Robin McCoy Brooks: draft, do not share

Introduction (draft)

Several years ago, Graham Harriman directly asked Robin McCoy Brooks why we had not written down our experiences of Project Quest's emergence. Within weeks of asking this question, we (Lusijah, Graham and Robin) organized our first meeting to reflect on our recollections about the AIDS pandemic in Portland, Oregon that had given birth to the Project Quest Clinic in 1989 and to consider writing this book. Each of our lives had moved onward, indelibly and singularly changed because of our mutual involvement in Quest's emergence. Graham had become the Director for the Treatment and Care Program for the Bureau of HIV at the NYC Department of Health and Mental Hygiene. Lusijah Marx remained in Portland in the role of medical psychologist and clinical director of what has become the Quest Center for Integrative Health. Robin had become a Jungian Psychoanalyst in private practice in Seattle and Trainer, Educator and Practitioner of Psychodrama, Group Psychotherapy and Sociometry. Even though we shared many life changing experiences in the forming of the Quest community, each of us had entered the work from a unique position and held a kaleidoscope of memories that informed our prospective about "what happened."

It is our view that the Project Quest community that emerged 30 years ago amidst an AIDS pandemic *was not* a random event engineered by a few caring individuals. The Quest community was instead a *timeless* social phenomenon that emerged through the singular critically held desires of the many individuals who shaped it, beginning with one person. The ideals of egalitarianism we shared and that emerged from the community of care that evolved are based in the belief that all human beings are equal in their fundamental worth regardless of their social or health status and deserve access to basic human resources available within their society.

We quickly realized that we needed to approach our project from a plurality of sources that included yet exceeded our own vantage point. A coherent vision for this book slowly emerged and became multi-faceted. Our over-arching desire is to identify and describe the variables that contributed to Quests emergence because we believe these variables are timeless and applicable to crises amongst disenfranchised populations today. Our project focuses on the articulatable factors that contributed to the *revolutionary* emergence of what became an *egalitarian community* of *care* amidst a backdrop of hopelessness. We break down the terms, *revolutionary*,

egalitarian, community and *care* as key concepts that we believe can be *creatively* applied at the grass roots of a catastrophic event amidst a stunned or indifferent populace.

Evolutionary sociologist Nicholas Christakis has extensively argued that as a species, how we care for each other is at least partially encoded in our genes and fundamental to building what he describes as "a good society" (Christakis, 2019). We are innately equipped, according to Christakis to band together and live cooperatively with each other, befriend each other, recognize uniqueness, show kindness, love and reciprocity in our relationships and learn socially while teaching what we know (13-16, 125-27). What is "goodness" in a society and who determines that narrative? One of our basic assumptions 30 years ago was that what was "good" for the Quest collective could emerge if certain conditions were in place. One of our guiding principles was that what was good for the community was subjective and further determined by how each of us defined what we needed and could offer each other.

Accepting Christakis's claim, these social sensibilities that are encoded in our genes as a species only provide *a possibility* for collective care. Our environment also has a powerful effect on how we may or may not optimize genetic variants that support a culture that sustains a livable life. Our environment, as we are viewing it here *is* our body, mind (psyche), brain in addition to everything else that penetrates the membrane of our skin. This understanding is key in the practice mind-body medicine elaborated more fully by Lusijah. Our bodies and our genetic predispositions of all sorts are in concert with our various environmental influences that include cultural status, our social networks, our personal history, world history, climate change, national and world governments, economic pressures, racial status, physical and mental health status, social status, identity politics, employment status, usefulness in one's social world, quality of life, educational status, global health crises, effects of technology and so on. Our species ability to adapt to these diverse environmental influences is dependent on the social groups to which we are inured including our culture. We are social animals. Our ability to "fashion" diverse cultures or social communities of care in response to environmental impingements such as a plague and creatively produce things, ideas, and actions to adapt to variabilities in part, relies our innate sensibilities for social relatedness, cooperation and learning from each other when faced with a crises (C, 365-373).

But what are the conditions that allowed for these biological predispositions to actually manifest in the emerging Quest community as they are only possibilities? Further, how do some

groups coalesce into societies that uphold what is innate and how do others not? Can we apply what we are now discerning were key elements to the emergence of Quest to contemporary global catastrophes? In what follows, we describe how the Quest community made use of these innate capacities to band together, mobilize towards a common good, struggle together in that process, learn from each other's sphere of influence, share goods, services and care, and transcend to moments of singular and collective loving, what has been called "trans-individuation" (Brooks, 2021).

