CHAPTER III
REVIEW OF LITERATURE

HIV infection and Psychiatric disorders have a complex relationship. Being HIV infected could result in Psychiatric disorders as psychological consequences of the infection or because of the effect of the HIV Virus on the brain. HIV infected patients have a high lifetime rate of Psychiatric and Psychological disorders. Despite the impressive reduction in morbidity and mortality related to HIV infection, and due to the consequent increase in life expectancy the gained important physical, psychological and psychiatric repercussions of this disease are expected to become more relevant. Many researchers aimed to establish the predictors and frequency with which psychological problems appeared. It was first noticed that it is very common for a substantial proportion of subjects to suffer persistent and pathological disturbances. Psychiatric morbidity was defined by the presence of a DSM-IV (or equivalent to ICD-10) diagnostic code reflecting psychiatric illness. However, most studies in the beginning of the epidemic referred to psychiatric morbidity and emotional distress in HIV-infected patient during hospitalization or after consultation.

3.1 MENTAL DISORDERS IN PEOPLE LIVING WITH HIV/AIDS:

It is well known that subjects suffering severe organic diseases are burdened by a higher prevalence of mental disorders which could rise to 30-50percent. Most diagnosis are: combined affective disorders mainly with anxiety and depressive symptoms which are frequently linked to adjustment problems.

It is important for mental disorders to be promptly diagnosed among HIV infected individuals. This morbidity might spoil the efforts carried out at primary prevention and frequently diminishes coping capacity. It is also associated with higher mortality and lower antiretroviral treatment compliance and causes severe
impairment of the quality of life among HIV infected individuals. Among HIV infected patients psychiatric evaluation should be made in the wide context of a multi systematic disease not only with an ample variety of psycho-pathologies, but also with organic alterations and drug toxicities. Psychiatric symptoms may be difficult to differentiate from some manifestations of AIDS. These facts make psychiatric syndromes diagnosis in HIV positive patient troublesome. Physicians may also erroneously view psychiatric symptoms as a natural reaction to HIV diagnosis which sometimes leads to the appropriate psychiatric or psychological treatment not being aggressively pursued.

3.2. PSYCHIATRIC HISTORY:

Psychiatric history prior to HIV infection acquires great relevance. HIV infection is more prevalent among populations known to be a higher risk for mental disorders such as subjects with homosexual practices or intravenous drug users. The most frequent diagnosis in homosexual men are major dependency and substance abuse especially alcohol use disorder. Psychiatric disturbances mostly associated with substance abuse and a higher risk for HIV infection include bipolar disorder, schizophrenia, schizoaffective disorders, borderline and antisocial personality disorders and depression.

3.3. PSYCHOSOCIAL ASPECTS:

Poor social support and the use of avoidance or denial as a habitual way of coping, are factors related negatively to disease adaption, but positively to Psychiatric morbidity. Other factors associated to the of significant Psychiatric and Psychological sequel are life events in particular diverse ones that can be associated with an increased rate of early HIV disease progression and exposure to grief due to AIDS.
3.4. SOCIODEMOGRAPHIC CHARACTERISTICS:

Personal and demographic characteristics such as older age, pre-morbid IQ, educational attainment, female gender, low income and ethnicity are also associated with Psychiatric morbidity.

3.5. STUDIES ABOUT PSYCHIATRIC MORBIDITY IN PEOPLE LIVING WITH HIV:

Chuang et al (1992) conducted cross sectional study on 173 subjects who were homosexuals using Semi-structured interview (DSM-III-R), Profile of Mood States (POMS) and Beck Hopelessness Scale (BHS). The conclusion were high current rates of Axis I disorders and adjustment disorders among HIV positive compared with HIV negative subjects and high current rates of organic mental disorder among AIDS subjects.

In a paper presented by Rabkin J(1996) he has placed primary emphasis on studies that have used structured interviews for diagnosis of prevalence of psychiatric disorders in HIV positive samples. Review of various studies suggested that HIV positive status or any stage of illness are not by themselves strong predictors of mood anxiety disorders. But they can also be a consequence of risk behaviour group membership.

A study was conducted by Kantin, S. Kolb, M.A., Hudzik, G. et. al (1998) with an objective was to describe psychiatric disorders among HV infected patients followed up in a general hospital to determine factors associated with these psychiatric disorders. The methods used in the study were psychometric scales, one hour standardized questionnaire and psychiatric diagnosis according to DSM IV and ICD 10. The number of participants was 65. Nearly half the participants were unemployed or without occupational activity. The prominent modes of transmission were heterosexual (53.1%) and IDU (29.7%). Nearly 60% patients presented
psychiatric disorders. According to the DSM IV criteria mood disorders were observed in 40% respondents, very few i.e less than 10% represented anxiety disorders and only 9.2% represented with other psychiatric disorders. The study revealed that psychiatric disorders were independent of occupational activity, viral load, HIV clinical stage and sexual activities. The conclusion was that more than half (57%) respondents presented psychiatric disorders. Two factors were associated with psychiatric disorders. one related to HIV disease and the other related to drug abuse.

The association of psychiatric disorders and HIV infection in a correctional setting was studied by Jaques B, Suzanne D, John P, et.al (2002) at the centre of Epidemiology and Biostatistics/Department of Paediatrics at the University of Texas, Health Science Centre. Psychiatric disorders such as bipolar disorder, schizophrenia and depression have been associated with both HIV associated risk behaviour and HIV infection. The present study examined the association of six major psychiatric disorders with HIV infection in one of the largest prison population. The respondents were 3,36,668 inmates of Texas Department of Criminal Justice. Information was obtained on medical conditions and information on socio-demographic factors was obtained from an institutional-wide medical information system. The results indicated that the inmates were diagnoses with HIV infection exhibited elevated rates of major depression, dysthemia, bipolar disorder, schizophrenia and schizoaffective disorder. The present cross-sectional study’s finding of a positive association between HIV infection and psychiatric diagnosis among inmates holds both clinical and public health relevance. It will be important for future investigations to prospectively assess the underlying mechanisms of these associations in the correctional setting.

The association of psychiatric disorders and HIV was studied by Olley B and Seedat S. et al. According to this study psychiatric disorders are common and emerge soon after diagnosis or during the subsequent course of illness. However, there are a
few prospective studies on the rates of psychiatric disorders in HIV/AIDS, particularly in the context of the developing world.

Olly B. and Seedat S (2005) also studied rates of psychiatric disorders in HIV this study. Sixty five patients recently diagnosed HIV were interviewed on presentation to a hospital-based HIV clinic and then 6 months later. The tools used were MINI International Neuropsychiatric Interview, the Carver Brief COPE and the Sheehan Disability Scale (SDS). Exposure to negative life events and risk behaviours was also evaluated. The results indicated that the overall prevalence of Psychiatric disorders in the follow-up period remained high i.e 56% of patients had at least one psychiatric disorder at 6 months.

Depression and Post traumatic Disorder (PTSD) were most prevalent at both the baseline (34.9% and 14.8%) and follow up (26% and 20%) respectively. More than half patients with depression at baseline improved i.e., 55.1%. A new onset of both depression and PTSD was observed in follow-up. Depression was said to have been associated with factors like disability in work/social life/family functioning; greater number of negative life events and a decline in CD4 count. Analysis revealed that a diagnosis of PTSD on follow-up was significantly associated with a longer duration of infection and a baseline disability in work/social life/family functioning. Persistence of risky sexual behaviour was also noted with a significant higher number of participants reporting non-use of condom on follow-up. There appeared to be a shift from maladaptive coping behaviour to more adaptive coping behaviour over a 6-month period. The study suggests that the rate of psychiatric disorders in HIV/AIDS patients was consistent over time. The findings emphasize the importance of regular evaluation for psychological disorders in HIV/AIDS patients, not only at the commencement of treatment but also during subsequent follow-up visits.
A study was conducted by Myer, Smit and Parker et al (2008) to study Common Mental Disorders among HIV-infected individuals in South Africa and predictors and validation of Brief Rating Scales. A cross-sectional study was conducted among individuals enrolled into HIV care and treatment near Cape Town, South Africa. Psychiatric diagnosis was measured using MINI-International Neuropsychiatric Interview. Brief rating Scales for depression (the Centre for Epidemiological Studies Depression Scale (CES-D), Post traumatic stress disorder (PTSD), the Harvard Trauma Questionnaire (HTQ) and alcohol dependence/abuse (the Alcohol Use Disorders Identification Test (AUDIT). Majority of the respondents were females. Forty Eight percent were receiving ART. Overall, the prevalence of depression, PTSD and alcohol dependence/abuse was 14%, 5% and 7% respectively. The data demonstrated high levels of depression, PTSD and alcohol dependence among HIV infected individuals.

3.6. ANXIETY:

Excessive anxiety contributes to a sense of helplessness in which a person feels little control over the present or future and continues maladaptive behaviour patterns. Anxiety is a major health hazard in HIV seropositive individuals. This is because it is probably one of the factors responsible for the quick progression of their HIV seropositive status to AIDS.

The study of anxiety among those with serious chronic medical conditions has emerged as an important area of research and public health interest. The term anxiety refers to the unpleasant sense of apprehension that accompanies physical symptoms such as sweaty palms, shallow breathing, rapid hearts rate, general nervousness and feelings of stress. Many people often perceive anxiety to be negative but anxiety is not necessarily detrimental. It can be helpful when it becomes the impetus for making behaviour changes to reduce future risk re-exposures, to discontinue practices that
would permit illness transmission and to adopt more healthy styles of living. However anxiety levels are harmful when they interfere with the clients comfort and effectiveness in daily life and create subjective misery. Anxiety can produce ulcers, headaches, rashes, backaches, skin rashes and a variety of other physical problems. Anxiety is one of the most common reactions of many individuals upon receiving a diagnosis that they are infected with HIV. Anxiety affects the well-being of HIV positive individuals when they preoccupy their minds with the possibility of future helplessness or dependency. There may even be awful feelings of abrupt and complete loss of control over one’s life. They often have profound feelings of grief about the loss they have experienced or are anticipating. As the need for care increases, a sense of loss of privacy and control over life is also experienced. This feared dependency might be physical as the person imagines future scenarios involving eventual depletion of saving. Loss of a job means loss of income which in turn means loss of physical attractiveness and sexual relationships, status in society, financial stability, independence and lifestyle.

