Chapter – V

DISCUSSION
The focus of the present investigation is on studying hope and resilience as related to psychological well-being among HIV positive patients. In order to meet research objectives the obtained data was processed by appropriate statistical techniques.

The correlation analysis was carried out to examine relationship among hope, resilience and psychological well-being. The intercorrelation among variables showed that there was a strong and positive relationship between hope, resilience and psychological well-being among HIV patients (table 4.2). Hope of HIV patients was positively and significantly correlated with resilience and psychological well-being. Similarly, resilience was also significantly correlated with psychological well-being among HIV patients.

Regression analysis also showed the significance of hope in predicting psychological well-being of HIV patients (table 4.21). Results indicate that hope emerged as significant predictor of psychological well-being of HIV patients. It means that people who are having high hope are more likely to cope with adversity. They experience less depression, anxiety and involve less in reckless behavior. Many studies showed that hope helps in fostering psychological well-being (indirectly related to less depression, less anxiety and less high-risk behavior) in HIV patients. With regard to above findings, Johson, Alloy, Panzarella, Metalsky et al. (2001) found increases in hopelessness predict increases in depression after controlling for baseline social support in HIV infected men. In another study, it was observed that most participants (HIV positive) having hope helped them to deal with the diagnosis of HIV to reduce high-risk behaviors (Harris, 2008). In another words, they deal with disease positively that enhanced their psychological well-being.
Table 4.21, also indicate that resilience did not emerge as significant predictor of psychological well-being among HIV patients. Although, according to correlation analysis resilience was significantly correlated with psychological well-being but regression analysis depicts that resilience was not a significant predictor. The reason behind this may be resilience had not that much effect on psychological well-being as compared to the effect of hope. But there are many studies that show resilience as a significant predictor of psychological well-being among HIV patients for e.g. Farber, Schwartz et al. (2000) examined the hardiness dimension of commitment, challenge and control as resilience factors in adoption among persons with HIV disease and AIDS. Results showed high hardiness was significantly related to lower psychological distress levels and higher perceived quality of life in physical health, mental health and overall functioning domains. Or it can be said that, they experience lower psychological distress levels and higher perceived quality of life in physical health and mental health that leads to high psychological well-being.

In the present investigation, resilience did not emerge as a significant predictor of psychological well-being among HIV positive, this is may be because of the fact individuals with a positive diagnosis are at high risk for mental health issues. Many experience distress from symptoms such as pain, fatigue, insomnia, anxiety and depression. In addition to these vulnerabilities persons with HIV and AIDS are also subject to family crises, financial stressors losses and a multiplicity of medical illness. These may be the factors that lead to low level of resilience in HIV patients in the present investigation.

In case of HIV negative people, the intercorrelation among variables showed that significant correlation was not found between hope, resilience and psychological well-being (table 4.3).
Similarly, regression analysis also explained that both, hope and resilience did not have any significant contribution in defining psychological well-being among HIV negative people (table 4.22).

Many studies are contradictory to this fact that hope and psychological well-being are not correlated or hope is not significant predictor of psychological well-being among HIV negative people. For e.g. Irving, Snyder et.al (2004) found higher baseline hope was associated with greater client well-being, functioning and regulation of emotional distress and few symptoms. Hence, it implies that hope plays an important role in enhancing one’s psychological well-being. Similarly there are some studies that show that hope is a significant predictor of psychological well-being among HIV negative people. Like, Clarke (2003) found that hopefulness and optimism were associated with positive health outcomes. Hopelessness was associated with poor outcomes. Valle, Huebner & Suldo (2006) provided support for consideration of hope as a key to psychological strength in youth. The findings were consistent with theories of motivation in which individual differences in hopeful thinking were conceptualized to play a functional role in linking life events and psychological well-being.

The explanation behind the results that hope did not emerge as a significant predictor of psychological well-being among HIV negative people, may be is that HIV negative people are healthier than their counterparts. They experience less distress, depression and anxiety and less likely to perceive their health as personally threatening. May be because of these reasons hope does not play much role in fostering psychological well-being among HIV negative people.

Similarly, there are many studies that relate resilience and psychological well-being among HIV negative people. Like Pushkar, Lamb, Mumford (1999) concluded
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that the identification of optimism may be vulnerable actor when screening adolescent mental health, (as discussed in the introduction part many people use mental health as synonym of psychological well-being). Chirstopher (2000) concluded on the basis of his study, higher resilience and greater life satisfaction were the strongest predictors of psychological well-being. Chinda and Steptoe (2008) found that positive psychological well-being had a favorable affect on survival in both healthy and diseased population.

