and those infected with a number of derogatory and negative meanings, be it promiscuity, deviance, pollution and blame. This may reveal that HIV/AIDS stigma is not, as Robert Miles indicated when referring to racism, a “bad-apple” problem, produced by ignorant and dysfunctional individuals that can be “weeded out” through education (Miles, 1989, as cited in Deacon, 2005: 16). The results from this study thus indicate that HIV/AIDS may not be the product of a lack of education or ‘faulty’ thinking. Rather, there may be a number of complex (and subtle) emotional and social dynamics at the heart of such stigma.

This study also has major practical implications. The findings from this highly educated sample of students sheds light on the fact that challenging HIV/AIDS stigma may need to go beyond providing ‘correct’ information and education. Rather, it may entail providing a space for people to engage with, and be open and honest about the fears and anxieties they may have around the epidemic. It may require encouraging reflexivity and making meaning of the non-rational parts of ourselves. It may involve helping people to recognize and face their proclivity for denial and dichotomous thinking when faced with the overwhelming threat of HIV/AIDS (Joffe, 1999). Furthermore, unpacking, exploding, and legitimizing alternatives to the potentially exploitative discourses we invest in for protection also needs to form an integral part of this reflexive process if we hope to even begin to address such stigma, and prevent other forms of oppression being perpetuated further. One of the participants ended her interview by saying *‘I suppose, I do tell myself that in practice, how you treat people with AIDS is the most essential thing. Like, what we do is most important’*. This however is not enough. We all need to face the protective shackles we wrap around ourselves to allay the anxiety HIV/AIDS evokes if we are to empower ourselves, and assuage the aura of fear and secrecy that seems to surround so many HIV-positive students at UCT. Ultimately, if it is the case that HIV/AIDS stigmatization is a *process* rather than a fixed and concrete attribute, the potential for change, and stigma reduction most certainly does exist.

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