Mwiya Hiamunga Imasiku conducted a studied the intensity of anxiety in HIV positive individuals. The samples consisted of 180 subjects. Half of the individuals came from India and half from Zambia. The findings of the study revealed that HIV positive individuals have higher levels of anxiety. Anxiety was found to be positively correlated with physical illness. This indicates that high level of anxiety and physical illness behaviour seem to co-exist. It is therefore likely that a high level of anxiety is a core factor that might be responsible for the quick progression of HIV infection to AIDS.

Grant and Atkinson (1994) through their study on psychiatric aspects of AIDS revealed that over 20% of sero positive individuals have been reported to experience anxiety symptoms at least once in a month, compared with negligible rates in the community among low-risk controls.
A study conducted by Atkinson et al (1988) having a cross-sectional design and using Diagnostic Interview Schedule (DIS) using DSM-III, Symptom Checklist 90- Revised (SCL-90-R) and Profile of Mood States (POMS) revealed significant elevated lifetime and 6 month rates of major psychiatric disorders (generalised anxiety disorder and major depression) in HIV infected and sero negative homosexual men.

Williams et al (1991) conducted a study with 208 homosexual men as sample. The methods used were SCID for DSM-III-R Global Assessment of Functioning (GAF), Hamilton Anxiety Rating Scale (HARS), Hamilton Depression Rating Scale (HDRS) and Brief Symptom Inventory (BSI). The conclusions of the study were low rates of current depressive and anxiety disorders in homosexual men with and without HIV infection and high lifetime prevalence for depressive and substance abuse/dependence disorders. Drown et al (1992) studied 442 men belonging to the age group of 18 to 44 years. The anxiety measures that were used are SCID for Axis I and II for DSM-III-R, HARS, HRDS, POMS, GAF, SCL-90-R, Beck Depression Inventory (BDI) and State Trait Inventory (STI). The conclusions were high prevalence of current anxiety diagnosis especially mood and anxiety disorders. High lifetime prevalence of mood disorders, alcohol use disorders and psycho-active substance use disorder. Amazingly in this study very high prevalence of current sexual dysfunction was also observed.

Catalan et al (1992) conducted a cross-sectional study with 73 men using Present State Examination (PSE), Profile of Mood States (POMS), Beck Hopelessness Scale and Self Esteem Scale (SES). The results of the study indicated that seropositive subjects had significantly worse total PSE scores and had high levels of hopelessness and symptomatic HIV positive subjects had higher depression levels than seronegative subjects.
Mary Ann Cohen, et.al (2002) conducted a study to assess the prevalence of distress, anxiety and depression in persons with HIV infection. The methods used were Hospital Anxiety and Depression Scale and the Distress Thermometer. The results of the Distress Thermometer revealed that 72.3% had a score of 5 or greater, demonstrating high distress. The results of the HADS revealed that 70.3% had high anxiety with a score of 7 or greater indicating depression. The study demonstrated a high prevalence of distress, anxiety and depression among persons with HIV. The HADS and the Distress Thermometer showed a good correlation with each other.

3.7. SUICIDE:

Suicide is another psychiatric disorder that has captured attention of many researchers in the west. Suicide is an off shoot of depression and has been studied by Kelichman and Heckman (2000). The objective of this study was to examine the suicidal ideation amongst middle aged and older PLWHAs. The sample size was that of 113 PLWHA subjects older than forty five years. The tools used were questionnaires which included questions on suicide ideation, Quality of Life, coping and social support. The results demonstrated correlations between suicide ideations and emotional distress. Disclosure within the family and lack of social support was also positively co-related to suicide ideation. However, less than 30% respondents had suicide ideations. The conclusion lics in the fact that age was a significant factor that was responsible for a greater degree of suicidal ideation which calls for greater targeted interventions.

Kathleen. J., et al (2000) studied suicide ideation rate amongst PLWHA at the Centre for Research at the Medical College of Wisconsin in 1989-99. In this study also the age limit was that of 45 years and older. The sample consisted of 85 men and 28 women. Tools used were self-reported questionnaires. The study revealed that less than 30% i.e., only 29 respondents tried to attempt suicide in the previous week. 27 of
them selected the statement indicating that they had thoughts of killing themselves but would not carry them, while 2 respondents selected the statement indicating they would like to kill themselves. Significant finding was that none said they would kill themselves. An unpredicted result in the study was that disclosure to friends was a significant factor giving rise to suicidal thoughts.

Both the above studies have suggested that disclosure has proved to be a precipitating factor that led to suicidal ideations. Hence counselling enhancing perceived support, increasing coping resources for persons who have thoughts of suicide but are yet not in need of crises intervention should be regarded as a priority.

A cross sectional study was conducted to investigate the prevalence and predictors of suicidal ideation and past suicide attempt in a sample of 229 HIV positive and negative homosexual and bisexual men. Sixty five of them were HIV negative and 164 were HIV positive. Tools used in this study were Beck Depression Inventory and the General Health Questionnaire. The aim of this study was to study current suicidal ideation and past suicide attempt as dimensions of psychiatric morbidity in HIV positive people. The results indicated that suicide ideation was greater in HIV positive respondents as compared to HIV negative respondents. However it should be noted that the study brought forth the fact that suicide ideation was not due to the presence of psychiatric disorder but it was the severity of HIV infection and lower patterns of psychological adaptation of disease. The findings provide a base for improving clinical knowledge about the factors that may increase suicide ideation and risk.

Andrew L. and Donnenberg J(1996) carried out a study with an objective of examining suicide risk among HIV positive. The tool used was the National Death Index. The sample consisted of 4147 HIV positive military applicants who were disqualified in the US, between October 1985 and December 1993. The results
indicated that HIV positive applicants were 92% male. 10 HIV positive and 24 HIV negative applicants died of suicide. It was noticed that the suicide rate was higher in these applicants as compared to the general US population.

In the Indian context suicidal ideation, depression and anxiety among HIV infected was studied by Chandra Prabha et. al (1996) at the National Institute of Mental Health and Neuroscience, Bangalore. The inclusion criteria was those PLWHAs who were recently diagnosed as HIV positive. Anxiety, depression and suicidal ideation were assessed amongst 51 seropositive men and women with various stages of infections. The results indicated that less than 14% showed serious suicidal ideation. Analysis also revealed that presence of pain, alcohol abuse, poor family relations and pressure of AIDS in the spouse were significant factors associated with depression, anxiety and suicidal ideation.

Timothy G. Heckman et. al (2002) studied the rates and predictors of suicidal thought among HIV-infected persons living in rural communities of 8 U.S. States. At baseline, participants reported thoughts of suicide, psychological symptomatology, life-stress or burden, ways of coping, self-efficacy, social support and barriers to health care and social services. Analysis showed that 38% of HIV-infected persons had engaged in thoughts of suicide during past week. It was also revealed that participants who endorsed thoughts of suicide reported more depressive symptoms and experienced more stress associated stigma.

Kelly B, Raphael B and Judd. F. (1998) performed a cross-sectional study to investigate the prevalence and predictors of suicidal ideation and past suicide attempt in an Australian sample of HIV positive and HIV negative homosexual and bisexual men. Sixty-five HIV-negative and 164 HIV-positive men participated. A suicidal ideation score was derived from using five items selected from the Beck Depression Inventory and the General Health Questionnaire (28-item version). Lifetime and
current prevalence rates of psychiatric disorder were evaluated with the Diagnostic Interview Schedule Version-III-R. The HIV-positive (Centre for Disease Control and Prevention [CDC] Stage IV) men (n=85) had significantly higher total suicidal ideation scores than the asymptomatic HIV-positive men (CDC Stage II/III) (n=79) and the HIV-negative men. High rates of past suicide attempt were detected in the HIV-negative (29%) and HIV-positive men (21%). Factors associated with suicidal ideation included being HIV-positive, the presence of current psychiatric disorder, higher neuroticism scores, external locus of control, and current unemployment. In the HIV-positive group analysed separately, higher suicidal ideation was discriminated by the adjustment to HIV diagnosis (greater hopelessness and lower fighting spirit), disease factors (greater number of current acquired immunodeficiency syndrome [AIDS]-related conditions), and background variables (neuroticism). Significant predictors of a past attempted suicide were a positive lifetime history of psychiatric disorder (particularly depression diagnoses), a lifetime history of injection drug use, and a family history of suicide attempts. The findings indicated increased levels of suicidal ideation in symptomatic HIV-positive men and highlight the role that multiple psychosocial factors associated with suicidal ideation and attempted suicide play in this population.

3.8. DEPRESSION:

Depression is prevalent and interfering yet potentially treatable illness commonly comorbid with HIV/AIDS. In HIV, symptoms and diagnosis of depression have been associated with poor adherence to antiretroviral medication regimens and to accelerated disease progression. Symptoms of depression include persistent sadness, loss of interest, decreased appetite, low concentration, sleep disturbances, guilt/worthlessness, feelings of decreased energy, psychomotor retardation and suicidal ideation. In addition to significant distress symptoms of depression can also cause other health related functional and quality of life impairments.
Treatment of depression in HIV/AIDS patients is jeopardized not only by the inability to diagnose the condition specifically but also by poor adherence to treatment, which has many social, medical and non-medical factors. Majority of studies done in India have reported higher rates of depression among women compared to men which is implicated to higher caregiver burden, more social stigma and poor health care. Greater severity of depression, on the other hand, has been found to be associated with greater frequency of injection risk among depressed injection drug abusers making them more vulnerable to HIV infection.

Cruess.D, Douglas, S et.al, (2005) conducted a study to examine whether improvements in the diagnostic status of major depression are related to increases in Natural Killer Cell activities among sero positive women. Among the 57 HIV sero positive women improvements in the diagnostic status of depression and decreased in scores on the 17 item Hamilton Depression Rating Scale. They were significantly associated with increase in NK cell activity over time. Eleven women (19.3%) had a major depression diagnosis that resolved over time and this group also had a significant increase in cell activity.

The study suggested that depression may impair certain aspects of inmate cellular immunity relevant to delaying the progression of HIV disease and that these alterations are reversible with the resolution of a depressive episode. These findings support an examine of NK cell activity in assessments of the relationship between depression and morbidity and mortality in HIV disease.