Our Method

Our method is organic and thereby often non-linear as the horror or trauma of the plague was fundamentally incomprehensible, unintelligible and inarticulatable as we approach it three decades later. One of the challenges we encountered in designing our research approach had to do with retaining a pluralistic view of Quest's emergence *while* investigating the many factors that contributed to the formation of an egalitarian community of care and describing what was revolutionary about it. We needed to recognize the chaotic poignancy of singular experience that contributed to a collective response to the plague. Therefore, we adopted a form of qualitative research called autoethnography. Autoethnography is *contrasted* to other forms of research often favored in studies that rely on quantitative data alone. Quantitative research is used to statistically enumerate defined variables with the goal of generalizing the results from a larger sample population. While our study includes quantitative research in some sections (such as long- term survivor trends), its exclusive use would tend to obliterate or disavow individual experience. Nevertheless, it is crucial to critically consider what can be known quantitatively about the plague from a prospective of 30 years later as it contributes to our thesis.

Auto-ethnography involves describing and analyzing personal experiences (including our own amidst others) through individual stories or narratives in order to understand a cultural phenomenon through the eyes of the many. Our approach resists falling into a very real human tendency to render what was a multi-dimensional phenomenon into a neatly unified narrative whole. Quest's emergence was messy, emotional, chaotic and multifaceted. It is a methodology that requires that researchers embrace our vulnerability, hold a stance of inclusivity as we attempt to include the lost and disenfranchised voices of the plague and make what is discovered

accessible to broader audiences (Adams, Jones Ellis, 2015, 36). The autoethnographic approach involves a nuanced investigation into the specific experiences of particular lives with feet on the ground. Ground level research follows the traces of where the action is or was in the very heart of things using a multiplicity of sources. This empirical method of study includes accessing existing stories of the times as depicted in various artifacts such as film, pictures, letters, journals, books, art forms, quantitative research, or other memorabilia including self-reflective observation and/or the memory of those who are dead or still living.

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Chapter: The Beginning of a movement: Philosophical and clinical perspectives

Philosophical perspective

Lusijah Marx would rise as a new figure of activism (although she would not characterize herself this way) in her own community from a vacuum of societal resources amidst a rapidly developing pandemic. This occurred as she actually encountered the raw reality of individuals living with HIV disease when she was conducting her dissertation research in the mid-80's. Lusijah and Graham elaborate their personal accounts of these events in chapter's (x, y.) Here, I portray a philosophical perspective that is applicable to other catastrophic events where novel responses are required to meet a new order of care in quickly developing situations. Lusijah's vicious exposure to her own helplessness encountering the person living with AIDS had a profound and destabilizing effect on her. Her capacity to turn towards and bear the horrifying reality of the pandemic gave her glimpses into another dimension of what it means to be fundamentally human. I described this "moment of truth" experience elsewhere:

> "Only from such an engaged position can a singular moment of truth (novelty) be revealed in a penetrating flash of pure possibility and beginning…When the subject makes the fundamental choice to act, a new and terrifying space opens to everything (possibilities) through a heightened awareness of lived time. The cost is perpetual struggle, uncertainty, the radial loss of identity and a decisive break with the empty abstractions (laws, traditions, ideological affiliations) contained within a social order that condones exclusivity (Brooks, 2018 18, Badiou, 2003)."

Truth lies at the basis of the psychoanalytic ethic. Truth can be seen as an iterative process of unveiling amidst the enigma of being human as we engage the rawness of *what is* (personal conversation, Ladson Hinton, 2018). The ancient Greeks called this process *aletheia*, which means disclosedness or unconcealment. Nobody holds the knowledge of what is, that can only come through each of us when we encounter the antagonisms of everyday life including its societal catastrophes. These ideas are crucial to how we might understand Lusijah's radical shift in philosophical terms, and how each of us might relate to creative possibilities when encountering adversities of all kinds, so I will briefly break them down further.

Alain Badiou's *secular* reading of the Apostle Paul searches for a "new militant figure" who breaks from the impotency of external figures that control the defining narratives defining who

or what is worthy of receiving the bounty of the republic. Such a break becomes the outcome of a "conversion" or transformational experience that allows for the possibility of creating a new world order from the grass roots during collective catastrophes (Badiou, 2013). Žižek specifies that an individual's decisive and sweeping break from a hegemonic social order whose deadening authority has utterly failed to include everybody in its mandate of care *is* what makes the act *political* . What drives such a break however is *psychological* (Žižek & Daly, 2009, Brooks, 2018 10). In other words, it is not enough to be brought to ones knees in the face of an event that reveals a new dimension of reality. For a conversion experience to occur, the individual must then be willing to *define for oneself what is real, true and good* and (this is crucial) *be willing to take full responsibility for one's belief and actions* (Žižek, 2013, 1-8, Brooks 2018 P 9).