But in the present investigation resilience did not emerge as a significant predictor of psychological well-being among HIV negative people. This is may be because these people are healthier than diseased patients and good health is a way to reduce stress and depression. It is said that more obstacles and losses one faces directly, the more times they have to get back on track, the more they struggle, the more resilience they will develop. Because they have not faced any obstacle in relation to their health, they have not developed much resilience. This may be a reason for the resilience not to emerge as a significant predictor of psychological well-being among these people in present investigation.

It can be observed from table 4.4 that there was a significant difference between the mean scores of HIV patients and HIV negative people on hope, resilience and psychological well-being. HIV negative people scored significantly high mean scores than HIV positive patients on hope, resilience and psychological well-being.

The study of Williams et.al (1990) support the finding, HIV negative people scored high mean score on hope than HIV positive. Whereas, in case of resilience and psychological well-being, as such no supporting study was found. The major cause of this result may be is that HIV negative people are healthier than HIV positive patients, they experience less distress, depression and anxiety than HIV patients. It is an
acceptable general fact that HIV negative people are better in health, and have better psychological well-being. HIV negative people are less likely to perceive their health as personally threatening as compared to their counterparts. Consequently, HIV negative people are more resilient, have more hope and have better psychological well-being in comparison to HIV positive patients.

Table 4.6 indicates there was no significant difference between HIV positive males and HIV positive females on hope and resilience. It seems because, as both males and females are going through same symptoms, pains, distress, and anxiety because of the disease. They all know the final stage of HIV is AIDS which means end of life. So there is no difference between them in terms of hope and resilience as they all are in the same situation and facing same adversity.

However, HIV positive males and HIV positive females differ significantly on psychological well-being. Chandra et.al (2009) also support the finding as they also found gender differences on quality of life among people living with HIV/AIDS.

It seems that male and female passes through developmental stages in different ways and meet dissimilar social, cultural and psychological demands. Therefore they have different kinds of mental set to cope with their demands. Both deal with life in their own ways. In case of HIV positive diagnosis, both deal with disease with different ways. Therefore, it can be said that both males and females differ significantly on psychological well-being.

Results also highlight that HIV negative males and HIV negative females did not differ significantly on hope, resilience and psychological well-being (table 4.7). Earlier men would work from the wee hours of the morning to the fading of the day to see that their families get the best that they could afford. Everything owned and everything purchased was so by the sweat of the men’s brow. Toady however that is
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no longer the case women are becoming highly successful as providers for their families like their counterparts. In today’s society females are as much educated as males are. Nowadays males and females are considered same in every aspect. So this may be the reason why HIV negative male and female did not differ significantly on hope, resilience and psychological well-being in the present investigation.

Results also depicts that there was no significant difference between two age groups i.e. 18-35 years and 36-60 years of HIV positive patients on hope, resilience and psychological well-being (table 4.9). This is may be because both age groups face the same adversity, same pain from the symptoms, and same level of distress. Both groups know the final end of the disease. This may be the reason that both age groups did not differ significantly on hope, resilience and psychological well-being.

Present investigation also found significant difference among HIV patients of primary/secondary and college/university educational levels of HIV patients on hope, resilience and psychological well-being (4.12). Though level of education does play a role with respect to resilience, hope and psychological well-being among HIV patients, but it is contrary to the speculation. In the present study HIV patients with low level of education had greater level of hope, resilience and psychological well-being. It may be attributed to the fact that with little knowledge about the disease and due to ignorance, the disease does not have that much impact on their hope, resilience and psychological well-being. On the other hand the HIV positive patients with higher level of education better understand the consequences of their disease. Hence their awareness and knowledge adversely affect their hope, resilience and psychological well-being.
Results also indicate that there was a significant difference between HIV patients who were from joint family system and who belonged to nuclear family system on hope, resilience and psychological well-being. (table 4.15)

In case of joint family, many families are living together. There is more responsibility, and work load in joint family. The HIV patient suffers more in joint families due to the stigma attached with the disease. As a result infected members of the family can find themselves stigmatized and discriminated against within the home. As compared to nuclear family relation bonds are very strong. Therefore, chances of providing support and care for people living with HIV/ AIDS are more in nuclear family. It was also observed by the researcher that the HIV patients belonging to joint family system had low socio economic status as compared to the nuclear family. May be because of these reasons HIV patients who were from joint family and who were from nuclear family differed on hope, resilience and psychological well-being.