Morrison and colleagues examined the prevalence of depression and other mood disturbances among HIV seropositive and HIV seronegative women and found that HIV seropositive women without an active substance abuse problem had a significantly higher prevalence rate of major depressive disorder (19.4%) than HIV seronegative women (4.8%).
Review of various studies done by Kalichman C and Kathleen J (2000) brought certain facts related to psychological sequel of HIV infection. Research has shown that depression appears to be prevalent in the early stages of HIV infection. Depression is also complicated by frequency of bereavement from AIDS related deaths. Suicide risk is high and in most cases is equal to the degree of depression. Two parameters that have not yet been given due attention in terms of research are anger and guilt.

Depression was studied in co-relation with stigma and discrimination amongst men and women living with HIV by Leickness C and Kalichman S et.al (2000). The objective of the study was to identify the prevalence of discrimination experiences and internalized stigma amongst PLWHA. The sample consisted of 420 HIV positive men and 643 HIV positive women. It was found that 40% of persons with HIV had experienced discrimination resulting from HIV infection and one in five lost a place to stay or a job because of his positive status. More than one in three participants indicated feelings of guilt, dirt and shame. A hierarchical regression model showed that lack of social support, demographic characteristics, health treatment status and internalized stigma were significant predictors of cognitive-affective depression. It can thus be said that an urgent need for social reform to reduce AIDS stigma and the design of Interventions to assist PLWHA are needed.
3.9. DEMENTIA

A proportion of HIV infected persons can develop brain disorders not only from secondary complications but also by direct effect of the HIV. Primary HIV related brain disorder include HIV associated dementia or AIDS Dementia Complex (ADC) and to a lesser degree, cognitive impairment, the HIV associated Minor Cognitive Disorder (MCD).

HIV associated dementia is characterized by marked impairment in cognitive functioning, involving the ability to observe, concentrate, memorize and quickly and flexibly process information. Marked disturbances in language abilities and psychomotor slowing are also observed. The prevalence and severity of AIDS associated dementia is related to the rate of immunosuppression and disease stage. In 3 to 10% of patients dementia is the first AIDS defining diagnosis. Before fulfilling dementia diagnostic criteria, cognitive impairment is detected in up to 50% of AIDS patients. Neuropsychological deterioration seems to parallel with CD4+ lymphocyte reduction which has been recently shows to be a better marker than viral load for cognitive impairment. A reduction in the incidence of ADC should be expected with the widespread use of HAART, but its impact on the incidence and clinical course of this complication is still unclear, controlled studies have reported a positive effect of antiretroviral treatment on the impairment of neuropsychological test in ADC.

Finally there is some evidence that psychiatric disturbances in symptomatic HIV infection may be associated with subtle brain involvement preceding the immunological and neurocognitive impairment characteristic for AIDS.
3.9.1. Diagnostic Criteria for HIV associated Dementia:

I. Acquired abnormality in at least two of the following abilities, present for at least one month and causing impairment in work or activities of daily living.

1. Attention or concentration

2. Speed of information processing

3. Abstraction or reasoning

4. Memory or learning

5. Speech or language

II. At least one of the following

1. Acquired abnormality in motor functioning

2. Decline in motivation or emotional control or change in social behaviour.

III. Absence of another cause of the above cognitive, motor behavioural symptoms or signs.

Sacktor N and Bacellar C et. al (1996) conducted a study at the Department of John Hopkins University, School of Medicine, Baltimore with an objective of determining if sustained decline in psychomotor speed test is associated with an increased risk of progression to dementia. AIDS, Clinical and neuropsychological data were obtained on 291 HIV positive homosexual men. The results indicated development of dementia AIDS and death. HIV positive subjects with sustained psychomotor slowing had a hazard of dementia AIDS and death.

Day et al.(1996) conducted a study to determine the incidence of clinical dementia in patients with AIDS and ARC, 29 men and 3 women, 19 with ARC and 13 with AIDS, were examined neurologically and neuropsychological every 6 months.
Though no patient was clinically demented at baseline, 9 (28%) dementia during the 2 yrs. Progression to dementia was associated with neuropsychological deterioration.

Chiesi A and Vella S et al. (1996) studied the epidemiology of AIDS Dementia Complex (ADC) in Europe the subjects were 6548 adult people with AIDS consequently diagnosed from 1979 to 1989. The main outcome of the study was co-diagnosis of ADC at the time of AIDS diagnosis. AIDS Dementia Complex was reported in 295 patients i.e., 4.5%. The study suggested an increase in the risk of developing ADC either at the time of AIDS diagnosis or thereafter is associated with increasing age, intravenous drug use, and decreased CD4 cell count. Women tend to have a higher risk of ADC at the time of AIDS diagnosis.

Wong M and Robertson K et al (2007) measured the frequency and associated risk factors of HIV dementia in an HIV clinic in Kampala. The sample consisted of 78 HIV seropositive patients. Participants underwent detailed socio-demographic medical history, functional, neurologic and neuropsychological evaluations. The results indicated that 31% (24 of 78) of the HIV patients had dementia. Advanced age and low CD4 counts were the variables identified as significant risk factors. Each additional 10 years of age conferred a greater than two-fold risk of HIV dementia. The study concluded that HIV dementia is common in HIV seropositive Ugandan individuals attending AIDS clinic. It is more frequently associated with patients.

3.10. SOCIAL SUPPORT:

The concept of Social Support is an omnibus term relating to different aspects of social relationships. It includes; the network structure or social interactions, emotional, psychological, informational support and the perceived quality or adequacy of this support. Researchers arrive at a consensus that access to social support and perception of feelings are important buffer (referred to as the buffering
model of social support) to the negative psychological consequences of stressful experiences. When it comes to life threatening diseases, it is likely that social support needs and type of support may vary over the course of the disease. Social support decreases the effects of stress (Cohen and Wills 1985). Social Support and HIV have been studied in relation to its impact on physical health but in particular psychological functioning. Social Support is strongly associated with mental health (Sandler and Barrera, 1984, Searson et al. 1983). For people with chronic illness there is a positive association between support and psychological resources that help the individual to cope with illness. There is also evidence, that diagnosis of a chronic illness may erode existing support and that people with poor prognosis may receive the least support. Although some studies have found a relationship between certain aspects of social support and self-reported physical health, Green emphasizes that as of yet no significant correlation has been found between objective measures of health status and social support. Many of the greatest difficulties faced by chronically ill persons result from their physical disability. People living with HIV related illness face not only the challenges and difficulties that accompany any serious medical condition, but also the additional problems of stigma and discrimination. There is a strong level of association between social support and psychological well-being among people with HIV. Psychological state has been correlated with number of confidants and satisfaction with perceived availability of support (Linn et al, 1993, Ostrow et al, 1987) and those who can are satisfied with their level of support received have a greater ability to cope (Lesserman et al, 1992).

Hays et al (1992, 1993) found social support predicts depression now and one year later. Social support also acts as a buffer against psychological distress. According to Turner there is evidence suggesting that to some extent depression is a determinant of support.
Ostrow et al. (1991) show that the relationship between social support and mental health among black and white gay men with HIV is quite different, with the former tending to be more reliant on gay friends and the latter upon their families. Gay men are reported to have better support than those belonging to have a degree of distance from their families.

Fleishman and Fogal argue that seeking support may be a response to distress; that is when distress reaches unacceptable levels the individual seeks support. Just as social interactions can be of support they can also be a source of stress.

Ingram et al. point that negative interactions may have important adverse consequences on psychological functioning and may be particularly salient for people with HIV given the stigma attached to the disease. They also emphasize the little attention paid to the nature of and effects of negative social interaction.

Ingram et al. also developed a measure to access HIV-related unsupportive or upsetting social interaction. They could identify four types of unsupportive responses that people with HIV might receive from others; insensitivity, disconnecting, forced optimism and blame. Their findings suggest that unsupportive social interaction and social support are relatively independent constructs. Data reveal that persons who reported more HIV related unsupportive social interactions also reported being more depressed. Unsupportive social interactions predicted a significant amount of variance accounted for by physical functioning and positive social support.

Ingram et al. thus emphasize the importance of accessing positive social support and negative social interactions separately and suggest that these variables make independent contribution to well-being among people with HIV.

Various functions of social support have been distinguished by various researchers. Few to mention are the emotional function, the instrumental function, the material function and the informational function. The emotional sustaining types of
help appear to be the most desirable by people with HIV, although they are not significantly correlated to physical health or psychological well-being.

Hays et al found that HIV/AIDS related informational support was critical in buffering depression for men experiencing HIV-related symptoms.

Thoits (1995) argues that coping and social support have several functions in common and therefore social support can be conceptualized as coping assistance. Some studies show that active behaviour coping is related to higher levels of perceived social support and avoidance coping to less social support.

Serovich, Julianne M, Brucker P and Kimberly J (2000) carried out a study with an objective to test a barrier theory of perceived social support to HIV positive gay men. The proposed model was tested for friends and family separately in order to investigate the uniqueness each provided. In both models it was hypothesized that the presence of barriers to social support (availability, intimacy and disclosure) diminished acquisition of social support. The influence of barriers on the relationship between social support and health outcome (i.e. depression, positive cell count) for both friend and family models was also investigated. Thus we can say that in general positive gay men support barrier theory premises for both family and friends. The study proposes implications for helping professionals and researchers.

Abramowitz, Susan; Koenig and Linda et al (2009) conducted a study to examine the nature, type, and source of social support available to a diverse group of HIV-infected adolescents and the relationship between social support and depression. Data were obtained from the baseline assessment of Adolescent Impact, a behavioral intervention conducted in 2003-2006 involving 166 HIV-infected youth, ages 13-21, in care at four urban medical centers. Youth completed the Medical Outcomes Study Social Support Survey, Beck Depression Inventory, and questions about HIV-specific social support including locus (family and friends) and type (structural, perceived,
instrumental, and satisfaction) Linear regression modeling examined the relation between HIV-specific and general perceived social support, and between social support and depression. Participants were predominately minority (72% black and 20% Hispanic); parentally infected (60% PIY), and female (53%). Most had someone to either remind them to attend (71%) or to bring them to clinic (60%), a majority family (53%) and fewer friends (4%). More youth reported being satisfied with family (64%) social support than that from friends (51%). Behaviorally Infected Youth (BIY) had significantly more friends who knew their serostatus than Perinatally Infected Youth (PIY) (means = 4.5 and 1.7; p < 0.001), but received significantly less help from family in accessing care (p < 0.001). Satisfaction with family social support was the best predictor of general perceived social support with general perceived social support and behavioral mode of transmission the best predictors of depression. Regular screening of HIV-positive youth for social support needs, especially BIY and identification of sources for social support should be a regular part of care.

