INTRODUCTION

Literature review is a crucial aspect of research as it enables the researcher to assimilate work already done in a given discipline and examine the areas that require further work thereby facilitating a more comprehensive understanding of the subject. The research of literature on HIV/AIDS is steadily growing since the 1980s when the epidemic came to the forefront. Both quantitative and qualitative studies have contributed to a greater understanding of the epidemic, its epidemiological position, behavior aspects of human being in the context of socio-cultural milieu, risk perception and behavior modifications to curtail the epidemic. The literature review for the research study includes books, electronic databases of the peer reviewed journals (Jstor, Emerald, Sage Publications, and AIDS data base reports, global HIV/AIDS websites and NACO websites.

In the 1980s, the study of HIV/AIDS was influenced predominantly by a biomedical approach to understand the epidemic and studies were conducted to gather information on the medical aspect of the disease, prevalence of the infection among certain population groups. The studies also brought out the trends in transmission and prevention and geographical spread of the infection. Certain groups were identified as high risk group such as men who have sex with men (MSM), Female Sex workers (FSW), Injecting drug users (IDU) and attendees of STD clinics. Follow up studies
showed a growing prevalence rate of the infection among the general population. The epidemiological approach bringing out the trends of the epidemic in a country highlights higher infection rates among certain subpopulation who were already recognized as marginalized position due to their low socio economic status namely commercial sex workers, homosexual men, injecting drug users. These groups have been labeled as high risk groups or core groups. A major critique of such an approach is that there is a heavy reliance on data collected in clinical settings along with a willingness to collaborate with studies of sexual behavior from pre AIDS era. Such an approach also black lists certain groups as people at risk of infection and therefore casts doubts on the grounds of morality and the rest of the population as those not at risk of the infection and viewed as virtuous on the same grounds of morality. Such a hegemonic stand increases stigmatization and discrimination of these groups who are in no position to defend themselves or break away from the vulnerabilities of the epidemic. Weeks Jeffrey (1988) opines that AIDS ceases to be simply a devastating disease and becomes more like a battlefield for conflicting values and political values and ways of life. In the United States with its first identification in 1981, it has become associated strongly with marginalized, oppressed or feared groups Haitians and subsequently black Americans, injecting drug users, prostitutes and male homosexuals. Weeks opines that AIDS has fed into wider anxieties and fears and this has resulted in a moral panic rooted in a genuine fear of the disease, but seeking scapegoats in those who were
chief sufferers from it.

Coxon (1986); Mc Manus and Mc Envoy (1985) raises doubts in general about the reliability of data gathered in such studies of sexual behavior. These studies rely on people’s willingness to report sexual behavior in order to make inferences. Very few studies attempt to triangulate upon same sexual events to assess their reliability of information.

Gradually there arose a growing concern to understand the why of the risk behaviors in the context of HIV/AIDS vulnerability. Studies were conducted to determine why certain individuals or groups are more vulnerable to risk of HIV/AIDS. Research on sexual behavior in 1990s using predominantly quantitative methods focused on finding patterns, contexts and condition under which premarital and extramarital sexual practices take place (Pelto, 2000). This is of particular importance while developing intervention strategies for the especially vulnerable population. Understanding people’s sexual behavior and the situations in which they occur is important. Constructing more effective intervention requires in depth studies of the context and the environment, of risky behavior in vulnerable population (Verma et al., 2004). Treatment efforts thus rendering these groups far more vulnerable. The social scientist opined it is imperative to gain a contextual understanding of the behavior patterns and to bring out the why of the risk behaviors. Thus the limitations of the biomedical approach were appreciated and studies on the knowledge level, attitudes and perception towards the behavior patterns, misconceptions regarding the
disease etc were conducted. Both quantitative and qualitative paradigms were used to in the research and the meanings attached to sexual expression and notions of sexual risk behavior within the socio cultural contexts were examined. Surveys measuring knowledge, practices and behavior (KAPB) related to sexual behavior were carried out science approach gained more credence (Gillespie et al., 2007; Parker, 2001).

This was followed by a third phase of study where the social scientists going beyond the KABP studies are also looking at the different vulnerable contexts of individuals at risk of HIV/AIDS such as mobility factors, poverty, economic and social marginalization, weak social cohesion, gender dimensions to name a few. In India, from the period 1983-2009 a breakdown of published HIV research shows that 46 percent of the studies were biomedical/clinical studies, followed by 25 percent epidemiological studies, 15 percent social research and 14 percent others (Working draft prepared for the National Consultation on HIV Social Research Priorities by Actionaid, 2009). Numerous epidemiological studies have been undertaken in India since 1985-86.