Table 4.17 reveals the fact that area of living had a significant influence on hope, resilience and psychological well-being of HIV patients. Because in urban areas, there are more hospitals, more facilities for the patients. More medical aids are available by the hospital staff to patients, HIV testing are more frequent in urban areas than rural area. Because of these facilities HIV patients in urban area significantly differed from HIV patients in rural area on hope resilience and psychological well-being, in the present investigation. Present finding can be corroborated from the Heckman et al. (2008) study, they compared the psychosocial profiles of rural and urban people living with HIV disease. Compared with their urban counterparts, rural people with HIV reported a significantly lower satisfaction with life, lower perceptions of social support from family members and friends, reduced access to medical and mental health care, elevated levels of loneliness, more community
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stigma, heightened personal fear that their HIV serostatus would be learned by others, and more maladaptive coping strategies.

Conclusion

Findings of the present investigation have led the researcher to draw the following conclusions:

1. Hope emerged as a significant predictor of psychological well-being among HIV positive patients, whereas resilience did not emerge as significant predictor of psychological well-being among HIV positive patients.

2. Hope and resilience were not found as significant predictors of psychological well-being among HIV negative people.

3. Significant difference was found between HIV positive patients and HIV negative people on hope, resilience and psychological well-being.

4. Significant difference was not found between HIV positive males and HIV positive females on hope and resilience. But HIV positive males and HIV positive females differed significantly on psychological well-being.

5. Significant difference was found among HIV negative males and HIV negative females on hope, resilience and psychological well-being.

6. Significant and positive relationship was found between hope, resilience and psychological well-being among HIV positive patients.

7. Significant relationship was not found between hope, resilience and psychological well-being among HIV negative people.

While recent scientific hard work have resulted in a series of discoveries and advances in understanding and controlling the virus that causes AIDS, this development has had limited impact on the bulk of HIV infected people and populations living in developing countries. The social and economic conditions that
cultivate the spread of the virus have to be confronted as essential essentials in local and global efforts to stem its spread and create successful solutions to halt the epidemic. The current demographics of the wave illustrate that this is particularly true of the conditions of human life during childhood.

HIV has found a wealth of opportunities to flourish among tragic human conditions fueled by poverty, abuse, violence, prejudice and ignorance. Social and economic circumstances contribute to exposure to HIV infection and intensify its impact, while HIV/AIDS generates and amplifies the very conditions that enable the epidemic to thrive. Just as the virus depletes the human body of its natural defenses, it can also deplete families and communities of the resources and social structures necessary for successful prevention and provision of care and treatment for persons living with HIV/AIDS.

As HIV continues to spread—and neither a vaccine nor cure exists—prevention remains key strategy for decrease the epidemic. The most common mode of HIV transmission is sexual contact; thus, HIV prevention is closely linked to men’s and women’s sexual behavior and reproductive health. Successful prevention programs should include interventions that encourage abstaining from sex, delaying the start of sexual activity, staying with one mutually faithful partner, limiting the number of sexual partners, consistently and correctly using condoms, and counseling and testing for HIV. The most effective mix of these interventions depends on the characteristics of the groups infected with HIV. Effective programs also consider the social, economic, and cultural factors that influence people’s behavior.

Future Research Suggestions

The investigator has the following suggestions to conduct future researches in the field of psychology with these and related variables.
• More research is needed to explore the effect of each dimension of resilience (five components, described by Wagnild & Young) on psychological well-being of HIV patients.

• Studies focusing on HIV disease and other chronic diseases and its impact upon mental health and on social interaction are needed.

• Research is needed to explore the experiences of the patients when their HIV positive diagnosis progresses to AIDS.

• More research is needed to explore the relationship between social support and mental health of HIV patients.

• Length of the disease and intensity of it will always play important role in determining the behavior of the patients. Therefore, more research is needed to be conducted on the duration of the disease.

• Duration of the medication and socio-economic status of the patients is needed to be focused upon.

• One important feature which needs to be considered in the prospective studies is the implementation of awareness programmes.