It was from such a stance that Lusijah made a fundamental decision *to act* without knowing how to proceed except for one wildly chaotic step at a time, an action that irrevocably altered the course of her existance. One of Lusijah's early acts of rebellion occurred when she radically departed from the protocol she laboriously designed that had been endorsed by her dissertation committee, as she was pursuing becoming a clinical psychologist in the late 1980's. From this perspective we can more easily imagine Lusijah naively designing her protocol from a medical paradigm that adhered to the ideology of the academy she was training in. While sitting with her first HIV positive study participant, she was baffled by an ethical dilemma. Do I follow the inner-directed need of the patient for psychological healing or do I adhere to the medical model that is recognized and valued by my qualifying committee? More traditional models of medicine hold the position that the provider is the *one who is supposed to know what is best* for the patient versus the position that the patient holds a kind of knowledge that is essential to one's own healing - in collaboration with our traditional sources of knowing. Lusijah spontaneously decided to follow the patient's process by asking him what *he* needed for *his own healing*. Further, she did not define *what healing was*.

What inevitably and repeatedly occurred (and she was astonished by this) was that the patient dropped into their own visceral memory of earlier trauma prior to infection. She realized that working with the protocol alone (which perhaps had some merit, still) was insufficient. In other words, *the trauma of the virus opened the patient to prior psychological trauma that suddenly appeared more urgent and relevant for his/her own healing* (footnote on *après coup* and

nachträglichkeit). This discovery is relevant today living with the COVID-19 pandemic, as après-coup events are common for all of us . Pervasive collective fear of death, prolonged collective grief for the loss of our way of life as we knew it and uncertainty about our future breaks through our coping mechanisms as we become more generally vulnerable. Old wounds may penetrate our psychological landscape seeping through the cracks of whatever prior allusion we had of safety.

Success or failure of a therapeutic process is dependent on the patient's ability to turn towards their psychological antagonisms again and again so that the possibility for a novel response to unearthed or newly revealed traumatisms may be engaged and worked with. French psychoanalysis Jacques Lacan, who himself was a figure of activism in the psychoanalytic community claimed that being able to *live with our fate* is one of the crucial goals of therapy. "Working through" trauma is a Freudian myth that promises a psychical cure (the talking cure) from the effects of what happened to us or is by the end of analysis, yet anyone who has had therapy knows that trauma becomes part of our mind/body landscape until the end of time. How we come to relate to or respond to our traumatisms *can* change, not the fact that they happened or that other traumas will happen again in our uncertain futures. As Gregg Carrigan, long term AIDS survivor recently put it; "Remembering the plague [thirty years later] is like a burning scar" (personal conversation, 8/5/2017). By engaging the wounds of our being we may become more able to *live with* our psychical scar tissue so that we may live fully *now*. Indeed, the conditioning ground for self-knowledge or self-formation (what Jung referred to as individuation) requires that each of us engage the radical enigma of being human while being accountable to oneself and others in everyday life. As there was a vacuum of traditional resources on the institutional level for those who were HIV positive, Lusijah turned to what she believed in: the healing power of human relationships, community and mind-body medicine.

The story of Project Quest begins with Lusijah's decision to surrender her own inner directive to follow what the patient said they wanted. Thus, Lusijah became a grass roots revolutionary, a pioneer in integrative medicine and eventually a co-founder of Project Quest. She would leave her marriage, the status of being a traditional psychologist, her big house with many room, antique rugs and couches and other material and social comforts of her former life. But, how does one individual's singular response to a moment of truth (the reality of AIDS) transition into the radical evolutionary response? The collective individuation that materialized

into a clinic was carried on the shoulders of many individuals who had themselves singularly encountered the horror of the plague and engaged it. Lusijah was not the only individual to have a transformational experience by engaging the reality of the plague but she was the *initial* visionary. At the best of times we joined each other with "non-hierarchical reciprocity" (personal communication, Betsy Cohen, 3/27/20). The Badiouian event of truth is *available to all* not just religious leaders at the magnitude of the apostle Paul. That is, *each of us has the potential* to authentically engage each other in novel and life-giving ways that reach beyond the nullifying norms in which we are all embedded and to lead from our own spheres of influence.

I now summarize key structural elements discussed above that we argue contributed to Quest's emergence and activated (Christakis's argument) our collective genetic pre-disposition as humans to work together towards a commonly held good.

