From Support by Health Staff to the Resilience of Adults Living with HIV/AIDS in their Relational Process of Social Stigmatization in the City of Yaoundé

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Abstract:- This study examines the role of support provided by healthcare staff in the resilience process of adults living with HIV/AIDS in the face of the adversity of social stigmatization in the city of Yaoundé. Health professionals must work to build resilience by highlighting and developing the potential of people living with HIV/AIDS. Emphasis must therefore be placed on a series of individual characteristics known to be protective factors and facilitators of resilience: positive self-esteem and self-image, the ability to arouse sympathy, a feeling of control over one's life, creativity, humour, etc. Hospital staff must strive to identify and assess their patients' resilience through a number of structuring dimensions: personal dimensions, family dimensions and extra-family (social and community) dimensions.

Keywords:- *HIV/AIDS, Adults, Stigma, Resilience, Healthcare Staff and Support.*

I.   INTRODUCTION

Illness, especially when it is serious, has a significant impact on both society and the people affected. As Augé (1984) and Bastide (1996) assert, it is a basic form of event that is accompanied by multiple interpretations and meanings (Laplantine, 1993). HIV/AIDS is no exception to these considerations. During our study, we observed that HIV-positive adults find themselves in a muddle of feelings of strangeness, narcissistic depression, permanent anxiety and depersonalization, in the grip of somatic (biological) and/or psychic failures resulting from the breakdown of the psychic barrier caused by the irruption of HIV. And in the ongoing attempt to find solutions to this profound malaise, their efforts come up against the effects of self-stigmatization, intra-familial stigmatization and community stigmatization. The individual and collective experience of HIV/AIDS infection has been, and continues to be, marked by stigma and discrimination, in a variety of forms in terms of meaning and actions, which have had the effect of polarizing social relations. This stigma may be expressed in different ways depending on the place, time and situation, but it leads to similar processes of rejection and exclusion, or self-deprecation. It produces what Goffman describes as a "robbed identity", by amplifying pre-existing pejorative and stereotypical discourse about this category of patient

(Goffman, 1975). Patients face de facto psychosomatic adversity, which they must be able to overcome for the sake of their well-being and the continuity of their existence, their family and their community. However, numerous studies have been carried out into the experiences of patients and their psychological economy. Our study on its part, targets adults more because they have come to the age of maturity, and it is a period in a lifetime during which all future life projections are made.

In the following paragraphs, we will first define what HIV/AIDS is, especially in adults, and assess the possible support strategy by resilient hospital staff, before focusing on the methodological aspects of the study; then we will set out the results of our survey; and finally, we will attempt to make sense of their data without forgetting to subject them to scientific criticism.

II.   REFERENCE FRAMEWORK

A. HIV/AIDS in Adults

For Sillamy (1991), disease is "the alteration of health because of the body's inability to use organic defenses against, for example, toxic-infection or to resolve its psychological conflicts". AIDS, the abbreviation for Acquired Immune Deficiency Syndrome, is a failure of the immune system due to infection by the Human Immunodeficiency Virus (HIV). In other words, it is a chronic infectious viral disease transmitted by the Human Immunodeficiency Virus or HIV, which is an RNA virus. HIV infection of children, adults or the elderly is not different in any particular way. Once a person is infected, the virus parasitizes and gradually destroys the person's immune system if left untreated.

Secondly, on a personal level, the infected person will develop feelings of fear, shame, guilt, distress, anxiety, etc., which will gradually parasitize their psyche. As we can see, HIV/AIDS infection is a source of both somatic and psychological suffering. Psychological suffering can have serious consequences, as it can interfere with medical care and response to treatment. According to Jose (1992), people living with HIV/AIDS suffer from psychiatric complications, adjustment and emotional problems, and suicidal behavior as a result of the neurotropic effect of HIV

on the central nervous system and the severe psychosocial stress associated with the infection.