Recent figures from UNAIDS (2005) are overwhelming as they illustrate how HIV/AIDS continues to decimate humanity, with sub-Saharan Africa being the worst hit. UNAIDS estimates for sub-Saharan Africa, which has just over 10 percent of the world’s population, indicate that the continent had more than 60 percent of all the people living with HIV/AIDS, estimated at between 23.4 million and 28.4 million in 2004 (UNAIDS, 2004). Similarly the
nine countries of the southern Africa region according to Kalipeni and Zulu (2008) constitute only 2 percent of the world population, yet globally 30 percent of people living with HIV/AIDS are concentrated in these countries. The effect of this on the individuals, families and communities that lies behind these numbers at the micro-level of society is an issue that can never be overemphasized. People fall ill, cannot work, and lose income while their families spend money on care and treatment as well as lose further income while taking time to care for them. People die, specialized workers, skilled artisans and educated officials disappear and replacements are difficult to find, businesses close and farms lie fallow. Current earnings are lost and future earnings foregone and time and money spent on funerals and mourning. Women too fall sick and die usually at an age considerably lower than men. Given their reproductive role in the home, in agriculture and in the informal sector of the economy, their land, shelter and inheritance are forced to depend on relatives or migrate to cities, and join underclass of commercial sex workers and street children.

Effects of HIV/AIDS at the home front still need more attention. The reason for this especially in Nigeria is premised on series of studies and findings (Adeokun, 2006; Igbalajobi, 2003; Abidogun, 2001; Orubuloye, 1997, 1996, 1992 and 1991) about prevalence of sexual networking in the countries. These scholars revealed that lots of couple were found engaging in extramarital relationship as a result of so many factors like inability of one spouse to satisfy his or her partners, inability to meet financial needs at home,
breakdown in communication at home, interference of in-laws, or distance problem as a result of working condition which is one of the major extents for most men and women that they need someone to take care of them at their various places or locations in detriment of the irrespective families. In view of the relevance of family system as the only viable bedrock and hope for the society for the proliferation of the human species, there is dire need for understanding of couple’s risk perception of HIV/AIDS and marital adjustment among Federal Civil Servants in Ibadan, Oyo State. What then is Risk Perception and marital adjustment? The situation world over for the HIV infected is grim and cruel, indeed, specially so for the poor, deprived and women. It affects marital adjustment very badly.

PERSONALITY AND PSYCHOLOGICAL WELL-BEING:

Arikian, Nacy-Jursik (2001) have explored the relationships among dispositional coping style (monitoring, blunting) global personality traits (neuroticism), situation specific coping (information seeking, rumination, avoidance, cognitive restructuring) and psychological adjustment (anxiety, depression). Male veterans (N=101) completed a questionnaire with cognitive restructuring, and monitoring was associated with rumination. Neuroticism moderated the relationship between monitoring and depression and between blunting and anxiety, and rumination moderated the association between monitoring and depression. These results contradict the characterization of monitors as individuals who seek information when faced with threat. Personality traits and situation specific coping are considered when assessing
the relationships between monitoring blunting and outcome that help in designing interventions.

Urmi Nanda Biswas (2007) studied the effectiveness of pharmaceutical polytherapies for the treatment of HIV (Human immunodeficiency virus) and AIDS (Acquired immune deficiency syndrome) have practically reduced HIV and AIDS to a chronic condition like any other chronic illness. People living with HIV and AIDS can now have an almost normal life expectancy; the challenge for them is to live a physically and mentally healthy life. These challenges involve avoiding and managing opportunistic infections physically on one hand and taking care of their mental health needs and promoting and sustaining psycho-social well-being on the other hand. Although a torrent of research has studied the psychosocial correlates of slower disease progression and psycho-social well-being among people living with HIV and AIDS, very few sustained approaches have been made to understand and isolate the contribution of different psycho-bio-behavioural parameters for the psycho-immuno-enhancement in people living with HIV and AIDS. Systematic search in different electronic databases as well as different relevant psychological and AIDS care journals have been done to assimilate and review the research studying the effect of different psycho-social, bio-behavioural interventions through randomized control trials on the health promotion, well-being and disease progression parameters in people living with HIV and AIDS. The article makes an attempt to synchronize and consolidate these research efforts, discussing the role of cognitive behavioural
stress management, exercise, spiritual practices, hypnosis, relaxation and guided imagery, social support for the psycho-immuno-enhancement in lives of people living with HIV and AIDS, and suggests a comprehensive three-tier intervention model, consisting of intervention at individual, dyadic and community levels, for psychological and immunological improvement in lives of people living with HIV and AIDS. These facts presented above here point towards the need to improve the quality of marital adjustment, psychological well-being and personality dimensions of HIV positive patients by psychotherapy. They need to be made to get along, be together and make a living together. In other words they are to be understood better for a better rehabilitation and any other helpful useful service.