3.11. TRAUMA AND COPING:

With regard to HIV/AIDS far less has been written about loss and grief than about other aspects of the bereavement. Although traditional bereavement models offer pragmatic approaches to dealing with the grief process, they are not able to address the trauma as that result from multiple losses, cumulative grief, HIV/AIDS stigma and the horrors of HIV infection. Martin (1988) studied the mental health effects associated with AIDS related losses in gay men and found traumatic stress responses such as panic attacks, nightmares, and numbing. Dilley, Pies and Helquist (1989) discussed the stresses endured by those affected by HIV/AIDS and how these stresses result in psychic trauma. Traumatic stress occurs when an individual is overwhelmed by personal and environmental circumstances and lacks adequate support to address these stressors. In adapting to traumatic experiences clients need help in integrating their conceptualizations of life events with their conceptualizations
of themselves and their world. Persons who experience chronic trauma feel that their lives have been altered and may feel like victims. Trauma victims often cope with loss through immersion (in work), avoidance behaviour, withdrawal, substance abuse and other addictive behaviour. Coping with HIV/AIDS trauma is complicated by various factors. Appraisal is made difficult by overwhelming nature of the experience and the formidable task of understanding its emotional impact.

Sowder (1985) discusses various factors that increase the likelihood of maladaptive resolution of trauma, many of which apply to HIV/AIDS trauma: the intense horror of the disease, the length of disease before death, lack of resources to respond to loss, the perceived loss of control, the prolonged alteration of lifestyle and environment as a result of trauma.

Kelly B and Raphael B (1998) et al. investigated the psychological impact of HIV infection through assessment of PTSD in response to HIV infection. Sixty one HIV positive homosexual/bisexual men were assessed for Post Traumatic Stress Disorder in response to HIV infection (PTSD-HIV) using a modified PTSD module of the DIS-III-R. In over 1/3 of the PTSD cases the disorder has an onset greater than 6 months after initial HIV infection diagnosis. PTSD-HIV was associated with other psychiatric diagnosis particularly the first episode of major depression after HIV infection diagnosis PTSD-HIV was significantly associated with a pre-HIV history of PTSD from other causes. The findings from this preliminary study suggest that a PTSD response to HIV diagnosis has clinical validity.

Raphael and Judd F. et al investigated the psychological impact of HIV infection through assessment of PTSD in response to HIV infection. They studied 61 homosexual/bisexual men. 30% met the criteria for a syndrome of PTSD in response to HIV diagnosis (PTSD-HIV). PTSD-HIV was significantly associated with a pre-HIV history of PTSD from other causes and other pre HIV- psychiatric disorders and
neuroticism scores indicating a similarity with findings in studies of PTSD from other causes. The results support the inclusion of the diagnosis of life-threatening illness as a traumatic incident that may lead to a PTSD which is consistent with the DSM IV criteria.

Simoni J et al. (2000) conducted a study in New York on women to examine the trauma and coping mechanisms related to HIV/AIDS. The study was conducted on 230 HIV positive women. Results demonstrated that 5% of them reported a prevalence of abuse during childhood and 68% in adulthood. 7% of women reported rape or physical abuse in the last 90 days. This study emphasized on the fact that recent trauma was a co-relation to childhood. It concluded that better implications were required for improving psychological functioning in women.

Another study in relation to coping strategies amongst HIV positive men and women was conducted by Sikkema and Kathleen J. et al (2000) at the Yale School of Medicine. The sample under study were 199 HIV infected men and women. This study was conducted with an objective of studying the prevalence of AIDS related bereavement and psycho-social predictors of grief severity. It was found that 80% of HIV respondents had experienced the loss of someone close to them. Two third of the participants who had experienced an AIDS related loss reported that grief was most closely related with emotional suppression and avoiding coping strategies.

In contrast to the previous study which stressed on childhood abuse resulting into greater trauma the above study stressed on the loss of a near one as a factor contributing to the trauma of being HIV positive.

Koopman ,Cheryl, George and Felcon C et.al (2000) conducted a study with an objective of examining the relationships of coping, attachment style and perceived stress to perceived stress within a sample of 147 HIV positive people. Amongst them 80 were men and 67 were women. Multiple regression analysis was used to examine
the relationships of demographic variables, AIDS status, three coping styles, three attachment styles, and perceived quality of general social support with total score on the Perceived Stress Scale (PSS). PSS score was significantly associated with less income, greater use of behavioural and emotional disengagement in coping with HIV/AIDS, and less secure and more anxious attachment styles. This indicates that HIV positive persons who experience the greatest stress in their daily lives are those with lower incomes, those who disengage behaviourally/emotionally in coping with their illness and those who approach their interpersonal relationships in a less secure or anxious style.

3.12. HIV RELATED STIGMA, DISCRIMINATION AND SELF ESTEEM:

3.12.1. Stigma:

Stigma is defined as an attribute or quality that “significantly discredits” an individual in the eyes of others. Stigma is a process and occurs setting—certain attributes are seized upon and defined by others as discreditable or unworthy (UNAIDS, 2002). The stigmatized person is, therefore, seen to possess a spoiled or polluted identity that deviates from social norms and which deserves sanctioning (Goffman, 1963, quoted. in UNAIDS, 2002). Stigma is not unique to HIV and has been seen throughout history in relation to other diseases, including tuberculosis, syphilis, and leprosy, which are associated with the transgression of social norms. HIV has been stigmatized because it can be fatal and therefore causes fear; it is often associated with behavior that is already stigmatized, such as sex work; infection is seen as the result of “choices” made by an individual (e.g., the “choices” to have unprotected sex or to share needles to inject drugs); and it is seen as punishment for “deviant” behaviour (Bollinge, 2002). The process of stigmatizing a person may involve the following steps: differences (such as HIV status) are noted and labeled; these differences are then given a negative attribute; a distinction is made between
“us” who do not have this negative attribute and “them” who do; the person with this negative attribute is seen as others can profoundly influence the way in which people living with HIV view themselves and cope with their HIV status. Stigmatizing attitudes tended to be associated with being male, older married, less educated and unwilling to be tested for HIV (Lee et al. 2005). Such attitudes have serious implications. HIV related stigma is frequently conflated with negative attitudes towards marginalized groups and may be reinforced by legislation and legal systems that attack basic human rights. Stigma attaches itself strongly to women because of negative assumptions made about sexual risk behaviour even when a woman has not engaged in any association with HIV. Stigma can persist even when treatment becomes readily accessible. In Brazil where anti-retroviral therapy is universally available, many HIV positive children and youth still face significant stigma. In Botswana, where free antiretroviral therapy, infant formula and safe drinking water are widely available stigma was given as the reason why over half of the pregnant women in a study did not feed their babies with formula an important means of preventing mother-to-child transmission of HIV.

A recent four city study in India found that while almost 90% of the HIV positive women were infected by their husbands, they faced more stigma and discrimination than men and were blamed for their husband’s illness. Women living with their husband’s family frequently faced exclusion if the husband died and many had trouble finding anyone to care for them when they themselves became ill.

3.12.2. Discrimination:

Discrimination as defined by UNAIDS Protocol for identification of discrimination against PLWHA refers to any form of arbitrary distinction, exclusion or restriction affecting people coz of their confirmed or suspected HIV positive status. Both place a burden on human development by denying thousands of people the chance of reaching their full potential. HIV related discrimination is found in all parts
of the world but its manifestation varies from place to place. In a study conducted in an eastern Chinese coastal city half the respondents believed that punishment was an appropriate response towards those living with HIV, over half (56%) were unwilling to be friends with HIV positive people and 73% thought that those living with HIV should be isolated. Research in other parts of the country shows that to avoid stigma and discrimination some HIV positive people refuse to get information about HIV and sexually transmitted disease, staying away from health care professionals and shunning those suspected of risk behaviour in an effort to blend in with the community norms (Lieber et.al 2005).

In 2005, the Asia Pacific Network of PLWHA reported on a study carried out in India, Indonesia, the Philippines and Thailand. Over half of 762 HIV positive in the survey reported having experienced some form of discrimination from health care systems including violations of women’s reproductive rights. People who reported coerced testing were significantly more likely than other respondents to face subsequent HIV related discrimination and many were refused treatment after being diagnosed with HIV. Within the family and the community, women were significantly more likely to experience discrimination than men including ridicule and harassment, physical assault and being forced out of their homes (Paxton et. al 2005).

A variety of stigmatizing myths surround the issues of AIDS and displaced population. For example, host country citizens commonly assume that the migrant population brings AIDS with them. In fact, the reality is more complex. Many refugees and other displaced persons flee countries with lower HIV prevalence to more stable countries with higher prevalence. Spiegel and Greikspoer et.al, (2004) have reported that sentinel surveillance among pregnant women in refugee camps in Kenya, Rwanda and Tanzania found that the refugees had lower levels of HIV infection than the surrounding population.
Santana, Marie-Anne and Dancy (2002) conducted a study on how AIDS related stigma had a strong impact on Haitian women living in US. The study explored Haitian American women’s perceptions of the impact of the AIDS epidemic on their lives. The study revealed five categories of long-term effects of AIDS stigmatization, like rejection by the dominant society, self-doubt, effect on self-esteem effect on intimate relationships and rejection by Haitians with their community living in France. Tools used in this study were semi structured interview to assess personal history of their HIV infection, social and family relationships, pre-occupation with child bearing and concerns about HIV infection and its prognosis. The study revealed significant differences between the comparison of psychological and psychosocial factors between HIV positive African and European women. Demographic differences did not differ except for current professional activity, with more African women being unemployed. The medical aspects of the HIV infection for both the populations were similar. The study further revealed interesting findings pertaining to the revelation of their HIV positive status to family and friends. It was found that more European women had informed their family and friends and had a greater desire to have children as compared to their African counterparts. The study suggests that all these differences emphasized the need to adapt medical and psychosocial care to gender and to the ethnic and cultural background of the person.