At family level, people living with HIV/AIDS are reclusive. They are sometimes unable to share their own health situation with their family, for fear of rejection on the one hand, and on the other, of creating a feeling of distress and reminiscence of their impending finitude due to the uncertainty of recovery and the fear of death. The infection also generates resentment within the family, because HIV is taboo and shameful in some African cultures, due to one of the modes of transmission (sexual intercourse) (Micheal & Czerny, 2006).

Feelings of distinction and differentiation based on the stigma associated with the disease or the risk of its transmission will emerge in their social environment. More concretely, and more expressively, these are feelings of exclusion, rejection, ostracism, discrimination and stigmatization, exposing them de facto to strong adversity in relation to themselves and their community. In this respect, the history of venereal diseases, for example, shows that the Syphilis, a chronic sexually transmitted disease, was considered a social scourge, a source of fear and shame (IPSO & Radeff, 2001).

B. The Process of Resilience in Patients

Resilience is a concept borrowed from physics, but which is finding increasing use in the human sciences, particularly psychology. Applied to humans, resilience is "the ability of a person to find his or her previous level of adaptation, or even to improve it, after having been subjected to stress" (Dufour & al., 2000). For an author like Cyrulnik, resilience is rooted in educational, therapeutic and social realities: "resilience is the capacity of a person or a group to develop well, to continue to project itself into the future - a veritable metamorphosis - in the face of destabilizing events, difficult living conditions and sometimes severe trauma" (Cyrulnik, 1999). The important point in this definition is that the resilient person must develop and be concerned about their future despite cruel situations.

Masten and Garmezy (1990) point to three phenomena linked to resilience:
- An adequate level of functioning despite the presence of risk factors such as poverty or family instability;
- Coping strategies that are effective in restoring or maintaining internal or external equilibrium when faced with a significant threat, such as the divorce of one's parents, a serious illness (HIV), etc.;

Recovery from prolonged or severe trauma (e.g. sexual abuse) when the immediate danger has passed.

It is precisely this second phenomenon that we are concerned with in this study. It raises the question of whether it is possible for an adult living with HIV/AIDS to resist and domesticate this infection. This domestication does not rule out the possibility that, despite successful adaptation, some resilient victims may experience a degree

of suffering, or even symptoms of trauma. These authors conclude that "being resilient does not mean being free of problems, but being able to return to a level of adaptation comparable to that prior to the traumatic event" (Masten & Garmezy, 1990).

As per Cyrulnik (2003), resilience happens or is explored only after a trauma, which is why he says: "we can only speak of resilience if there has been a trauma followed by the resumption of a type of development, a mended tear". Trauma and resilience would therefore be two fundamentally linked phenomena, one of which is upstream: trauma, and the other downstream: resilience, if it materializes. But they must be preceded by a situation of vulnerability. The irruption of HIV into the human body leads to a kind of vulnerability resulting from an injury. This narcissistic wound creates a break in the continuity of the patient's existence. This narcissistic wound creates a rupture in the continuity of the person's existence following the breaking down of the psychic barrier by the onset of the infection.

Our investigations into the resilience of adults living with HIV/AIDS in hospitals and health centers in Yaoundé revealed two main points. The first stemmed from the fact that some patients living with HIV/AIDS were not keeping their routine appointments. Patients who had previously been unable to control their infection were finding it difficult to keep their appointments. Most of the time overcome by depression, anxiety and feelings of shame, some patients found it difficult to keep their appointments. This initial observation led us to focus on the link between the psychological functioning of this category of patient and the normal functioning of any ordinary patient.

To better understand this observation, we need to start with the first definitions of trauma according to Freud (1920), where trauma constitutes a violent shock, affecting the subject who was not expecting it, and accompanied by fear. Laplanche and Pontalis (1978), who drew inspiration from Freud's definitions (1920), consider that psychological trauma is an "event in the life of the subject which is defined by its intensity, the subject's inability to respond adequately, the upheaval and lasting pathogenic effects it causes in the psychic organization". It is precisely the traumatic effect of discovering one's serological status that creates this instability in patients' treatment follow-up.