Scand J. Caring (2010) examined the association among reduced psychological well-being, anxiety, sleep disturbances and HP by comparing people with HP and general population. A national survey of 12,166 individuals (hypertensive n = 2047; rest of population n = 10,119) was conducted using two-step multiple logistic regression with an odds ratio and a 95% confidence interval. The study was in accordance with Swedish legislation pertaining to ethics. Reduced psychological well-being, anxiety and sleep disturbance were higher in the HP group and, in addition, reduced psychological well-being was, still higher in the presence of severe anxiety and serious sleep disturbances. These three factors are of major importance for HP, but it is difficult to know whether they are causes or consequences. In order to prevent HP, support for people who exhibit such risk factors
should be a matter of high priority.

Nathawat and Asha Mathur (2010) compared marital adjustment and subjective well-being in Indian-educated housewives ($N = 200$) and working women ($N = 200$) who were administered a Marital Adjustment Questionnaire (Kumar and Rastogi, 1976) and 10 measures of subjective well-being (Warr, 1984). Results indicated significantly better marital adjustment and subjective well-being for the working women than for the housewives. Specifically, working women reported higher scores on general health, life satisfaction, and self-esteem measures and lower scores on hopelessness, insecurity, and anxiety, compared with the housewives, although the housewives had lower scores on negative affect than the working women. Findings were insignificant on positive affect and depression.

The study by Vishwakarma Harshita and Chengti S. (2010) examined the influence of stress on psychological well-being of the hypertensive patients and normal. The study consists of 200 samples out of the 100 were normal and 100 were hypertensive patients. Attempt was made to examine the influence of stress on psychological well-being in normal and hypertensive patients. The sample of 100 was chronic hypertension with $>140/90$ Hg mm (clinically measured) and 100 normal sample, on psychological well-being scale and Stress inventory were administered. It was hypothesized that there would be significant influence of stress on psychological well-being in normal and hypertensive patients.
Adeline Nyamathi, Anisa Heravian, Jessica Zolt-Gilburne (2015) said that depression may be commonly experienced by persons living with AIDS, it may be challenging for health care providers to identify persons who are suffering from depression symptoms, particularly if they are living in the more isolated rural areas of India. The purpose of this study is to assess correlates of depression among women living with AIDS in rural Andhra Pradesh, India. A total of 68 rural women living with AIDS (WLA) completed baseline data and were assessed by means of structured instruments. Regression modeling revealed that disclosure avoidance and making at least six health care visits in the last six months were all associated with depression. Further, living with a spouse was associated with lower depressive symptom scores. Stigma was not found to be associated with depression. Understanding correlates of depression can lead the way toward designing culturally-tailored interventions that can mitigate disclosure avoidance and improve the health of women. A more comprehensive health focus may be needed to empower the women to seek quality care for both physical health, as well as mental health, symptomatology.

Enith E. Hickman; Carol R. Glass; Diane B. Arnkoff; Roger D. Fallot (2013) examined the role of religious coping in psychological distress and adjustment both cross-sectionally and longitudinally among 141 HIV-positive African American women. Cross-sectional analyses showed that negative religious coping was associated with poorer mental health and functioning, and greater perceptions of stigma and discrimination. Longitudinal analyses
revealed that greater negative religious coping at baseline significantly predicted greater changes in mental health in a negative direction 12 months later. Positive religious coping was not associated with any measures of psychological well-being, nor did it predict any mental health outcomes at 12 months. However, participants who experienced high levels of HIV-related stigma and reported high levels of positive religious coping were less depressed than those who reported lower levels of positive religious coping. These results suggest that for this population, negative religious coping was a more salient determinant of psychological distress than positive religious coping was of psychological health.