1). **The appearance of a catastrophic event**: The AIDS epidemic silently spreads to Portland Oregon in the 80's. The local and national polity has failed to adequately recognize and/or come to terms with the crisis it is undergoing under its own nose. The living experience of the disease itself was terrifying and out of control. Medical care was non-existent or primitive and social response was alienating, hostile, or largely indifferent (See chapter z on context).
2.) **Turning towards the reality (rupture) of a collective catastrophe**: Lusijah encountered the reality of the effects of living with AIDS through a singular encounter with a patient recruited to meet the demands of her PhD study. She was violently wrenched out of her own shameful indifference/ignorance about the effects of living with HIV disease. See also Gregg's and Graham's story from the perspective of a person living with an AIDS diagnosis chapters z , x).
3.) **Staying engaged so that novel responses to the catastrophe can arise:** Lusijah's sustained engagement with individuals living with AIDS revealed an inescapable and singular poignancy in the face of unrelenting hopelessness and profound uncertainty. In so doing she must now define for herself what is real, true and good and be willing to take full responsibility for her belief and actions. A novel possibility emerged not only for the direction of her dissertation but more poignantly how her practice of mind-body medicine would be informed by the individuals she worked with. In other words, theory is shaped by practice not the other way around. The theories for how to care for pandemic patients did not exist. As clinicians (mental health, eastern and western medicine) we had to listen to what individuals needed in a creative collaboration.

4.) **Action: The ongoing everyday work of taking concrete responsibility to the object of one's calling *with and amongst others* from which a new egalitarian ethos may emerge**: Lusijah commitment to working with patients living with AIDS exceeded the perimeters of her dissertation. She denounced her former investment (way of practice) in the social order that alienated society's refugees. She goes off trail. Sustained fidelity over time is often characterized by inevitable and tortuous trials of uncertainty, radical loss of identity, and ambivalence regarding what the truth is in the first place and if I am actually serving it.

5.) **Reaching out to others who can contribute to a shared cause from their own spheres of influence:** The need of so many isolated afflicted persons was beyond the capacity of one person's capacities. Lusijah realized she needed the help of other therapists/physicians/group therapists/alternative healers etc. sensitive to mind-body medicine as there were no pharmacological treatments early on. Having a singular vision is only the beginning. A grass roots subversive enterprise is not a top down organization although there exists a soft hierarchy that is determined by the leader who arises within their sphere of influence (initial visionary, patient, physician, acupuncturist, nutritionist, accountant, group leader and so on). Once Lusijah reached out to another person, she had to surrender to the wisdom of the other's sphere influence. From this stance, an ethos of cooperation, collaboration, sharing/teaching each other and sharing responsibility towards the concretization of building a community of care with many developing parts can take shape.

Clinical Considerations in Group work

Graham, Lusijah and I co-led many local groups and residential therapy retreats together. We often co-created new clinical responses to unpredictable and unprecedented demands. Generally speaking, we had to rethink or disregard the theoretical models we had trained with because the demands of group participants living with AIDS exceeded these theoretical frames. While various psychoanalytic and psychological traditions have today extended our understanding of the relational unconscious as inextricably bound to biological being (such as transgenerational trauma), contemporary theory has not adequately articulated how material forces, such a plague influences or impinges a person and collective. We understand today, for example from a neuroscientific stance that the forces of nature and nurture work together in an ongoing series of

complex correspondences between brain and mental life in our daily activities with others (Brooks 2013 619). Thirty years ago, we did not have access to today's explosion of knowledge about the neuro-dynamics of the brain and its cross disciplinary applications. It needs to be said, however that mind-body medicine has been around for thousands of years and has only recently been provisionally accepted by Western Medicine practices (footnote about acupuncture, naturopathy, chiropractic care etc.).

Each plague has its own biological and psychical traumatic manifestations. Imagine a room filled with individuals who may not live through the winter. Imagine bearing all kinds of physical discomfort and shame for what is happening to you and uncertainty about your future except for certain death. Imagine the terror of watching of watching your friends dying with you. One sociodrama we led, for example revealed that many of the 30 participants had lost from 10 to 100 loved ones to AIDS. Imagine how it feels to lose a way of life that is no longer available to you as a societal leper-thing and that your identity group (if you are a gay man) is being wiped out by the plague. I shamefully recall my own personal visceral reaction to the feeling of plague trauma while leading my first retreat. On a break, I rushed to the bathroom and dry heaved into the sink, not making it to the toilet bowl. I was struck by the smell of the disease, of body sweat and flatulence. I was also struck by how eager each person in that room was to be there, to be with each other, to tell their story, to be cared about, to be real with somebody. Beta elements (unassimilable split off affect) hung in the air like raw sewage and at times I felt I was suffocating. Yet, I was overcome by the utter poignancy, the wicked humor, and oh the deep laughter release, the unfiltered frankness about all kinds of bodily functions, about fucking, terrors, desires, hopeless-ness, raw life. I grabbed onto the basin to steady myself and looked in the mirror and cried. "I'm in", I said to myself. "I'm in."