The second point is that some patients opt for a different treatment path, while others combine so-called modern and traditional medicine without measuring the consequences. This hesitation in the choice of therapeutic pathway is not likely to encourage better care; on the contrary, it sometimes destroys the efforts made to date.

The HIV-positive patient, faced with the psychic intrusion of the virus, sometimes finds himself at odds with the continuity of his existence, continually swaying in a state of liminality and unable to determine the obvious therapeutic trajectory for his salvation.

Observation of the reactions of individuals faced with adversity, particularly those with HIV/AIDS as a disability, shows the diversity of adaptive responses of each individual and underlines the extent to which analysis of these situations cannot remain confined to an approach centered on vulnerability, risk factors and maladjustment. Behavioral singularity, the variety of their psychic development and the social environment complicate the process at play and influence the trajectory of the patient's future.

It is true that some patients may present psychological disturbances and disorders or social problems, but other patients in the same situation will not be able to present them, thus demonstrating extraordinary and inexplicable forms of adjustment; they are then said to be resilient.

However, in another category of patients, adaptation is difficult, forcing healthcare staff to provide support to boost and rebuild the patient's resilience through holistic support. This is precisely what our research aims to demonstrate through this study, which seeks to identify the process of resilience in adults living with HIV/AIDS through the support provided by healthcare staff working in the care sector in the city of Yaoundé.

C. Explanatory Theories

HIV infection is far from being an infection like any other; it affects people's biological bodies and, at the same time, colonizes their psyches. So, for the person affected by HIV, the revelation of the disease is violent and often traumatic. The announcement of a serious illness is a traumatic event, because the person is confronted with the unthinkable reality of their own death (Bailly, 1998). In other words, they are overwhelmed by a sense of rupture in the continuity of their existence, of annihilation of self and desire, because of the infection (Tovmassian, 2015). We explore the theoretical foundations of this interaction between the psyche and the biological (HIV) through a few theories:

➤ *Labelling theory*

According to Cornut and Grenier (2011), "labelling theory is based on the use of labels or tags to qualify, identify and characterize others". Some labelling theorists, such as Tannenbaum (1938) and Becker (1963), assert that labelling a person with a deviant seal has negative effects, such as aggravating criminal or deviant behavior: the person would come to accept the label and adopt the behaviour expected by the label. Tennenbaum asserts that the individual's self is greatly influenced by the way he or she is perceived by society.

Lacaze (2008) describes the pernicious effects of labelling as follows: "The possession of a status that is perceived in a depreciatory way in society is correlated with an inequality of opportunity experienced by people with the differences and deficiencies suggested by the stigma.

For Link and Phelan (2001), the consequences of labelling and stigmatization are that individuals or groups who are stigmatized become the bearers of pejorative attributes and are the object of "stigmatization". In this way, a labelled and stigmatized individual, category or group is often destined to experience a loss of status and unequal treatment. We can understand, for example, the stigmatization and discrimination faced by people living with HIV/AIDS since the advent of the pandemic, and which continues in a more flexible form today because of the label attached to them due to the fact that they cannot be cured permanently. According to Goffman (1975), the labelling process is also the result of a discrepancy between real social identity, what the individual is, and virtual social identity, what is expected of the individual.

The stigmatization process lies at the interface between the social and the individual. Its rationality can be summarized as follows. Stigma is part of a relationship with others. It is the other who invests the field of stigmatization by setting desirable standards and discrediting differences at a given moment. It indicates the stereotypes by which a society determines at a given moment in its history what it considers desirable. The rejection of the undesirable state requires the development of a discourse that legitimizes stigma and the subordinate condition of its bearers.