Stigma and discrimination are major obstacles to combating HIV/AIDS, because it leads people to avoid being tested, and disclosing their HIV status. Keeping this theme as a pivot, Ranjana Singh conducted a study in Mumbai. 65 % male and 35% AIDS patients who attended the outpatient Department of AIDS Research and Control (ARCON) Centre, Mumbai (2007). Tools used in the study were interview schedule, in depth interview and case studies. The findings suggested that migration was noteworthy factor which led to risky behaviour. It was further observed that sharing about the status was more with the spouses followed by any other member.
The study revealed clear evidences of discrimination like divorce, separation etc. Many women were deserted by their in laws after the death of the HIV positive husbands. Fear of miscommunication led to limited disclosure of HIV status outside the family. Finally it was observed that half the respondents have isolated themselves from any kind of social gathering. The limitation of the study cannot be generalized because the sample selected was not a proper representation of HIV/AIDS persons selected in the selected area.

Emlet (2005) administered the 13-item HIV stigma scale to a sample of 88 adults who were HIV positive. The age range of half of them lay between the ages of 20 and 39, and the other half were 50 years and above. This study suggested that younger adults recorded higher score on the discrimination subscale than did their older counter parts.

3.12.3. Self Esteem:

William James played an influential role in the development of self-esteem, although he often did not refer to self-esteem but rather "to his own regard" (Katz, 1998). He described self esteem as a judgmental rating of the self, self-worth when one has high self-esteem and self degrading or self-hate when one has low self-esteem. Another influential figure to the notion of self-esteem is Morris Rosenberg (1965). Self-esteem has been described by Rosenberg as the favourable or unfavourable attitude toward the self (Rosenberg, 1965). He contends that every individual has attitudes towards a multitude of objects in the world, and one of these objects, probably the most important, is the attitude toward the self. Self-esteem is believed to play an integral role in the understanding of normal and abnormal behaviour (Roland and Foxx, 2003; Van Zyl, Cronje & Payze, 2006). This association of self-esteem to mental health asserts that self-esteem is related to positive mental health. It is believed that higher levels of self-esteem can be associated with variables
such as internal control, autonomy and high ego function. Conversely, it is suggested that lower levels of self-esteem can be associated with negative outcomes, including certain mental disorders (Roland and Fox, 2003).

With regards to HIV and AIDS, research has shown that people who are HIV positive often develop internalised stigma due to personal beliefs around the diagnosis. People who are HIV positive may therefore base their self-concept on the internal stigma of being HIV positive. On the contrary, individuals who can turn the experience of HIV-related stigma into a positive experience may be able to build their self-concept in relation to their physical well-being based on these positive evaluations. Roberts et al., (2001) contend that low self-esteem can be a risk factor for conditions such as depression and the possibility of suicide. Improvement of self-esteem can therefore be a valuable tool in addressing problems such as depression and suicide brought about by the daily demands society brings (Van Zyl, et al., 2006).

Nicholson William and Long Bonita (1990) examined the relationship between self-esteem, social support, internalized homophobia and coping strategies amongst HIV positive. The results indicated that greater homophobia and less self-esteem predicted avoidant behavior, while less homophobia and less time since diagnosis predicted proactive coping. Greater time since diagnosis, less avoidant coping, less homophobia and greater self-esteem predicted a better mood state.

Klein H and Elifon W (2002) conducted a study and examined the role played by self-esteem and HIV risk taking behaviour. The results indicated that self-esteem is associated with a variety of risky practices including the number of sex partners that people had, the number of different illegal drugs they used, their condom use self-efficacy, likelihood of having multiple sex partners. The analysis showed that the factors that impacted the PLWHAs level of self-esteem yielded six factors: educational attainment, coming from a family of origin whose members get along
well, the extent of alcohol problems, the extent of experiencing symptoms of post traumatic stress disorders.

3.12.4. Factors associated with HIV-related stigma that impact on the self-esteem of people who are HIV positive:

**Personality Organisation:**

The sub-theme personality organisation was used to classify personal characteristics that contribute to the responses that individuals who are HIV positive have towards stigmatising experiences from society. Personality organisation encompass internal resources that contribute to a person’s level of resiliency against internally threatening facets of life and hence are important factors to understand the self-esteem of people who are HIV positive.

**Levels of accessed social support as a determinant of changes in the self-esteem:**

Self belief depends on a considerable level of social support. In order for a person to overcome the stresses his or her life path takes, he or she requires social support to give meaning and worth to what they do (Bandura, 1986 & 1989). HIV positive individual’s reactions to stigma are not only pre-determined by a specific personality organisation but that adequate social support serves as a strong sustaining factor as to how a person’s personality organisation can uphold an individual who is HIV positive’s self evaluation.

**Social Identity:**

Social identity is that part of an individual’s self-concept which derives from his or her knowledge of his or her membership in a social group, together with the value and emotional significance attached to that group membership. (Tajfel, 1981, p 255 in Katz et al.,2002).
3.13. QUALITY OF LIFE:

World Health Organisation (WHO) has defined quality of life as ‘individual’s perception of their position in life in the context of the cultural and value systems in which they live and in relation to their goals, expectations, standards and concerns. Quality of life is often regarded as a concept that is too nebulous to be measured reliably with a structured questionnaire and is subjected to too much variability across cultures and individuals to have any useful validity. Perception of Quality of Life varies according to culture, personal view, habits and career advancements. The age at which most infected persons show the first signs and symptoms of AIDS, falls during the period in which they, and many of those caring for them are demonstrating their status as adults through financial and emotional independence from their family of origin, as well as consolidating career or new family plans. The appearance of symptoms and the need for care requires changes in the role of partners or friends, or a return to dependence on their family of origin. It thus results in modification in aims, resources and life habits which affect the quality of life of both the person infected and his natural caregiver. The multiple losses associated with AIDS reduces the amplitude of plans, aims and life projects of both the infected person and his caregiver. The threats and issues are thus stressful because they are undesirable and involve psychological change. The QOL of an individual depends greatly on the adoption of behaviour which is appropriate to the accomplishment of his goal and his day to day projects. According to Brown, Renwick and Negler the interest in QOL stems from trends towards greater appreciation of the personal needs and wishes of the individual within the health and social services. Although the concept has been and is used frequently there is no exact definition or thorough conceptualization of QOL. It is described in terms of positive subjective feeling of experiencing a good life.
According to Franchi and Wenzel (1998), the definition of QOL in a clinical setting the definition of QOL is directly affected by the health state and is often referred to HRQOL.

Another approach to QOL is characterized by the focus on the individual’s subjective evaluation of well-being independent of health status. Just as severe disease does not necessarily cause illness studies show that despite a severe disease people are able to maintain a feeling of well-being and satisfaction with life. QOL is viewed as being socially constructed and multidimensional. There can be no absolute value of QOL as there are many different values and expectations on what constitutes QOL. Ross and Ryan cite an example of male gay culture. Since sexuality has such a central place in construction of the HIV disease, sexuality is a central component of QOL. Contrary to this in Nilson Schonnesson’s study of QOL among gay men with HIV sexuality was not included as an aspect of their subjective perception of QOL. On the other hand, the importance of intimacy appears to be higher valued than having sex with respect to QOL.

The multidimensional character of QOL is reflected the variety of aspects in instruments measuring QOL. The traditionally constructed scales designed to measure QOL focused on measuring the impact of a given disease on physical functioning and to a lesser extent on psychological well-being. It has been observed that current researchers underscore the importance of not only physical but also psychological, social, cognitive functions as well as intimacy or sexual functioning, community and spiritual domains. It has been suggested that as HIV evokes extensile concerns, they ought to be acknowledge when assessing QOL. HIV-treatment advances and increased life expectancy have contributed to a growing concern about the QOL among people living with HIV. Empirical research is still sparse and most of it is so far related to QOL incorporated as an outcome measure in clinical trials for medication. Several generic instruments have been used (eg. quality of well-being)
but also generic instruments that are adapted to people with HIV. A common assumption by lay people is that people with HIV/AIDS experience an impoverished QOL. QOL may even be increased when people get seriously ill with their HIV infection.

Gulen and Mc Donald (2001) et. al conducted a study with an objective to study the Quality of Life among women living with HIV. The paper described the relationship between psychosocial factors and health-related Quality of Life. The study measured the physical functioning, mental health and overall QOL. The psychosocial factors under study were a history of child sexual abuse and adult abuse, social support and health promoting self-care behaviours. The average age of women was 33 years and they had known their HIV positive status for 41 months. The major findings of the study were that more than half of them i.e 55% had a history of injecting drug use and more than 60% had reported physical or a sexual assault at least once as an adult. The study revealed that women with larger social support networks reported better mental health and QOL. Women who practiced more self-care behaviour (healthy diets, adequate sleep and exercise) reported better physical and mental health and overall QOL. The study concluded that the high prevalence of physical abuse and child sexual abuse reported by this sample underscores the importance of screening for domestic violence when providing services to HIV positive women. It can thus be said that factors like social support and self-care behaviour are strongly associated with HRQOL.

A study was conducted by Guy Morineau, Mean Chi Yun and Hubert Barenes et. al. (2009) to study the survival and its related Quality of Life on HIV Positive people on antiretroviral therapy in Cambodia in 2004.HRQOL was assessed using the Medical Outcome followed up at 3 months, 6 months and each consecutive 6 months thereafter. The study was conducted from March 2005 to January 2008. Incidence of mortality was 9.1 per 100 person-years which is comparable to initiating ART. The
mean of overall HRQOL score from 63.0 at baseline to 81.1 at 1 year and 89.9 at 30 months of follow-up increased from 48.8 % to 95.7% The conclusion lies in the fact that the rapid scaling up of ART delivery in a resource poor Asian setting dramatically improved lives within the community.

Osowieck Diana. M et.al. (2000) studied the impact of neurocognitive and emotional distress and immune system dysfunction on QOL in women with HIV. They administered Profile of Mood States (POMS), Quality of Life Questionnaire for persons with HIV and cognitive functions on 36 HIV women. The results indicated that independent of severity of emotional distress, neurocognitive deficits on measures of executive control and speed of information processing were associated with QOL together with neurocognitive performance accounted for most of the variance associated with QOL. It can thus be concluded that QOL among women who were infected with HIV is strongly influenced by both neurocognitive and emotional status as women with the greatest neurocognitive impairment and emotional distress report the poorest QOL.