MARITAL ADJUSTMENT IN RURAL AND URBAN

Neeta P. Chaudhari and Hemlata J. Patel (2009) say that marital adjustment, happiness, satisfaction or a number of variables that attest to the quality of a marriage may be the most frequently studied dimension in the marriage and family field. Many attempts have been made to assess the quality of marital relationships using such concepts as “marital adjustment”, “success”, “satisfaction”, “stability”, “happiness”, “consensus”, “cohesion”, at adoption, integration, role strain, and the like sometimes these terms are used inter changeably other times each denotes something different, sometimes the terms are used in a psychological sense referring to the state of one of the marital partners, sometimes they are used in social psychological sense referring to the state of the relationship and sometimes they are used in a sociological sense, referring to the state of the
group or system, in addition there are times the terms are used to refer to the achievement of a goal and other times they are used to refer to a dynamic process of making changes, all the concepts emphasize a dimension that contrasts with male adjustment, dissatisfaction, instability, unhappiness and so forth. The adjustment of married mates is unlike any other human relationship, it may share many conditions of friendship groups, peer groups, work groups or religious groups but the husband and wife companionship, fulfilling the expectation of the community and so forth marital happiness distinguished from either adjustment success is an emotional response of an individual. The study was effort to focus on the aim of the study necessity of marriage and marital adjustment among female of Urban & Rural Mehsana (Gujarat). Means calculated attempts to put in order or agreement living conditions or ways of living to ensure an overall feeling in couples of happiness and satisfaction with their marriage and with each other. Significant relationships also were observed between self-reported marital adjustment and particular personality traits, such as psychoticism, agreeableness, and internal locus of control. A high level of psychoticism was negatively associated with self-reported marital adjustment, and the other two personality factors were positively associated (Russell and Wells, 1994; Smolen and Spiegel, 1987). Furthermore, personality factors such as perspective taking (the tendency to put oneself in another person's place), emotional expressiveness, and ambivalence in emotional expressiveness also were significant predictors of marital adjustment. The first two related
positively to marital adjustment, and the last one related negatively (King, 1993; Long and Andrews, 1990). Finally, outcomes of the personality factor of extraversion offered mixed results. A high level of extraversion was positively related (Richmond, Craig, and Ruzicka, 1991), negatively related (Bentler and Newcomb, 1978; Geist and Gilbert, 1996), and unrelated (Russell and Wells, 1994).

Historically, researchers have found that married men and women report better psychological well-being than their unmarried peers (Hughes and Style, 1983; Gove and Shin 1989; Gove, Style and Hughes 1990; Lee Seccombe, and Shehan, 1991). Yet despite a significant lengthening of life expectancy during this century for both men and women, younger birth cohorts of American adults are spending proportionately less of their adult lives married. This is due to historical trends toward a later age at marriage, a higher rate of non-marriage, a higher rate of divorce, and a lower rate of remarriage (Schoen, Urton, Woodrow, and Baj, 1985). Larger proportions of younger birth cohorts are now more likely to be single (never married, divorced, or widowed) during their midlife and older years. Uhlenberg, Cooney, and Boyd (1990) Project that almost one third of white women in the 1995-1959 birth cohort will be unmarried at midlife between the ages of 50 and 54, and one half will be unmarried when they enter young old age between 65 and 69.

Suneetha B. Manyam and Victoria Y. Junior (2014) report that adjustment depends on how well couples understand and cooperate with each other despite their
differing personalities. The current study examines the marital adjustment trend of 480 Indian spouses from eight stages of the family life cycle. Results from the data collected through the Marital Adjustment Inventory (Developed) demonstrated a curvilinear trend concluding that the marital adjustment of couples decreased with their transition to parenthood, for launching couples, and for empty nest couples, while it steadily increased for couples during other stages of the family life cycle. All 13 areas of the Marital Adjustment Inventory yielded significant F values across the different stages. The results suggest the need for counselors, marriage and family therapists to assist couples on how to successfully adjust through various stages of the family life cycle.