➤ *Coping theory*

Individuals are subject to many life events which they try to cope with. "Coping" refers to the various strategies put in place by a person to control, reduce or simply tolerate a stressful situation. Coping is a recent concept, having first appeared in Lazarus' 1966 book Psychological Stress and Coping Process, where it is defined as "the totality of cognitive and behavioral efforts designed to control, reduce, or tolerate internal and external demands that threaten or overwhelm an individual's resources". Strategies may consist of an activity or a thought process and may be cognitive or affective in nature. They can also include more direct forms of behavior, such as confronting a problem or avoiding it. With this coping approach to stress, we are no longer trying to describe and understand stress reactions based on the situations with which the subject is confronted, but through the way in which he or she manages the situation.

• *Stress and Coping*

Coping cannot be dissociated from stress. A coping strategy is only implemented and developed when there is a stressful situation. Perceived stress is made up of all the assessments of the situation and the resources available. It is a dynamic process, which explains why different people experiencing the same stressful situation will not react in the same way. Various circumstances can be at the root of this stress: the individual himself (state of health, personal history), the family (conflicts, relationship or communication difficulties) or the professional and social environment (relationship, career, socio-economic difficulties). Coping is a form of resistance to stress that makes it easier to eliminate. It helps to maintain good health despite stress.

- *Coping and Adaptation*

Coping also has its origins in theories relating to adaptation and the evolution of species. Defense mechanisms and coping processes have two objectives: affect regulation (by reducing or eliminating negative affects) and homeostasis (by restoring a comfortable level of functioning or returning to the basic level of functioning). The individual has a range of responses necessary for survival in the face of threats: attack or flight. Adaptation is a broad concept that includes psychological and biological processes, all the modes of reaction of living organisms in interaction with the environment, most often repetitive and automatic. Coping is more specific and only concerns reactions to variations in the environment perceived as threatening. The cognitive and behavioral efforts made are conscious and specific.

According to Lazarus and Folkman (1984), a coping strategy is good if it enables the subject to control or reduce the impact of the aggression on their physical and psychological well-being. This implies that the individual is able not only to control or resolve the problem, but also to regulate his negative emotions and distress.

III. METHODOLOGY

Our research question is as follows: What is the role of support provided by hospital health staff in the emergence of resilience in adults living with HIV/AIDS during the process of social stigmatization in the city of Yaoundé? To answer this question, we developed the following general research hypothesis: the support provided by healthcare staff influences the resilience of adults living with HIV/AIDS in the face of social stigmatization in the city of Yaoundé. The research objective of this study is to understand the role played by healthcare staff in the resilience of adults living with HIV/AIDS in the city of Yaoundé.

We used qualitative research techniques. The problem thus posed is that of the break in continuity of existence among adults living with HIV/AIDS in their stigmatizing social environment. As part of this study, we wanted to explore the contribution of support provided by healthcare staff to patients' quest for resilience. We used a purposive sampling technique and interviewed five different categories of staff in three health centers in Yaoundé.

The inclusion criteria were as follows: to be staff of these three health centers (doctor, nurse, psychosocial support worker, psychologist, specialized educator, etc.); to work in a department of the care unit for people living with HIV/AIDS; to agree to take part in this study and to have at least two years' seniority in the department.

The exclusion criteria were: health staff from the three health centers who did not work in the unit for the care of people living with HIV/AIDS; staff who refused to take part in this study; and staff with less than two years' service in the unit.

In the context of this study, once a staff member (doctor, nurse, psychosocial counsellor, psychologist, etc.) has been made aware of our problem and has agreed to take part, we thank them for their availability and ask them to read the consent form designed to obtain the assent of the participants. The reading ended with the subjects signing the form. After signing, we placed our interview guide, a format and a pen for taking notes on the table in front of us. We began the interview with inductions relating to general information about the respondents. Then came those relating to the guide's areas of interest.

A content analysis enabled us to understand how patients were cared for, what support measures were used, the interrelationship between staff and patients, the communication used during exchanges, etc.

IV. RESULTS AND INTERPRETATION

A. Results

We were able to interview two doctors, two nurses and a psychosocial support worker. They readily agreed to take part in our study because their day-to-day work involves caring for people living with HIV/AIDS in these health centers.