Franchi and Wenzel (1998) in their review of HRQOL conclude that HRQOL scores do not always correlate with disease stage or health indices and that symptoms have significant impact on HRQOL. Whereas Clary et.al (1993) found that both physical health status and psychological functioning status correlated with and predicted life satisfaction. Other studies suggest that degree of physical impairment is not related to life satisfaction. Holmes et al. (1997) studies the effect of AXIS 1 psychiatric disorders on psychological well-being and QOL. Their findings indicate that the presence of AXIS 1 psychiatric disorders in the previous six months is associated with diminished scores in multiple areas of functioning and well-being, independent of HIV related disease progression. Holmes et.al thus conclude that AXIS 1 disorders therefore appear to impact QOL. Rubin et.al (1991) reported that
those who developed depressive symptoms over a six month period showed a decline in their QOL of well-being scores.

Coping and social support may influence QOL, just as does psychological functioning. Renwich and Friedland (1996) conducted a study on coping, social support and QOL in persons with HIV. Due to the multidimensional character of QOL three different types of measurements were used: behavioural aspects of QOL (e.g. Job satisfaction, personal growth, health related QOL (different aspects of life that have been affected by HIV) and life satisfaction. The participants scored lower on overall QOL, physical well-being, material well-being and partner relationship than the norm groups. Findings indicate that health status is not a useful indicator for assessment of QOL. Further, data showed that different types of social support and coping strategies influenced different aspects of QOL. Problem-oriented coping, lack of denial, and emotional, social support influenced behavioural dimensions of QOL. Emotional social support in combination with the absence of practical support and perception oriented coping (e.g. positive reappraisal of one’s situation) positively affected HRQOL.

The dimension of QOL was also studied by Kimberlin et.al (2000) in 118 HIV+ adults in Carasa Venezuela. The study focused on the relationships of Quality of Life (QOL), social support and diseases related factors in HIV positive. Tools used in this study were Medical Outcomes Study Short form (SF-36) and a symptom Inventory. Multiple regression analysis was used to model SF-36 sub scales scores as a function of symptoms social support HIV-status and use of antiretroviral drugs the study showed that AIDS symptoms was significantly related to all the Health Related Quality of Life. (HRQOL) domains except social functioning and role emotional scores. Social support was significantly associated all HRQOL domains except physiological functioning and bodily pain. The use of antiretroviral drugs was significantly associated social functioning of social support to the QOL of HIV
infected individuals in the culture. Anxiety, depression and distress in PLWHA was studied by Chen and Hoffman with a sample of 101 patients using the Hospital Anxiety and Depression Scale in 2002. The study demonstrated a high prevalence of distress anxiety and depression among PLWHA. The study further revealed that there was no significant difference amongst PLWHA of different ethnicities. Patients who had low CD4 count or high viral load were significantly more distressed than patients than high CD4 count. Another significant finding of the study was that patients screened also exhibited a high prevalence of distress, anxiety and depression due to high prevalence of psychiatric disorders in the patient population. The analysis showed that majority of the respondents i.e 72.3% showed distress and nearing it were those who showed anxiety i.e 70.3%. It is noteworthy that depression was observed be significant only in less than 50% i.e 45.5%.

Sherbourne D and Hays D (2000) conducted a study on the impact of co-morbid psychiatric symptoms on the Health Related Quality of Life (HRQOL) symptoms in PLWHA. The study was conducted on a mixed sample of urban and rural population. The results indicated that the respondent with a probable mood disorder had lower scores on HRQOL. From this study it can be thus concluded that optimization of Health Related Quality of Life is important now as HIV is chronic with a long term survival. Co-morbid psychiatric conditions may severe as makers for impaired functioning and well-being in PLWHAs

Das Mukerjee et al (2009) conducted a study to assess the Quality of Life (QOL) and Psychosocial problems of HIV infected children. The study was a cross sectional survey. QOL of the enrolled children was assessed by using a Paediatric Quality of Life Inventory (Pedsq1) and Paediatric Symptom Checklist (PSC) was used to assess the psychosocial problems in the enrolled children. Forty one HIV infected and 30 children with cystic fibrosis were enrolled. According to child self-report in the Pedsq1 the difference of perceived physical health status between the two
study groups was statistically significant where HIV infected children demonstrated a better QOL in this domain. A significantly greater number of children who suffered from cystic fibrosis had greater psychosocial problems as compared to HIV children. The quality of life and psychosocial functioning is reasonably good in children with HIV infection. Thus, we should strive to maintain and optimize the overall quality of life of these children so that they can have a productive and meaningful future.

Another study was undertaken to study the QOL of HIV infected persons in south India by Solomon S. and Batavia A (2000). Data was collected on 136 individuals receiving clinical care at Y. R. Gaitonde Centre for AIDS Research and Education at Chennai, South India. The QOL questionnaire was administered to participants at baseline, 6 months follows-up, and 12 month follow-up. Study findings shows that QOL scores significantly improved between participants baseline visit, second interview, and third interviews, we conclude that a multidisciplinary approach to managing HIV infection can enhance patients QOL, independent of antiretroviral therapy.

Chandra P. S and Satyanarayan V.A. et al. (2009) conducted a study at the Department of Psychiatry, NIMHANS, Bangalore. The study examined gender differences in Quality of Life (QOL) among people where HIV/AIDS in South India using the locally validated version of the WHO Quality of Life instrument for HIV (WHOQOL-HIV120). Of the 29 facets of QOL, men reported significantly higher QOL, in the following facts – positive feelings, sexual activity, financial resources and transport, while women reported significantly higher QOL on the forgiveness and blame facet. Of the six domains of QOL, men reported better quality of life in the environmental domain, while women had higher scores on the spiritually/religion and personal beliefs domain. Understanding these gender differences may provide potentially useful information for tailoring interventions to enhance QOL among people infected with HIV/AIDS.
Health related quality of life was studied by Nojomi M et.al (2008). The study was cross-sectional and was conducted using a convenience sampling method on 139 patients living with HIV or suffering from AIDS. The main measured outcome in this study was QOL and some related demographic and clinical variables. The results indicated that gender, marital status, level of education, CD4+ count and clinical stage of disease had a significant effect on the quality of life of the patients. The most important predictor of the quality of life was clinical stage of the disease. The most important factors, association with decreased quality of life of the patients were being female, separated or divorced, having less CD4+ count, and being at severe stage of the disease.

3.14.1. GENDER AND PSYCHIATRIC ILLNESSES:

A decade ago, women and children seemed to be on the periphery of the AIDS epidemic. Today women and children are at the centre of our concern. AIDS has not spared them. On the contrary, the epidemic wave has affected millions of women and their children, and millions more are threatened. Dr. Michael Merson, Executive Director, WHO Global Programmes on AIDS, (1993) had said, “Women of every age, ethnic background, class and sexual orientation have contracted HIV. All over the world AIDS is becoming a leading cause of death among women. In many societies in many cultures, being a woman is a significant risk factor for HIV acquisition. As more and more women become infected with HIV an ever increasing number of children will be born infected with this virus. Women are central to the concept of family: to nurturing, protection and caring. They have complex relationships and structures in their daily lives and sophisticated and subtle responsibilities and commitments. Their demise, consequent to HIV disease, will increasingly rock the stability of communities in every country where AIDS exists.” (The Impact of AIDS on People and Societies- 2006 Report on the Global AIDS Epidemic. Women and AIDS: Confronting the Crises- A Joint Report by UNAIDS/UNFPA/UNIFEM.)
Level of Psychiatric Illness
Action oriented research and programmes developed involving women infected and affected by the epidemic and aimed at enhancing the responses of families and communities to the HIV epidemic combined with efforts to sensitize and engage decision makers are the first steps to countering the potentially devastating psychological and economic impact on women of HIV in developing countries.

Elizabeth Kubler Ross has stated, “We are solely responsible for our choices and we have to accept the consequences of every deed, word and thought throughout our lifetime”. Whereas women with HIV infection are clearly living with the consequences. HIV infection has been prevalent in women from the onset of the epidemic. Yet attention has been focused on women only in the second decade of the epidemic. Earlier studies targeted pregnant women and understanding of disease in women generally was overlooked until recently. Such delays have hindered the assessment of viral expression and transmission in women, disease course, opportunistic infection ramifications and prognosis and treatment issues. Similarly psychosocial understanding lags behind and treatment maybe misdirected or inappropriate. Such neglect may enhance the risks to vulnerable women who may be concentrated in the very groups which are abandoned by the society. Such groups are also jeopardized by their lack of power and their weak voices in the arenas of politics and policy. Any program to provide for the psychosocial needs of women with HIV infection or at risk of acquiring HIV infection must involve an understanding of the psychosocial functioning of such women.

3.14.2. RISK FACTORS AND FEMALE VULNERABILITIES:

As a group women are more vulnerable to get infected with HIV than are men for a variety of reasons which are as follows:
Gender differences:

Few studies have been conducted specifically to examine gender differences. For some women their major (and only) risk factors are associated with the behaviour of their male partner rather than their own behaviour. For some women the element of choice in sexual relationships is limited, and they may be unwilling or unable to implement and sustain changes in these relationships. The notion of choices implies a freedom that may not be available to many women who are dependent on men for social and economic support. Countless studies report on how women lack power. Studies have shown that how women are less likely than men to abandon an HIV positive partner. They are less likely to withhold knowledge of their own status but more likely to be kept in ignorance about partner’s status. They will often put the care of their partner or their children before their own care. Such behavioural patterns may not simply reflect lack of power but may reflect alternative lifestyles and a philosophy that should be admired. Studies often look at change of women as a solution but an educational effort geared towards men would be helpful. Kamenga (1991) found that pregnancy was more common when the male partner was HIV positive rather than the female partner. This finding is rarely highlighted and is not transformed into policy framework in worldwide prenatal clinics that treat women rather than men.

Women with HIV may not be identified if symptoms are misinterpreted, if they are involved in care giving to the detriment of their own health care needs or if HIV is not considered as a possible diagnosis. Many women are identified at routine screening rather than as a result of medical care. Hankins noted that women with AIDS were twice as likely as men to present initially with opportunistic infections. Informing partners may be difficult for women who fear rejection and abandonment. Such fears are greatest when dependence is high.
Ryder et al. (1991) found that 97% of their sample of HIV positive women in Kinshasa, Zaire were unwilling to inform their sexual partners of HIV. Major reasons for this include fear of divorce, physical harm or public rejection.