Karolynn Siegelz; Daniel Karus; Victoria H. Raveis; Debra Hagen (1998) assessed the relationship of race and ethnicity with standardized measures of depressive symptomatology and mental health was examined in a sample of HIV-infected African American (n = 48), Puerto Rican (n = 50), and White non-Hispanic (n = 48) women in New York City. Mean scores of women from all three racial and ethnic groups were higher than those reported for normative samples on measures of depressive symptomatology and psychological distress, and mean scores on measures of psychological well-being were lower. Puerto Rican women reported significantly higher levels of depressive symptomatology than either African American or White women. Puerto Rican women also reported significantly higher levels of psychological distress and lower levels of psychological well-being than African American women. The findings suggest that while all HIV-infected
women are at risk of poor adjustment, Puerto Rican women may be especially vulnerable. They also point to the need for future research to determine what factors in these women's lives are predictive of adjustment, especially those factors amenable to intervention.

**GENDER AND MARITAL ADJUSTMENT**

Nadine F. Marks (1996) studied gender and marital status differences in psychological well-being across an extensive array of measures using data from a sample of non Hispanic, White, midlife adult participants in the Wisconsin Longitudinal Study, 1992-1993 page no 917-937 (N=6,876). Evidence for how selection and social causation might account for differences also is evaluated. Multivariate analyses reveal several gender interactions, usually indicating a greater disadvantage for unmarried men than for unmarried women. Separate analyses by gender show a complex picture of both positive and negative effects of being single. Contrary to what the selection argument hypothesizes, single women have higher scores on relatively enduring personality characteristics associated with better psychological well-being than married women. Single men do not compare so favorably with married men. Overall, selection does not account for marital status differences in well-being. Household income and having a kin dominant mediate some of the remaining effects.
Newmann S, Sarin P, Kumarasamy N. (2000) conducted retrospective study was conducted on 134 HIV-infected females evaluated at an HIV/AIDS centre in south India to characterize their socio demographics, HIV risk factors and initial clinical presentations. The mean age was 29 years; 81% were housewives; 95% were currently or previously married; 89% reported heterosexual sex as their only HIV risk factor; and 88% reported a history of monogamy. The majority were of reproductive age, thus the potential for vertical transmission of HIV and devastating impacts on families is alarming. Nearly half of these women initially presented asymptptomatically implying that partner recruitment can enable early HIV detection. Single partner heterosexual sex with their husband was the only HIV risk factor for the majority of women. HIV prevention and intervention strategies need to focus on married, monogamous Indian women whose self-perception of HIV risk may be low, but whose risk is inextricably linked to the behaviour of their husbands.

Since 1986 when the first reported Indian cases of HIV infection were diagnosed among sex workers in Tamil Nadu, the majority of research in India has focused on high-risk populations. More recent research in Pune and Manipur has demonstrated that HIV infection is spreading to the sexual partners of high-risk individuals. The results of this study support changing notions of high-risk behaviour in India in that the majority of these HIV-infected women did not report a history of multiple partner heterosexual sex, intravenous drug use, or blood transfusions, and appear to have been infected
with HIV through monogamous sex with their HIV-infected husbands. These are women whose self-perception of HIV risk and HIV/AIDS awareness may be low since traditionally HIV/AIDS education/prevention programmes have targeted high-risk populations. Additionally, adherence to deeply ingrained social norms regarding arranged marriages and gender relations, hinders married and engaged women from actively protecting themselves due to both ignorance of their personal risk for HIV and lack of social and cultural support necessary for them to comfortably engage in risk-reducing behaviours. The women seen at this clinic may be representative of a larger population of Indian women who individually appear to be at low risk for HIV, but whose HIV-infected husbands, place them at significant risk.

Bloom SS, Agrawal A, Singh KK, Suchindran CM. (2015) investigated the distribution and determinants of HIV risks among married couples in North India. Gender inequality emerged as a potential driver of HIV risks in this region. Data collection took place in 2003 in a probability survey of 3385 couples living in India's most populous state - Uttar Pradesh - and Uttarakhand. Couples' analyses utilizing generalized estimating equations showed that compared with husbands, wives were less knowledgeable about HIV (OR = 0.31, 95% CI = 0.27-0.36), more likely to consider themselves at risk for infection (OR = 6.86, 95% CI = 4.65-10.13), and less likely to feel that a wife had the right to refuse sex with her husband (OR = 0.50, 95% CI = 0.44-0.58). The proportion of husbands reporting non-marital sex in the past year was 7.1% and transactional sex in the past year, 2.2%. Among their wives, 73.4%
were unaware of their husbands' non-marital sexual behaviors and only 28.9% of husbands reported condom use during their last non-marital sexual encounter. Logistic regression analyses showed that husbands' alcohol use, husbands' mobility, and urban residence were positively associated with husbands' non-marital sexual behaviors adjusting for other covariates. The data demonstrate that HIV prevention programs among couples in North India should consider both sexual risks and gender inequalities which potentially fuel HIV spread in this region.