A synoptic analysis of the accounts emerging from our interviews shows that all the staff, whether doctors, nurses or psychosocial support workers, recognize the fact that HIV/AIDS infection is not experienced in the same way as other illnesses. It generates a great deal of resentment among patients, giving rise to multi-faceted and negative representations.

Therefore, when it comes to the so-called self-stigmatizing factors in infected adults, many practitioners think that they result from patients being told their serological status incorrectly. It is in this sense that the nurse at the Centre Hospitalier Dominicain Saint Martin de Porrès in Mvog-Betsi believes that this is a delicate moment and that the practitioner must show professionalism. Patients' difficulties begin when the test results are announced. Our respondent answered "yes, except that the announcement should be gentle and measured so as not to frighten the patient". All the other respondents agreed that the announcement should be flexible and reassuring for the patient. The doctor at Biyem Assi district hospital also said that: "HIV/AIDS is a pathology that is considered taboo for many patients, mainly because they are considered to have a bad lifestyle (sexual disorder by others)". This means that the patient's capacity for resilience begins as soon as his or her status is announced. The procedure must be measured and convincing on the part of the staff, to help patients accept their status and follow their treatment from now on, without listening to the various speeches made in their immediate or distant environment. Staff at the Monseigneur Jean ZOA Medical Centre in Nkolndongo add: "An illness understood as a socio-cultural phenomenon can be a source of negative emotions, if the explanatory approach to the illness and its symptoms have not been properly explained

to patients. Fear and the approach of death can push some people towards suicide".

As far as intra-familial stigmatization factors are concerned, they include the quality of intra-familial communication, family interaction, the support relationship that develops within the patient's family, and so on. This is precisely what led one of the participants to say, about the intra-family relationship, that "it's not just any family member, you have to choose someone who is close to the patient and whose morals cannot deteriorate their psychological state and general physical health". There are ways of circumventing the effects of intra-familial stigmatization, and the doctor at Biyem Assi hospital suggests: "doing psychological work on oneself to prepare oneself for the disavowal of people who are sometimes very dear to us". As we have said, HIV/AIDS is not a disease like any other; it causes patients to stigmatize themselves and leads to a kind of rejection of the patient by those around them. This is why our nurse, who works daily in the care of this category of patient, tells us: "I don't think it's very wise to inform any family member. If the healthcare staff are unable to tell the patient about their condition and get them to accept it, they can work with a family member which can have a positive influence on the patient to maintain individual confidence".

The community stigmatization factors highlighted raise questions about the quality of social communication, social relationships (with neighbors, at work, in the care environment, etc.), the helping relationship, etc. Our psychosocial support worker believes that in this case, the patient must demonstrate psychological maturity to better cope with the behavior of others, as he says: "For my patient to be able to cope with the possibility of a breakdown in social and emotional relationships, I suggest that he be mentally constituted to better overcome the opinions of others and remain in the community. Above all, don't close in on yourself. Learn to accept the opinions of others, whether they are in your favor or not". Psychological care was also explored, and the doctor at the Bishop Jean Zoa Medical Centre in Nkolndongo believes that the practitioner must not only consider the illness, but the whole person. And in doing so, they must be able to understand that the HIV-positive person is not a patient like the others; he or she faces an enormous psychological burden that should be considered in his or her treatment. These staff seem to recognize the need for psychological care as a helping relationship, when they respond with a simple "Yes, they do! They are seen for counselling and their morale is boosted". Confidentiality of status is also a social problem: patients need to be in high spirits, so that they can accept their illness and live with it without remorse. As for revealing one's illness to everyone, it is not normal to do so. Illness is a personal problem, and it can only be revealed to a resource person who can provide care and compassion. It is in this sense that our participant finds it logical to say that "When you are psychologically boosted because you know the disease and its symptoms, by following medical advice; you can show your status to anyone because the disease is

no longer a fatality. You can have contracted it and still die of something else".