**Mental health needs of women:**

The natural history of HIV infection in women has only recently been studied. Clear documentation of mental health impact of AIDS on women is also sparse. The majority of studies focus on homosexual men and thus the information about this group is quite comprehensive. Women differ from homosexual men in the nature of their social support, their roles in the family, their childbearing and child rearing situation, their possible role within sexual relationships and their life opportunities and aspirations.

In the mental health literature women are recorded as suffering from greater levels of mental health problems than men. The simple reason is that women are more likely to report emotional trauma than men although it is experienced equally by both. The differences may be real and may reflect the fact that female lifestyles are more susceptible to emotional burden with the demands of childbearing and homemaking.

Mental health considerations extend from early in the disease process at the time of HIV testing through disease progression, illness and death.

**Emotional trauma experienced by HIV positive women:**

Sherr et. al. (1991) explored the emotional trauma in women referred to a specialist HIV psychiatric service in London. They noted late attendance, the low rate at which outpatients availed themselves of the services provision of emotional support and high levels suicide attempts and rape. These resulted in a heavy emotional burden on the patients. Psychological crises were high. Four women out of an initial group of
33 female clients reported rapes. For 3 of them this was their only risk factor and probably accounted for their HIV infection.

Another HIV positive woman had been raped and suffered grave trauma and guilt at the thought of infecting her assailant. Two women had attempted suicide. Rape is always traumatic for women and poses enormous adjustment problems. Psychological trauma is associated with symptoms directly linked with rape (such as fears and phobias, obsessive thoughts sleep disturbances, nightmares, psychosexual barriers, fear of pregnancy and STDs) and with the aftermath of rape. There are feelings of guilt, self-blame, hopelessness and a loss of control after a rape incident. A rape that has resulted in HIV transmission is all the more difficult. Subsequent sexual experiences can never be resumed in the same way as they were prior to the attack. Where rape signifies HIV infection the woman has to cope with unprecedented emotional burden too. Some women report post-traumatic stress like symptoms when they constantly remember the events leading up to rape, wishfully questioning how they might have behaved in order to avoid the incident.

Incest and childhood sexual abuse are other potential traumatic situations in which HIV infection can occur. The very nature of HIV infection results in a concentration of infection among the poorest and most deprived groups and the female population. Mental health resources often take second place to medical resources.

**Anxiety among HIV positive women:**

Women experience emotional trauma typified by anxiety and depression in a way similar to others with HIV or AIDS. Many of the physical symptoms of anxiety can be confused with AIDS related symptoms that may feed the cycle of anxiety. Fear of rejection often makes women reluctant to divulge their status to people who may well provide support. Women who lose their employment due to HIV infection or
associated illness may suddenly face traumas of livelihood, of providing for their
dependent children, of maintaining housing and a standard of living and the heavy
costs of health care.

**Depression among HIV positive women:**

Depressive symptoms lead to mild or severe behavioural manifestations such
as social withdrawal, mood swings and isolation. These give rise to reactions where
social support is alienated, relationships are strained and individuals become isolated
from possible avenues of benefit. These situations may be more acute for women if
they have limited social outlets. The advent of an HIV diagnosis can herald many
triggers for depression. Women are faced with the possibility of a curtailed life span,
of never having children or never seeing their children grow up. With AIDS many
women have physical manifestations that may mar their self-image eg. severe weight
loss, Kaposis Sarcoma lesions in visible places or hair loss associated with treatments.
HIV infection may necessitate dramatic changes in their sexual behaviour. Some
women may cease sexual intercourse or alter their feelings about sexual expression.

Valverde et al (2007) conducted a study to examine the correlates of
depression among HIV positive men and women. The results indicated that
approximately one third of women reported more depressive symptoms than men.
Correlates linked with depression were functional limitations, low self esteem, low
social support, greater negative feeling regarding condom use and lower sense of
empowerment.

**Bereavement among HIV positive women:**

With AIDS, bereavement is often multiple in nature. Bereavement is enhanced
when the mode of bereavement is the same as the personal health care. A woman
bereaved by the loss of a loved one to AIDS loses both her relationship and the person
whom she relied for care when she was ill. If she has cared for her partner during the
terminal phase of illness, she may have fears about her own death or about abandonment. This issue is more complicated if there are children to consider. Due to the age distribution of HIV infection, such children tend to be young. Women are bereaved by losing a shared future with children and by the additional burden of knowingly leaving orphaned children. For some women with HIV infection associated with childlessness for which much grief may be experienced.

A study was conducted in the area of bereavement by Alita Damar (2011) with an aim to understand the coping mechanisms AIDS bereaved women used. The study found that each woman experienced at least three traumatic experiences. The most challenging experience was learning that they had contracted a disease which they regarded associated with prostitution. Secondly, the concerns about protecting their children were found all the more challenging. Specific counselling programmes for women affected by IDS are needed, but emphasis should first be placed on improving their well being and their perception of stigma.

**Suicide among HIV positive women:**

Sherr and Smith et.al (1998) noted high levels of female suicide attempts. In one of the studies conducted by them there was no suicidal history prior to HIV diagnosis and hence suicide attempts were not seen as the behaviour of unbalanced individual but rather as a research of despair or crises. Suicidal risk is higher if an individual has clearly thought out plans rather than vague emotions, if they have limited social support and if there are triggering events, such as an HIV diagnosis. Studies in suicide and AIDS have shown an increased risk initially among women on HIV diagnosis and a risk at the end stages of illness.

**Guilt among HIV positive women:**

Another key emotion affecting the mental health of women with HIV infection is guilt. This may surround their own mode of infection, their feelings about possibly
infected loved ones such as partner or children, and their emotional trauma associated with their limited ability to provide care and attain a lifestyle that they may have aspired to. This may be further compounded by the problems of self-esteem that may be induced when HIV infection and allied opportunistic infections restrict the physical, career, relationship and social aspects of one’s life. They may feel guilty about their past behaviour in an effort to understand their HIV infection, focusing especially on behaviour that is directly linked to possible infection, such as sexual behaviour, drug use, infidelity or they may see their infection as punishment.

*Education level of Women:*

The link between education of women and health has been documented quite clearly. The lack of educational and economic opportunities for young girls acts and encourages early partnership formation and early sexual activity and affects child mortality rates in their children. (World Bank, 1993) Education strengthens women’s ability to perform their vital role in creating healthy households. Demographic and health surveys in 25 developing countries have shown that even 1 to 3 years of maternal schooling reduces child mortality by about 15% and when mothers have 7 or more years of schooling child mortality risk are reduced nearly 75%. Education increases the chance that they will make good use of health services, increases their access to income, and enables them to make healthier choices. Improving the access of girls and women to formal education, not only helps to equalize the age of partnership formation which can reduce the risk of HIV but it also increases women’s competitiveness in urban economies which could positively affect the unequal gender mix seen in many cities. A study by Over and Piot (1992) revealed a strong correlation between female to male school enrolment ratios at the secondary school level and HIV prevalence in the general adult population. The results suggest that significant decrease in sero-prevalence could be achieved if the secondary school sex ratio could move steadily toward parity. Investing in women through improved
education is not simply a desirable end in itself, it is a key not only to reduce HIV transmission but also to higher productivity and growth for developing countries and economies in the long run.

3.15. WOMEN AND AIDS IN INDIA.

3.15.1. Historical Position of Indian Women.

The subordinate position of Indian women has its roots in historical tradition. Under the Harappan or Indus Valley Civilization women had been accorded equality with men and liberal attitude towards women in society were evident. The earliest reference of decline in women’s status occurred with the arrival of the Aryans in India around 1750 B.C. Prior to this time, ancient India was ruled by the Dravidians-who were agriculturalists. Nomadic pastoralists, the Aryans had the basis of their social life, the patriarchal family—the oldest male member was the absolute head. It was during the development of the Hindu Aryan India that attitudes towards women began to decline. Role expectations, role status and inadequate support for Indian women cause them to be at greater risk for HIV infection.

3.15.2. Women’s health in India:

Social and cultural determinants relating to women’s position in society directly affect their ability to care for health. This is especially so in regard to HIV/AIDS. Women’s dependency and their lower level of education limit the access to resources. Due to their subordinate role, middle, lower class and especially village women are sexually vulnerable. Women’s social standing and the inequality between men and women directly affect their health interventions. This is clearly reflected in the low female life expectancy especially in northern India. The Indian sub-continent has the dubious distinction as being one of the few places in the world where females have lower life expectancy than males. Further more women are vulnerable to the risk of contracting AIDS than men. Basically women have a larger internal surface in their
reproductive tract which makes them more susceptible. Socio-cultural factors exacerbate women’s risk. Low economic status and social inequality make it difficult for women to take preventive measures regarding safe sex. Also women’s negotiating position with sexual partners is very much undermined by economic dependency.

Bangerner C and Marchand G (2000) studied HIV positive status of African and European women with an objective of comparing psychosocial and practical aspects of both. They used a semi-structured interview schedule which assessed variables like Personal history, family relationships, preoccupation child learning and concern about HIV infection its prognosis. The study revealed significant differences between the psychological and psychosocial factors of African and European HIV positive women. The important findings were based on the disclosure of HIV+ status to friends and family and more Europeans women disclosing to friends and fly, while the desire to have children was greater in African women. The differences emphasised in the study require a greater need to adopt medical and psychosocial care to gender and to the ethnic cultural background of the person.

Another study was undertaken by Kwalomba M (2002) to study the mental health of pregnant woman who were diagnosed as HIV positive in Lusaka, Zambia. The sample consisted of women who knew their HIV positive status prior to their pregnancy or came to know about it during the course of their pregnancy. Results revealed that majority of respondents i.e. (85%) showed symptoms of major depressive episodes along with suicidal ideations. More than 50% women whose who were diagnosed positive status before pregnancy did not show severe depressive symptoms but showed anxiety about positive status of their babies.

With reference to disclosure followed by discrimination British investigators Jarman, Walse and DeLacy conducted study in (2005) and interviewed six women being HIV positive for the purpose of exploring how these women experienced their
intimate partner relationships. The central theme was the psychological protection which was an underlying tension for these women. The study revealed that the tension could be reduced if HIV positive women shared their sero status with their partners. The study highlights the fact that the exploration of issue of psychological protection may be helpful for women experiencing difficulties in relation to disclosure. It could be useful to consider the pros and cons of disclosure in terms of psychological protection especially in the context of partner relationships where the long term costs of non disclosure may outweigh the short term gains. Thus the study suggests the importance of offering support to individuals and couples in relation to helping them adjust to the impact of during HIV infection and help them find ways to frame the problem as a shared problem.