Beena E. Thomas, Chandra Suresh, Basilea Watson, Jamuna M, Vijayalakshmi R. and Soumya Swaminath (2013) studied the issues around marriage and sexual behaviour in persons living with HIV whose married partners were HIV negative. This was a descriptive study on 111 persons living with HIV, 83 of them being male and 28 of them being female. Early marriages were reported by both males and females but more among the females and most of the respondents reported their spouse to be a relative. A quarter of the female respondents were married the second time, having lost their husbands of the first marriage, early in their marriage. Premarital unsafe sexual intercourse was reported by 55 (66%) of the males thus posing risk to their partner. Furthermore extra marital sexual intercourse after diagnosis of HIV was reported by one third of the males. Those who have reported extra marital sexual intercourse report less condom usage with their spouse (HIV negative) as compared to those who have not had extra-marital sex. (Adjusted O.R. = 0.29 (95% C.I.: 0.12, 0.73); p-value = 0.008). This furthers the risk
of HIV transmission. This information calls for the need to evolve strategies that could work toward HIV risk reduction which needs to be included in premarital counselling as well as within the marriage.

GENDER AND PSYCHOLOGICAL WELL BEING

Reddy G. Lokanatha and Reddy V. Srikanth (2013) investigated the to fin dout significant difference between male and female HIV/AIDS affected people with regard to their source of stress. Gender is the independent variable and a source of stress is the dependent variable. 244 male and 236 female HIV/AIDS affected patients constituted the sample of the study.

Gordillo, Victoria; Fekete, Erin M.; Platteau, Tom; Antoni, Michael H.; Schneiderman, Neil; and Nöstlinger, Christiana (2009) studded indicate that emotional support is strongly associated with physical and psychological adjustment in persons living with HIV/AIDS. While gender-differences in health and health behaviors of HIV positive patients are well studied, less is known about how men and women living with HIV/AIDS may differentially perceive and integrate support into their lives, and how it subsequently affects their psychological well-being. This cross-sectional study examines how emotional support received from partners and family/friends and gender explains psychological well-being (i.e., stress, depression, anxiety) in a sample of 409 partnered European HIV positive individuals. They hypothesized that gender would modify the associations between support and psychological well-being such that men would benefit more from partner support whereas women would benefit more from family/friend support.
Results revealed that regardless of the source of support, men well-being was more positively influenced by support than was women well-being. Women difficulties in receiving emotional support may have deleterious effects on their psychological well-being.

**HIV STATUS AND PSYCHOLOGICAL WELL-BEING**

Hayasi and Fukunishi (1997) examined the kinds of social support which are related to mood states in a sample of 50 HIV positive patients without AIDS. In the early stages of HIV infection, HIV positive patients without AIDS may be prone to depressive symptoms. The depressive symptoms were not significantly related to lack of ordinary social support such as friends and family but were significantly associated with dissatisfaction with HIV/AIDS related medical support.

Robert A. Carels; Donald H. Baucom; Peter Leone; Amy Rigney (1998) tried to find out association between psychosocial factors (e.g., social support, coping, stress, relationship status, sexual orientation) and psychological symptoms within an HIV-positive sample population that has been underrepresented in prior research was examined in this study. The study's sample reflects many African Americans, injecting drug users, heterosexuals, and women. Structural equation modeling was used to examine the relations among psychosocial factors and psychological symptomatology. There are several notable findings from this study. First, this study's sample appeared to exhibit greater psychological symptomatology than community samples and other HIV-infected
demographic groups. Second, both internal factors (i.e., coping response) and external factors (i.e., life stress) influenced psychological symptomatology. Finally, sexual preference and relationship status influenced the association between social support and psychological well-being.

Eugene W. Farber; Hamid Mirsalimi; Karen A. Williams; J. Stephen McDaniel (2003) explored the relationship between meaning of illness and psychological adjustment in persons with symptomatic HIV disease and AIDS. A group of 203 participants completed self-report questionnaires measuring meaning of illness, problem-focused coping, social support, psychological well-being, and depressed mood. Positive meaning was associated with a higher level of psychological well-being and a lower level of depressed mood. Further, meaning contributed significantly to predicting both psychological well-being and depressed mood over and above the contributions of problem-focused coping and social support. These findings have implications for HIV coping and adjustment models and for HIV-related psychotherapy.