B. Interpretation

Our research hypothesis maintains that the resilience of adults living with HIV/AIDS is more satisfactory when the support provided by care staff is effective, efficient and holistic. It highlights the possible relationship between the comfort provided by care staff for adults living with HIV/AIDS and the development of resilience in patients. In this respect, analysis of the data from our survey leads us to conclude that the supportive relationship developed by hospital staff when caring for patients can either make them feel better or, on the contrary, can exacerbate their situation and create a breeding ground for experimentation and the expression of their own depression.

From a theoretical point of view, Ionescu (2004, 2011) has developed a strategy for minimizing the risk factors involved in crisis situations and accentuating distress in people in difficulty. From there, he developed procedural strategies for moving on to a new stage and rebuilding resilience in people in situations of adversity. But this time, accompanied by mental health professionals, psychologists and specialist educators. It therefore seems obvious to recognize that resilience in children and adults is the result of a balance involving the dynamic interaction between the various protective factors present in the individual themselves, but also in their family and social environment (educational system and extra-familial social and emotional relationships). It should therefore be understood as a multidimensional construct (Fortin & Bigras, 2000), resulting from a state of balance between risk factors and protective factors in the face of stressful and/or traumatic events.

Between 1960 and 1970, Ionescu and his colleagues developed programs which were not specifically designed to promote resilience, but rather to prevent the effects of chronic adversity experienced by children living in poor and disadvantaged families in the United States. From the 1990s onwards, however, various publications began to focus on 'promoting', 'building', 'stimulating', 'improving' or 'increasing' the resilience of children and adults experiencing situations that could have consequences for their mental health. Techniques and programs have been developed to help individuals and groups cope as well as possible with traumatic situations and adversity.

Gradually, a new approach to intervention has been developed, in which mental health professionals provide support in building resilience. This process is 'assisted' by competent professionals who are familiar with the processes leading to resilience and the factors involved in these processes.

The adjective 'assisted' is used here to describe the building or strengthening of resilience with the help of mental health professionals in people experiencing trauma or chronic adversity, emphasizing the fact that these professionals are merely assisting and accompanying the

individual in this process. He also shows that it is the individual himself who remains 'in the driving seat'. The process of resilience can be summed up in slogans and attitudes such as 'support', 'help' and better still, it is a kind of co-construction between the patient and the carer. This is why our Biyem Assi Doctor says that "the announcement of the diagnosis should be gentle and measured so as not to frighten the patient". This reserve is necessary and imperative, as we do not want to create an emotional shock in our patients, but rather to create the conditions necessary for them to develop the resilience mechanisms needed to overcome it.

From this point of view, the phenomenon of emotional shock and vulnerability, as well as having an impact on the state of health of a large number of people, has consequences for their therapeutic itineraries, which can be expressed in poor compliance with treatment, the search for a possible treatment from charlatans, and so on. Professionals working in the field of assisted resilience must highlight and develop the potential of HIV-positive people. Emphasis must therefore be placed on a series of individual characteristics known to be protective factors and facilitators of resilience, including positive self-esteem and self-image, the ability to elicit sympathy, a feeling of control over one's life, creativity, humor, and so on. All this knitting together must be done in synergy with family members (certain trusted members indicated by the patient) to help the patient, move towards overcoming the social gaze. In other words, to revitalize the previous biopsychosocial homeostasis.

Furthermore, given the probable or possible multiplication of harmful interactions between patients and those around them, it seems urgent to seek to optimize the patient's resources and the results of staff interventions in a way that guarantees the patient's well-being. In so doing, intervention should be geared towards strengthening the patient's psychological potential, so that he or she does not lapse into depression or anxiety.

Patient care staff must position themselves as facilitators of the patient's adaptation, i.e. their accommodation or acclimatization to their new condition and even to their social ecosystem. Adaptation must lead the patient towards an apparent adjustment to their new health condition and living environment, which preserves them from any spirit of stigmatization in the interaction they will have from now on with those around them. However, the results of our interview show that the resilience of our patients is certainly dependent on themselves, but it cannot be dissociated from the idea that it is a co-construction between the patient, who is desperately trying to regain their health, and the health care staff, who must be prepared to help them regain it.