How the virus effected each individual's body and mind were realities that needed to be built into the frame of our group work. We organized our work sessions to accommodate physical needs by structuring in frequent bathroom breaks, resting breaks, nourishing food and drink breaks, medication breaks, making allowances for sudden vomiting and/or sleeping while in session, to name a few examples. In addition to accommodating physical needs, we had to pace the emotional effects of plague trauma in each session using a variety of psychodramatic methods (endnote about pd techniques and resources). Imagine a dial on a stove that regulates temperature in our case libidinal material of trauma. We had our hand on the dial and were

tracking the libidinal tensions of individuals and group as a whole through our own transferences and capacity to bear its intensity at all times.

Psychoanalytic theory, then and now does not adequately consider unconscious group dynamics that can bring a group together or tear it apart. Generally speaking, psychoanalytic treatment focuses on the unconscious dynamics of the subject, the transferential dynamics played out in the analytic dyad and the "working through" developmental trauma that is felt to impair adult functioning. These dynamics can to some degree also be explored in group psychotherapy if the clinician is psychodynamically trained. While we worked with life trauma that preceded an AIDS diagnosis, our growing edge as clinicians was developing new ways of understanding and working with plague trauma as it effected the individual and group as a whole. The participants who came to our groups often saw one of us in individual therapy as well, but not always. What is more difficult to work with in individual therapy/analysis is the kind of inter-subjective dynamics that leap out into the foreground in group sessions. I elaborate on this further in the section on trans-subjectivity below.

Group psychotherapy on the other hand works with the group process as a whole while exploring how individual psychology and inter-subjective dynamics contribute to group process. Depending on one's training, the group leader generally in interested in applying various techniques that engender group cohesion *and* self-development. If the group leader has psychodynamic training, they can apply that in their interpretative style with the whole group and also in the examination of projective process and transference phenomena. Lusijah, Graham and I had diverse clinical orientations but each of us had psychodrama training in common that we believe contributed to our shared egalitarian ethos and belief in the healing power of group psychotherapy. Psychodrama theory and practice was founded on egalitarian principles. Briefly stated here, Jacob Levy Moreno (189-1974) argued throughout his life that the individual's access to spontaneity and creativity was a key component to a possibility of living a fully in a diverse world (Brooks, 2018). In his inaugural text, *Who Shall Survive*, Moreno famously claimed that a real therapeutic process should have nothing less for its objects "then all of humanity" (1953/77). Moreno believed and advocated for the power of group processes in that group members could be healing agents for each other if their barriers to creativity could be worked through. His therapeutic methods allowed for sociometric explorations that could enhance group cohesion by examining what Jung would call "shadow" or unconscious dynamics

through examining projective processes that impair singular and collective creative possibilities (end note here with references for PD). While Moreno's theoretical arguments lacked depth in understanding unconscious underpinnings within groups (such as transference), the practitioner trained in psychoanalysis can adapt his methodology to the situation at hand, as we all did.

Nevertheless, the theoretical/clinical gaps I had going into group plague work had to do with understanding group unconscious processes at play with the unique manifestations of collective plague trauma and HIV positive experience. These very ideological/experiential gaps of knowing became the very working edges or impetus for creative change in how we worked because the situation called for a novel collective response when facing shared dilemmas, over and over again. Below, I describe a moment in group life where a singular truth about a particular disturbing event becomes known (perhaps by many simultaneously) and then expressed in such a manner that enabled others to collectively act on behalf of a shared truth that resists and inverts abusive social norms. The times were dark yet illuminating. We were afraid but not alone. Solidarity existed only in those moments that lifted and informed individuals and sometimes groups of individuals towards a kind of concrete action that often furthered its collective purpose (Brooks, 2018 in Brooks 2021).