Srikanth Reddy and Jayanthi (2006) provide measures on six sources of stress. A two way randomized group design is employed in the study. The data obtained on the sample are subjected to ‘t’ test, significant differences are found between male and female HIV/AIDS affected people with regard to emotional problems and family problems. Male HIV/AIDS patients experienced more stress due to emotional problems and family problems compare to female HIV/AIDS patients.
Annil Mahajan, Vishal R. Tandon, Sudesh Kumar, R.P. Kudyar, Anil Sharma, Kulbir Singh (2008) say HIV/AIDS is a disease that affects families in a profound and tragic way affecting family structure by erasing decades of health, economic, social progress and reducing life expectancy. There is limited empirical data on HIV/AIDS affected families. The present one and half year prospective study was conducted to identify HIV/AIDS existing in families. HIV/AIDS cases were diagnosed as per the NACO, 2000 criteria. The study enrolled a total 230 HIV/AIDS patients. 65.21 % (150) of the patients were married and 34.78% (80) were unmarried. Among total unmarried population 27.39% (63) and 6.52% (17) were adults and pediatric population respectively. Among total pediatric population 4 were orphan, 3 were partially orphan with mother alive and 10 were with both parents alive but both positive for HIV/AIDS. Among total married 13.04% (30) were widow/widowers who had lost their spouse, whereas those living with live partner were 52.17% (120) forming a total of 60 pairs of couples. Among these 60 couples 40 of them were both positive for HIV/AIDS, in 15, single partner was positive with interesting finding in one case where male was negative and female was positive and mode of transmission was unclear and in another 5 status of spouse was not known due to unknown reasons. Among 40 couples where both partners were affected, 3 couples were isolated where complete family i.e., all children were affected by HIV/AIDS; in another 20 couples children’s were not affected; in 4 couples children were partially affected i.e., some children’s were affected; in 9 couples status of their
children’s were not evident and another 4 couples were without any issue. The results of present study suggest HIV/AIDS affects whole family and not an individual and thus whole family should be screened, evaluated, treated and educated for HIV/AIDS.

Gregory M. Herek; Sona Saha; Jeffrey Burack (2013) Used a community sample of 197 people living with HIV/AIDS, examined how awareness of societal stigma (felt stigma) and negative feelings toward oneself as a member of a stigmatized group (self-stigma) are related to psychological well-being. Both felt stigma and self-stigma were significantly correlated with symptoms of depression and anxiety, but controlling for felt stigma reduced self-stigma's association with depressive symptoms to non-significance. Global self-esteem and social avoidance fully mediated the associations between self-stigma and distress but only partially mediated the associations between felt stigma and distress. Felt stigma mediated the relationship between distress and HIV-related changes in physical appearance.

Oppong K Asante (2008) report that considerable amount of research has been conducted in many countries on the variables related to the psychological well-being of different populations of PLHA. Current research confirms that receiving social support from significant social network members can promote positive psychological adjustment in people living with HIV. Greater amounts of social support have been shown to be associated with less negative and more positive affect in people living with HIV and AIDS. Moreover, people living with HIV and AIDS who are satisfied
with the amount of support available to them tend to experience less psychological distress, a higher quality of life, and more self-esteem whereas those who perceive low levels of social support experience increased distress. Researchers suggest that sexual orientation influences the association between social support and psychological well-being among people living with HIV/AIDS. Women living with HIV/AIDS experience lower quality of life, fewer social supports and more depressed than men living with HIV/AIDS.

Sophie Le Coeur; Michel Bozon; Eva Lelivre (2014) say that before the advent of effective antiretroviral treatment (ART), the sexuality of people living with HIV was mostly discussed in terms of risk. To assess the extent to which ART allows people living with HIV to regain a regular sexual life, we surveyed all HIV-infected people treated in four hospitals in Northern Thailand and a control group from the general population matched by sex, age and residence. Data included socio-demographic and health characteristics, frequency of sexual intercourse in the last month and condom use. Our findings indicate that people living with HIV less often live in steady partnership (50% of the HIV-infected people versus 79% of the controls). After adjusting for factors known to influence sexuality, their probability of being sexually active was estimated to be about half that of the controls. When sexually active, men had a reduced sexual activity compared to controls (2.8 intercourse in the last month versus 4.0), while levels of reported sexual activity were similar among women (2.2 versus 2.8, respectively). Consistent
condom use was high among people living with HIV (66% for women and 70% for men).