Epele Maria and Esther (2002) proposed that gender-inequality promotes directly or indirectly vulnerability to HIV as a consequence of a multidimensional violence (structural, symbolic and physical) experienced by injection drug-users (IDU). Given the female subordinated position stipulated by the street ideology, they have analysed how drug dependence afforded by precarious strategies of subsistence places IDU women under multiple dangers and threats. In this way setting unequal gender relations are a part of a complex system of transactions in the street economy and a way to reduce or increase the everyday violence. Facing multiple dangers and risks, some women adopt a subordinated position, some try to negotiate the conditions of the exchange and others resist the exploitation. Finally, everyday violence under conditions of gender inequality and security of resources imposes a logic defined by the challenge of survival under the threat of immediate dangers which transform HIV into secondary risk.

Campbell T and Kelly M (1995) examined the psychosocial factors associated with HIV transmission, focusing on the social factors that contribute to the high risk status of women in Zambia. It is suggested that women’s socio-economic status
beliefs about sexuality and lack of access to health education will continue significantly to worsen the AIDS crises in Zambia. Intervention strategies must consider the complex inter-relation of these factors for women.

Littlewood B (1994 in her paper argues that much of what is known about AIDS excludes women’s distinctive experiences, which can be illuminated by a feminist perspective. In this paper the researcher has obtained data through interviews and informal group discussions with HIV positive Scottish women about their personal relationships, their experiences of health care and their hopes for future. Safe sex and disclosure of status pose particular problems for women attempting to negotiate responsible risk reduction behaviour in relationships marked by imbalances of power. Single sex support groups are an important source of solidarity for those who are often isolated and stigmatized by their HIV status.

The study conducted by Simoni J examining the trauma and coping mechanisms related to HIV/AIDS emphasised that recent trauma was co related to childhood abuse. The study stressed that better implications were required for better functioning of women. Coping strategies were also studied by Kathleen J. et al. In contrast to the study by Simoni J. this study stressed on childhood abuse which resulted into greater trauma, this study emphasised that loss of a near one is one of the factor of being HIV positive.

3.16. The Researcher’s reflections on the reviewed literature:

The review of the past studies suggests that origin of an HIV positive person plays a vital role in obtaining the level of social support. The benefits of social support are particularly important for people with HIV/AIDS because of the concomitant stigma and social isolation accompanying the disease. As with other illnesses emotional support might be crucial in the lives of PLWHA. AIDS is characterized by interminent periods of sickness and debilitation. Those in the
advanced stages of the disease often experience serious opportunistic infections and
cognitive impairment that can cause visual problems, ambulatory difficulties and
dementia.

Further when faced with a life threatening illness individuals strive to find
Meaning in their lives, gain a sense of control and restore their self-esteem.
Significant others may play key role in these processes by offering emotional support,
validating one’s experiences and providing practical help and advice. Social support
has been positively associated to psychosocial adjustment to HIV disease including
positive coping styles. The stigma and fear associated with HIV/AIDS may impede
support.

Certain studies conceptualize social support as a coping assistance. Studies
show that higher levels of perceived social support and avoidance coping to less
social support. Social support helps an individual to have a better psychological
adjustment and acts as a buffer against stress. It is believed that when distress reaches
a level that is unacceptable an individual tries to find social support. Social support
can act adversely i.e negative social support in terms of insensitivity, disconnecting,
forced optimism and blame.

The nature of the disease and its social construction produce similar
challenges and issues for men and women, since it poses serious threats to physical
and emotional well-being. However, as with most social phenomenon gender matters.
Differences in social status, resources, roles and responsibilities produce distinctive
experiences and needs. Similar to HIV positive men, women with HIV/AIDS men,
women with HIV are faced with physiological effects of the virus, functional decline,
demanding regimes, disclosure decisions, stigma and discrimination and financial
insecurity. Fear of rejection and abandonment often curtails the women’s social
involvement. Women’s domestic burdens also contribute to HIV related stressors
such as poverty, physical impairment and psychological distress. On the other hand, given the centrality of caring in women’s lives, the inability to continue nurturing, due to sickness or other circumstances may negatively affect self-esteem and facilitate biographical disruption. Women’s powerlessness in sexual relationships make disclosure of seropositivity to a partner particularly traumatic. This fact is emphasized in the study undertaken by Jarman et al. (2005) which reveals that disclosure tension could be reduced if HIV positive women shared their positive status with their partners. The gender inequality embedded in many cultures directly promotes HIV vulnerability. This fact is studied by Epele, Maria Esther et al. Psychological and psychosocial factors used as coping mechanisms differ from people to people. Studies have brought forward the fact that the coping strategies used by African and European women pertaining to their disclosure of HIV status are different. More European women disclosed their HIV positive status while greater number of African women desired to have children. Women who are diagnosed with HIV during pregnancy showed suicidal tendencies and were anxious about their child being HIV positive.

Rape has been considered as one of the leading causes of HIV infection amongst women. Rape not only has made many women HIV positive but also has led them to guilt and trauma. Post-traumatic stress disorder is another offshoot of rape resulted HIV infection. Followed by HIV infection women definitely suffer with anxiety, bereavement and grief. Research has shown that many women tend to commit suicide because of their HIV positive status. This is also because of being HIV they tend to lose the social support post HIV diagnosis. Suicidal ideations are more reported amongst women at the time of diagnosis and at a later stage.

Guilt is another emotion that has captured attention of the researchers. Studies point out that women develop a guilt behaviour which focuses on their sexual practices and infidelity. Stigma and discrimination are other areas where studies are undertaken and the results suggest that isolation is one type of punishment whereby
the PLWHAs can be punished. In response to this, it was often observed that PLWHAs don’t furnish themselves with HIV/AIDS information. Studies conducted in African nations like Brazil and Botswana have brought forth the fact that stigma is deeply woven in places where ART is easily available. Further, due to the fear of stigma women in these regions do not feed their babies with formula which itself is a means of preventing mother to child transmission of HIV. Though women are infected by their husbands they are faced with greater stigmatizing attitudes than do their husbands. The study conducted on Haitian women by Marie Anne et.al reveals five major categories of long-term effects of AIDS stigmatization. The women face a strong rejection by the dominant society, effect on self esteem, effect on the relationship with the significant others and self doubt. In a country like India where women occupy a subordinate position studies show that sharing their HIV positive status with their husbands was more common rather than sharing with any other family member. Sharing of their HIV positive status led to divorce, separation and discrimination. Discrimination was more observed by PLWHA who were younger in age than their older counterparts.

Anxiety is a very common psychiatric problem prevalent amongst the PLWHA. This could be because PLWHA develop feelings of helplessness, loss and dependency. Research in this respect suggests that high levels of anxiety are responsible for quick progression of HIV. High prevalence of an anxiety, mood disorders, lifetime prevalence of depressive and substance disorders are observed in PLWHA. The study conducted by Brown et.al suggests a high level of sexual dysfunction. In connection to anxiety another important psychiatric problem that is studied is suicide. Suicide is considered to be deeply connected with depression. Studies have shown that there exists a deep connection between suicide, depression and emotional distress. The intensity of suicidal ideation is largely dependent on age. A noteworthy finding in one of the study was that though PLWHAs nurtured thoughts
of suicide, they actually did not say that they would like to kill themselves. Amazingly disclosure to friends about HIV positive status was a factor that contributed greatly to suicide ideations. Suicidal ideations were also due to the lower levels of psychological adaptation of HIV infection and severity of HIV infection.

In India suicidal tendency amongst PLWHAs was studied by Chandra Prabha et.al. It was observed that suicidal ideation was less due to the HIV positive status, but was greater due to presence of pain, lack of family support and alcohol abuse. The spouse’s HIV positive status was a reason leading to suicidal ideation. To conclude it can be said that depressive symptoms, stigma, discrimination, poor social and family support, past history of suicidal behaviour, injecting drug use etc are leading causes of suicidal ideations.

Depression as stated earlier has its connections with HIV positive status, anxiety, helplessness, suicide, guilt and rejection. Studies have shown that women are more prone to depression after being diagnosed HIV positive as compared to men. The reason could be higher caregiver burden, negligence towards their own health, proneness to social stigma etc. Research points that depression level is high amongst PLWHAs in the initial stages of the infection and secondly depression is also observed due to AIDS related deaths. Depression when studied in co relation to stigma and discrimination showed that feelings of guilt, dirt and shame are an off shoot of depression. Interestingly stigma and discrimination are two factors which are directly or indirectly related to depression, anxiety etc. It is due to the stigmatizing attitudes and discrimination faced by PLWHAs in the society, feelings of rejection, helplessness, loss of friends take place. This further leads to psychological problems. These psychological problems call for urgent social reformation and need for proper intervention strategies.
Quality of Life is another dimension that has been studied in the present study. The review of the past studies under consideration has brought forward certain important and noteworthy fact which can lead us to understand the Quality of Life of PLWHAs’ in a better way. Studies have contradicted a layman’s assumption that people with HIV experience an impoverished lifestyle. On the contrary their Quality of Life may even be increased when people get seriously ill due to HIV infection. Quality of life is also affected by incidences of child abuse and physical abuse. For such individuals it is important to have greater social support and greater self care behaviour.

Studies conducted to study the Health Related Quality of Life (HRQOL) of PLWHA suggest that HRQOL should be optimized because with the introduction of Antiretroviral therapy (ART) HIV has become chronic with long term survival.

A study conducted to assess the QOL and psychosocial problems of HIV infected children, showed better QOL of HIV infected children. Thus we need to strive to maintain the overall QOL of HIV infected children. With regard to gender differences and QOL, it is observed that men experience an overall better QOL as compared to women. This can be considered as an important finding as we can target interventions which can help enhance QOL amongst women who are HIV positive.

Lastly studies have put forward certain important factors which to a very high degree are responsible for the diminishing QOL. Few factors which need a mention are being female, clinical stage of illness, separation and divorce and low CD4 counts. In the Indian context many factors that supplement the burden of HIV infection are poverty, low education level, prostitution, polygamy, unemployment and lack of resources.