I refer to this dynamic as "trans-subjectivity (Brooks, 2021)" (endnote about references). Trans-subjectivity is a building block or precuser towards a community's individuation. Of course there were many trans-subjective moments that occurred within the many group settings of all kinds that led to the actual founding of Project Quest. In the following section, I clinically describe how we may understand the dynamics that contribute to trans-subjectivity through my interpretation of a case vignette. What informs my clinical interpretative assumptions almost 30 years later are culled from recollections, process-notes and other artifacts collected from our autoethnographic study I conducted with my colleagues and others who attended this retreat. I follow Lacan's depiction of three stages of time through which he articulates the developing unconscious discourse of self-formation of and with the other towards a shared truth event (Brooks, 2021, Lacan 2006/1945).

Trans-subjective moment and the emergence of a novel collective response

I start with a vignette:

Lusijah, Graham and I were leading a psychodrama retreat on a remote island in the NW in the early 90's. During the night, one of our participants (whom I refer to as Connie) started to menstruate in her sleep and bleed out slowly through the night. Who ever saw her first (nobody remembers who) walked into what looked like a crime scene. Connie's blood had flowed-out of her body onto the mattress and was still coagulating into little pools on the floor. The smell of her blood permeated the tiny dark room. She was in a coma, inert and lifeless. There were 29 participants living with AIDS attending this retreat. The group lunged into action once the word was out. Within moments, Connie was being carried on her bloody mattress out of her dark and lifeless room into the light of day to one of our vans. She looked like Mantegna's image of the dead Christ, yet she was still alive. Greg Carrigan describes the moment this was: "We could all see our own death then and it was at the same time so healing because we were all lifting her on her mattress, over us…she floated over the top of us." Somebody spontaneously started to play their flute and a soulful melody followed the somber procession to the van. "We were quite suddenly thrown from the order of the everyday into a sur-reality that we were already immersed but had somehow eluded us." The plague's bloody presence violently punctured our banality and reminded us what that foretold, our powerlessness to it and responsibility to Connie's impossible demand. We watched Lusijah and Deb drive her away towards the ferry, the hospital off island and her fate. Next, I remember, Graham and I were sitting on a tiny sofa in the sunlight as everybody else gathered into the room for the first session of the day. We were instinctively holding on to each other for dear life, half mad with shock and horror. Such a tender moment. "We were all engulfed in a fierce eddy of unintelligible forces that were swirling around and through us". We then stood up and "moved into the gathering storm" (end note about my use of this now altered vignette in other works Brooks, 2018, 2021).

First Structural (unconscious) moment of time, individual encountering the Real

The sight of Connie's blood presented each us with a singular dilemma. Her bleeding out reminded us not only of the plagues deadly omni-presence, but how this reality affected us personally. Lacan refers to this moment as encountering the *Real,* or in our situation the Real of AIDS stimulated by encountering Connie's bloodless body. We know we have encountered the Real when we are in the face of an event that we cannot comprehend, make sense of or articulate in a cohesive narrative. Each of us was brought to our knees by the sight of her blood and what that foretold. The effect of her blood would become a nodal point of convergence for each of us and enabled everything else that happened next. I belabor this point because the reality of a plague in its many dimensions - biological and psychological effects are fundamentally ungraspable except in those moments when its effects touch down and incarnate itself into our body. We are thrown into another dimension of time, disoriented and disregulated. Vulgar repulsion, shame, unshakable anxiety and horror take hold and we cannot shake it. Nevertheless, it is within this state that we may bear witness to fragments of a truth about our own existance. We are no longer entirely held by the invisible constraints that bound us into some kind of conformity prior to the engaging the real her blood.

Second structural moment, that of person in relation to others

We move into the second structural moment baffled in our dysregulation but gripped by an awareness that there is something to know about our shared predicament that exceeds the factual evidence. "What is happening?" "What am I to do?" Instinctively, each of us turns outside ourselves to the broader social field of psychical inter-subjectivity to verify what we have witnessed and to ascertain who I am in it. A lot of what happens within inter-subjective activity is unconscious (or barely conscious) fantasy and this is a focus of analytically driven group psychology. My fantasy of who I think I am to you in a given community forms the very core of my identity, sense of belonging and existential purpose (Hook, 2008, 279). These interactions shape my story about what to believe, what I must do to belong and who I identify with. Lacan refers to this early inter-subjective discovery as "egomimiming" (Lacan, 1991). Egomimiming is limited to the individual's perceptions of others as being contrasted with one's own. Fantasmatic communications at this level happen at a glance. We can imagine that at this point in our vignette, there must have been some milling around so that group members could seek answers to implicit questions about one's place and status as it regards the shared dilemma that remains yet undefined.