Social stigmatization is not a new practice in contemporary society; it has always been a way of life exist in the human environment whenever man is faced with something extraordinary. It is more a question of finding ways and means of either circumventing them or containing them so as not to allow them to express themselves. It is

with this in mind that all the categories of staff encountered in the various hospitals insist on good communication and education for patients. Every disease has a social and cultural dimension, and HIV is no exception. The fact that it is a taboo disease, because of the way it is transmitted and the innuendo it conveys, makes it even more so. So, to help patients, staff must sometimes act as confidants, sometimes as carers. Finally, for this help to be effective, healthcare staff must become resilience tutors. They are also better placed to identify the safe distance needed to protect the patient in his or her entrenchment, and the degree to which he or she can open up to escape the effects of social stigmatization.

V. DISCUSSION

Resilience, as we have said, is the capacity to succeed, to live and develop positively, in a socially acceptable way, despite stress or adversity which normally carry the serious risk of a negative outcome (Vanistendael, 2001). With the discovery of antiretroviral drugs, HIV/AIDS infection has become a disease that can be treated like all other diseases of this type. It requires patients to accept their situation and deal with the infection. It's not just a question of being able to manage the biological side of things, but also of coping with the psychological damage and the way society views them. Our research hypothesis sets out to demonstrate the need for external intervention to help the patient build what we might call "inter-mediated resilience". In other words, resilience which involves the intervention or assistance of others. In other words, our research hypothesis postulates that the resilience of adults living with HIV/AIDS is more satisfactory when the support provided by care staff is effective, efficient and holistic.

Over the course of their lives, individuals undergo a number of life events, including serious illnesses such as HIV infection, and try to cope with them. Coping" refers to the various strategies put in place by a person to control, reduce or simply tolerate a stressful situation. These strategies may consist of an activity or a thought process, or they may be affective in nature. They may also involve more direct forms of behavior, such as confronting a problem or avoiding it. As we can see, cognitive and behavioral efforts can, in certain cases of stress, escape a patient's capacity for self-control, which is why sometimes, to control or even reduce certain threats, it is necessary to be accompanied or guided by certain more experienced people. This is what we call support towards resilience or assisted resilience.

Analysis of the results of our survey clearly shows that, through the interviews we had with the health staff in charge of HIV-positive adults in these three hospitals, there is a spirit of supporting patients in their quest for resilience. Our psychosocial support worker at the Mgr Jean ZOA Medical Centre in Nkolndongo, for example, believes that "when the diagnosis is announced, patients think they have lost everything in life". This suggests that when the diagnosis is announced, a state of shock cannot be ruled out. It's the most delicate moment for staff, because they must find the right words; they have to find the right words to alleviate the

negative impact of the infection on the patient's mind, and to be able to follow the patient in his or her quest for health.

Healthcare professionals need to work from a perspective of assisted resilience, highlighting and developing the potential of HIV/AIDS patients. Emphasis must therefore be placed on a series of individual characteristics known to be protective factors and facilitators of resilience: positive self-esteem and self-image, the ability to elicit sympathy, a sense of control over one's life, creativity, humor, etc. Hospital staff need to identify the resilience skills of their patients. They need to assess the personal, family and extra-familial (social and community) dimensions of the patient's resilience by looking at certain pillars of the resilience process. It is in this light that Giroletti and Paterson-Young (2023) point out that resilience is not a static or one-dimensional process dependent on a single factor, but rather a dynamic and continuous process determined by several factors.

Alongside their previous actions, professionals need to identify the resources available in the patient's entourage. First and foremost, these are adults who can maintain meaningful and empathetic links with the ill person over a long period of time. These are what Colley refers to as mentors or "personal anchors", defined by Garbarino (1982) as people in the child's environment with whom the child has a positive and stable emotional relationship. These are also what Cyrulnik (2001) refers as 'resilience tutors'.