Elizabeth Betsy Joseph and Ranbir S. Bhatti (2008) say that socio-cultural milieu provides HIV positive women with fewer resources and more role responsibilities. The present research aimed at studying the psychosocial problems encountered in living, post HIV infection, and the coping patterns adopted by HIV sero positive wives of men with HIV/AIDS. In the background of an exploratory research design, thirty (n = 30) HIV positive women, attending Counseling Clinics in Bangalore (South India), selected through purposive sampling, were assessed using an interview schedule and a standardized coping scale. Majority of the respondents were the primary caregivers for their infected spouse and/or children. Content analysis of the problems revealed increased financial difficulties; problems in child care and support; compromised help-seeking due to stigma; problems in sexual interactions and communication in their marital relationship; role strain in care giving; gender discriminatory and inadequate care; and increased concerns about parenting efficacy, post HIV infection. Escape avoidance was the most preferred coping strategy adopted by them. Situating the illness in a socio-familial context is indicated, and implications for social work and mental health practice follow from the findings.

Jocelyn Dejong (2007) say that Lack of reproductive health (or the health consequences of sexuality and reproduction) constitutes a significant deficiency in well-being in developing countries, yet the field is often
marginalized within development studies. This paper explores whether applying Amartya Sen's capabilities framework to reproductive health may provide one means of bridging this gap. It asks whether it has advantages over prevailing approaches based on disability adjusted life years, which are disease-focused or reproductive rights, which are often perceived as being too individualistic. The paper draws on analysis of three reproductive health problems, namely obstetric fistulae, maternal mortality and female genital mutilation, that occur disproportionately in developing countries. It argues that the capabilities approach offers an opportunity to address the social bases of health (including deprivation and poverty) and one class of societal claims to social justice. However, there are barriers to fostering the kind of cross-disciplinarity needed to undertake such research, which would combine the more technical orientation of economics and epidemiology on the one hand, with the more qualitative social sciences on the other. Even where such cross-disciplinarily can be achieved, however, there are both informational constraints and methodological challenges to illuminate health capabilities – as opposed to functioning’s as measured in quantitative surveys – in such a sensitive field.

Safiya George Dalmida; Marcia McDonnell Holstad; Colleen Diiorio; Gary Laderman (2011) say that many HIV-positive women regard spirituality as an important part of their lives and spirituality may have positive impact on their health-related quality of life (HRQOL). Particularly among African American women with HIV, spirituality may serve as a cultural and
psychological resource. This descriptive, cross sectional study examined associations between spiritual well-being (SWB) and its components, existential well-being (EWB) and religious well-being (RWB), and dimensions of HRQOL among a non-random sample of 118 African American HIV-positive women. A secondary analysis of data from two similar, NIH-funded studies: The Get Busy Living (GBL) Project and the KCHARMA Project, was conducted. Baseline data on women from both studies were combined into one database and statistical analyses, including descriptive, correlation and hierarchical regression analyses, were conducted. Existential well-being was significantly positively ($\beta=+.74; p=?.014$) associated with the physical composite of HRQOL and accounted for a significant amount of unique variance (10.0%) beyond that explained by socio-demographic variables, religious well-being (RWB), HIV medication adherence, CD4 cell count and percentage, HIV viral load, and depressive symptoms. EWB was also significantly positively ($\beta=+.57; p=?.024$) associated with the mental health composite of HRQOL. Depressive symptomatology was also significantly inversely ($\beta=+.40; p=?.004$) associated with mental HRQOL. EWB accounted for a significant amount of additional variance (6.3%) beyond that explained by other variables. Spirituality is an important factor in the lives and quality of life of African American women and women living with HIV/AIDS. Further research is needed to examine relationships between spirituality and HRQOL among HIV-positive African American women.
The review of research undertaken and presented here above with regard to this research reveals that psychologists have not done much in this field. The studies undertaken are few and far between. The impact of HIV positive status on personality, psychological well being and marital adjustment would be really serious. But there is very scant and insignificant regard has been shown to this area of this research. There are not many studies related to HIV positive status people coming from rural and urban backgrounds and gender. So the present research it is hoped that assumes all the significance and relevance in relation to HIV positive patients and may be their betterment.