The individual goes outside himself hoping to obtain the answer from others regarding what is happening and what I should do about it. "Are you thinking or feeling what I am thinking and feeling?" "What did you see?" "What do you want of me?" "What is my place here?" "What do I want from you?" These recognition/identity seeking fantasies are in part determined by the historical structures that the individual has not created and whose frame of reference is impossible because of his place in history (Butler 1997). For example, the gay man living with AIDS in the height of the pandemic is in double social jeopardy. He cannot be recognized by a polity (or society) on two counts. First, the historical structures that determine *who* is valued in a society do not recognize the gay man as worthy and second, the person dying of AIDS has a mysterious deadly disease beyond the society's capacity to care for him even if he was worthy. "You are a leper-thing and unworthy of care or consideration. We do not recognize your existence." His predicament then is to find himself standing *in-between* the struggle for identity through the recognition of the other and the individual for whom identity is impossible due to the historic-political forces that foreclose openness to multiple identities that exceed societies

nullifying norms (Butler, 2004 150-151). Within this in-between, the individual may find the opportunity for his own psychological individuation as well as *with others* through the emergence of a novel collective individuation.

Connie's arresting predicament not only penetrated our protective encapsulation about the real of AIDS but also penetrated a void in each of us that in turn singularly inaugurated transferential fantasies directed towards *her* and *who she is to me*. While the real of Connie's blood is shared by all of us in spite of our differences, our incompatible identifications, values and life experiences - who she is to *me* cannot be adequately obtained through recourse to the other (inter-subjectively) who is thought to hold the answer to what I am seeking. Thus, the frustrated individual now turns inward. "What does she want of me?" "What hold does her tragedy have on me?" "What am I to her?" Eventually, a new thought dawns on me that requires me to role reverse with the group on this matter. "Who is she to them, of which I am one?" (Brooks, 2021). The second moment of time culminates with the growing awareness of a singular truth that has to do with returning to Connie's impossible claim *on me* sustained in the first moment when I encountered her bloodless body.

The third moment of time, that of trans-subjectivity

In the third moment, *who I am* is not only mediated by the *inter-subjective* transactions with others but also by a third, a third that exceeds the "we," the *other's Other*. Let's break this down. In part, the other's Other has to do with my primal transferential relation to Connie that is displaced from my original caregiver. My original caregiver's enigmatic (unconscious) demands on me were driven by enigmatic demands displaced on her by her original caregiver (endnote here about Lacan and Laplanche, basic theory). Lacan's theoretical augmentation of Freud's original theory allows us to conceptualize another dimension of ancestral heritage that is unconsciously transmitted across the generations shaping personhood in addition to our genetic heritage. Lacan (and post-Lacanian thinkers) takes this principal even further because he also considers how we transfer these primal enigmatic messages that shape how we come to think about who we are in relation to each other onto societal authorities of all kinds. The other's Other, or the big Other timelessly dominates the narrative about what matters in all levels of collective discourse and is carefully sutured into significance by fantasies that are generated by

our transferential relationships between the image we have of ourselves and the belief that the big Other is *not lacking* (Žižek, 2008, 147-8). This plays out in all of our uncritically held dependencies on institutional authorities of all kinds (my boss, my president, my mentor, my parents, my doctor, my analyst, my lover, my priest and others who are *supposed to know*). Let's turn now to how this these complex unconscious dynamics play out between me, my people and my world as we return to our vignette.

The subject of our narrative now turns to Connie, the fantasy place holder for the other's Other. The claim Connie has on me is unconscious and has to do with my psychical investiture on her made known through her *lack*. For example, when we notice that our insurance company is not attending to our health care needs adequately, it is through the system's *lack of care* that we become aware of our own dependency. Through the gaps of care in any relation we may be struck with a truth about our own dependency and therefore lack. Returning to our vignette, the subject intuitively returns to the wound of his encounter with Connie's bleeding out through which her devastating lack is made known. He must face her impossible demand to give her what she lacks psychically and physically. Her psychical lack has to do with her own original trauma (with her caregiver) and transferential investiture on others to resolve that enigmatic relation. The physical lack is generated from the *evidence* her illness for which there is no cure. It now dawns on the subject that what she lacks is not his to give. She needs me to give her *what I do not have and is not mine to give* her in the first place. What Connie needs is beyond her own capacity to acquire (her own primal relational dilemma) and my ability to help her. Further, I cannot save her, heal her from AIDS, transfuse her body with my own infected blood. *Nor, can I save myself*. He must now face two lacks, his own failure to meet Connie's impossible demand and the truth about his *own* constitutive (from birth) lack sutured in his own primal wound - through which he only have a momentary glimpse. He floods with the momentary glimpse of a meta truth that his dilemma is singular but also interconnected with Connie's dilemma and that of the group's in relation to the world. This revelation inaugurates what we are calling a *trans-subjective* moment.