Another important environmental resource is the support networks (formed by friends, school or work colleagues, associations, etc.), which help to create a secured and accepting framework, a real 'safety net' around the ill person. The role of the professional is to identify and assess these resources, to direct the patient towards these identifiable resources, to help create such networks when they are lacking, and sometimes even to activate existing networks that are at a low ebb.

In other words, these resources cannot be effective at everything; because if wrongly used, they can be transmuted into risk factors and in a manner that they are considered to be active in a "trans-adversity" way.

The staff have a keen eye for this. It is in this way that, on the one hand, staff provide protective factors and, on the other, point out risk factors to patients that, ultimately, resilience is built up in adults living with HIV/AIDS. Furthermore, if we focus on individuals, and particularly those living with HIV/AIDS, according to Lighezzolo and de Tychey (2004), criteria for operationalizing the resumption of development can be defined, according to criteria which are internal and external to the subjects and to which reference must be made for good support of the patient. External criteria concern, for example, socialization skills, bonds of attachment outside the family, professional integration, the absence of disabling psychosocial symptoms and the non-repetition of trauma to offspring (non-transmission of HIV to unborn children). Internal criteria concern the ability to express and share one's inner states or affects (quality of mentalization); the feeling of subjective well-being (enjoyment of life despite infection); and psychosomatic balance.

The psychological workings of resilience are therefore complex to analyze and define, because they lie at the crossroads of several dimensions. Resilience is both a process of psychic reorganization and a way of coping resilience is the result of this work in terms of defensive processes, but also in terms of adaptability to the social and psycho-affective environment. In addition, we have just seen that resilience has roots which are internal to the subject (psychic structures, personality, defense mechanisms) but also external (resources of the environment). There is therefore not one form of resilience but specific resiliencies resulting from a dynamic and evolutionary process which is specific to each subject and each context and which must be allowed to blossom and develop. It must be said that resilience is underpinned by internal and external psychodynamic factors which are products of the subject's pyogenesis, ontogenesis and socialization. It is therefore important to know how these processes are activated in the patient, to be better able to help him or her on the road to resilience.

The objective of a resilience tutor such as a healthcare worker is to be able to identify possible interventions that can encourage the formation of mechanisms that work towards building the resilience of our patients when they do not arise spontaneously. The clinical applications of resilience theories concern areas such as: individual or group care for people who are ill or suffering (individuals, families and communities), and preventive practices aimed at moderating the deleterious effects of illness in the context of anticipating the negative consequences of risks incurred by individuals. Examples include deterioration in health because of poor compliance with treatment, and misdirected treatment, which means that some patients end up going to traditional healers at some point in their follow-up.

The aim is to help adults living with HIV/AIDS or members of their families to find resources within themselves and to stimulate the psychological resources needed to cope with these difficult situations for their patients. This support should include educational approaches, approaches to preventing the risks of recontamination, approaches to promoting good health through good therapeutic compliance and good clinical/biological monitoring, and the creation of a salutary environment around the patient. Finally, it should be noted that this support dynamic must be based on investigations which, as Anaut (2015) points out, take an interest in the social, community, religious or socio-cultural support on which the individual can draw.

VI. CONCLUSION

This study of the issue of resilient support by healthcare staff for adults living with HIV/AIDS in the city of Yaoundé has enabled us to make two observations. On the one hand, it leads us to observe that adults living with HIV/AIDS are faced with a biopsychosocial and emotional problem which leads to a few negative effects. These effects arise from a poor social representation of this infection in society and from certain cultural and anthropological considerations linked to this infection. On the other hand, it also appeared to us that better support for patients in hospital helps to improve their resilience in the face of the psycho-traumatic effects and the breakdown of family and social ties caused by this infection. This resilient support involves mitigating these biopsychosocial and emotional effects and re-establishing patients' broken social links, to control, reduce or tolerate the internal and external demands that threaten or exceed patients' resources.

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