In a flash, or so it seems this psychical unbinding (from all kinds of heretofore restrictive norms) reveals a new dimension of temporality where the individual is given a present (now) that is not cut off from a haunted past or a future worth living. He can see Connie, himself and the group with raw and open eyes. Another question suddenly arises. "What do I want of myself in

relation to your impossible demand?" "What do you need of me that requires me to exceed how you have been cared for and how I have cared or been cared for in this wretched world?" The weight of his awareness sinks in further. "She relies on me to know how to be and what to do no matter what" (end note about ego ideal Verhaeghe and Vanheule). He can now coherently acknowledge his own limits and culpability in Connie's dilemma and extends this responsibility to the group through what he now believes is a "shared" but yet unspoken truth. "Her fate is also mine, and all of ours" (endnote about my use of 2021 chapter is revised but palpably present).

Putting his private revelation into a narrative form may look like this:

> I am ashamed that I was repulsed by Connie's bleeding out, by her naked vulnerability and need. I am ashamed that I treated her like a leper-thing. I now recognize that I am ashamed of myself for having AIDS. My shame is perpetuated by a brutish and senseless society to which I have been complicit. **We are participating victims in a society that condones exclusivity and "we must conceive of ourselves as formally responsible [and] guilty for it"** (Žižek, 2008 247). These societal forces only gave us a sense of belonging, identity and hope for a future worth living if we denied that we were gay. Now, we are rejected for being gay and for having AIDS/HIV. The medical system, the government and people on the street, even our own friends and family members disavow our suffering, treat us like leper-things and look at us with terror and contempt. We turn against each other. We have to lie about our health- status or we will lose our jobs, our sexual desirability, our families, our friends, our homes and any desirable social standing within a society that we contributed to and depended on for care. These norms create the very criteria through which each of is judged. They are no longer my own, your own, or Connie's (Brooks, 2021, amended).

This private revelation, for which Connie has made her sacrifice unveils a crucial void within a social order whose implicit messaging conveys an *ideology of carelessness*. From this crack in the social order and *only from it* can a new basis of care be created through novel interpretations of what matters based on a reality of our shared precarity as beings. In response to his revelation, the subject makes a fundamental choice to act thus opening a new and terrifying space to everything. The stakes are high however as he cannot be certain if he is up to the task and continues to doubt why he has this mandate in the first place. Lacan poignantly describes the juncture prior to acting this way:

> "Only the slightest disparity need appear in the logical term "Others" for it to become clear how much the truth for all depends upon the rigor of each: that truth – if reached by only some – can engender, if not confirm, error in the others; and, moreover, that if in this race to the truth one is but alone, although not all may get to the truth, still no one can get there but by means of others" (Lacan, 2006 212).

In other words, the demonstration of a shared truth does not mean that everyone spontaneously receives the same revelation and acts on it all at once. More realistically, the revelation of one becomes the basis for a collective action that is simultaneously shared by enough of the others in

various stages of a similar (enough) awareness, so that a "rigorous" gestalt occurs and is acted upon through the "means of others." What makes the moment trans-subjective, or "trans-individuating" as Gilbert Simondon poses the phenomena is the psychological and social buy-in made by each of us towards a common good (endnote about Simondon). What makes the action *political*, recalling Žižek, is each individual's decisive break from a hegemonic social order whose mandate condones exclusivity in how care is distributed. What makes the action *psychological* is that each of us must wrestle with our own psychical traumatisms so that we may define for ourselves what is real, true and good with regard to how we respond to Connie's dilemma and be willing to take responsibility for our beliefs and actions from that basis.

Let us return to our vignette where the root of this discussion stems. There, I stated that our entire community moved into action with many moving parts. It is not known if somebody actually said, "Let's all carry her together to the van on her mattress." We do recall the group functioning in tandem to a shared knowledge that whooshed out of our collective body into a new order of care. As Greg Carrigan described years later, "We could all see our own death then and it was at the same time so healing because we were *all lifting her on the bloody mattress*, over us, she floated over the top of us." A flute player played his flute, others guided the mattress carriers, others maneuvered her body carefully into the van. We all watched the van pull out into the morning sun, down the driveway towards the hope that she might survive her personal ordeal that had awakened us all to a new form of intelligibility and collective organizing mandate of care. "Disease was momentarily elevated from the shame stained status of the leper-thing towards another side of care" (Brooks, 2021).

References