SUMMARY
The objective of the present endeavor was aimed to study hope and resilience as related to psychological well-being among HIV positive people. Keeping in view the objective of the study, an empirical investigation was undertaken and thereafter data were tabulated and analyzed with the help of Product-moment coefficient of correlation, t-test and Regression analysis for obtaining results.

The thesis comprises of five chapters. Chapter-I emphasizes on the present scenario of the HIV positive patients vis-à-vis independent variables i.e. hope and resilience and dependent variable psychological well-being as a part of the introduction of Ph.D thesis.

Few years ago, the subject of HIV (human immunodeficiency virus), which has been found to the source of AIDS (acquired immunodeficiency syndrome), would not have been the topic of a foremost and serious worldwide tragedy. The AIDS disaster extends far beyond its death toll, because more than seventy percent of the thirty-six million people with HIV/AIDS live in Sub-Saharan Africa. Data from the AIDS epidemic update 2009 show that at 33.4 million, [31.1 million – 35.8 million] there are more people living longer due to the beneficial effects of antiretroviral therapy and population growth. However the number of AIDS – related deaths has declined by over 10% over the past five years as more people gained to access to life saving treatment.

HIV, the human immunodeficiency virus, is the virus that causes AIDS, a debilitating and deadly disease of the human immune system. HIV is one of the world’s most serious health problems. Human Immunodeficiency Virus (HIV) is a lent virus (a member of the retrovirus family) that can lead to acquired
immunodeficiency syndrome (AIDS), a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections. HIV infects certain cells and tissues of the human immune system and takes them out of commission, rendering a person susceptible to a variety of infections and cancers. These infections are caused by so-called opportunistic agents, pathogens that take advantage of the compromised immune system but that would be unable to cause infection in people with a healthy immune system. The collection of diseases that arise because of HIV infection is called acquired immune deficiency syndrome, or AIDS. HIV is classified as a lentivirus (‘lent’ means ‘slow’) because the virus takes a long time to produce symptoms in an infected individual. One of the most disastrous effects of HIV infection is the loss of the immune system’s CD4T cells. These cells are responsible for recognizing foreign invaders to a person’s body and initiating antibody production to ward off the infection. Without them, people are susceptible to a variety of diseases. HIV destroys the T cells slowly, sometimes taking a decade to destroy a person’s immunity. However, in all the time before an HIV-infected individual shows any symptoms, the virus has been reproducing rapidly.

A damaged immune system is not only vulnerable to HIV, but also to the attacks to their infections. It won’t always have strength to fight off things that wouldn’t have bothered it before. As time goes by, a person who has been infected with HIV is likely to become ill more and more until, usually several years after infection, they become ill with number of particularly severe illnesses. It is at this point that they are said to have AIDS - when they first become seriously ill, or when the number of immune system cells left in their body drops below a particular point. AIDS is an extremely seriously condition, at this stage the body has very little defense against any sort of infection. Acquired immune deficiency syndrome or Acquired
immunodeficiency syndrome (AIDS or Aids) is a set of symptoms and infections resulting from the damage to the human immune system caused by the human immunodeficiency reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections and tumors.

Because the worldwide spread of AIDS has had such a great effect on millions of people worldwide, a number of misconceptions have arisen surrounding the disease. From the moment scientist identified HIV and AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic. Discrimination has spread rapidly, fuelling anxiety and prejudice against the groups most affected as well as those living with HIV and AIDS. Despite a wealth of information about HIV transmission, HIV/AIDS remains the single largest sexually transmitted disease of our country. Because many misconceptions and stigma related to this disease, it can affect the person’s personality, emotional health and well-being.

Constructs related to hope began to be introduced into the psychological and psychiatric literature in the 1950’s. An early stream of literature highlighted the role of hope in human adaptation. French (1952) and Menniger (1959) noted the significance of hope in initiating therapeutic change, willingness to learn and a sense of well-being. Dufrane and Leclair (1984), Frank (1968) and Lazarus (1980) articulated the critical role of hope in investigating therapeutic change and other type of action. Although there are varieties of conceptualizations of hope, there is agreement on the essential characteristics of the concept. Hope, a factor in coping, is future oriented and considered to be multidimensional by most theorists. It enables an individual to cope with a stressful situation by expecting a positive outcome. Because a positive outcome is expected, the individual is motivated to act in the face of uncertainty. Hope is rarely discussed without considering hopelessness and vice
Summary

versa; the relationship between these concepts is rarely explicated, however. In the psychology literature, many authors have linked hopelessness with negative emotions. Some, such as Beck (1963, 1967) and Bernard (1977), identify hopelessness as a core characteristic of depression and suicidal behavior (Alloy, Abramson, Metalsky & Hartlage, 1988; Beck, Kovacs & Weissman, 1975; Beck, Weissman, Lester & Terxler, 1974; Minkoff, Bergman, Beck & Beck, 1973). It was noted that hopelessness or lack of hope introduced significant risk not only of mental disorders generally of depression, sociopathy and suicidal behaviours specifically (Beck, Rush, Shaw and Emery, 1979; Erikson, Post & Parge 1975; Frank; 1968; Hanna 1991; Melges & Bowlby, 1969).

Hope is a particularly interesting attribute that can serve as a motivational factor to help initiate and sustain action towards goals and has also been linked to happiness, perseverance, achievement, and health (Peterson, 2000). Early theories of hope conceptualized the construct as a unidimensional motivational force. For example, Stotland (1969) described hope as an “an expectation greater zero of achieving a goal”. More recently, Snyder (1994; see also Snyder, 2000; Snyder et al.; 1991) developed a model of hope that built upon and expanded that of Stotland’s definition.

Both the Snyder hope theory and the definition of hope emphasize cognitions that are built on goal directed thought. In addition to defining hope as the positive expectation of goal attainment, Snyder et al expanded the definition of hope to include two interrelated related cognitive dimensions: agency and pathways (Snyder, 1994; Snyder et al; 1991). Snyder et al. defined hope as goal directed thinking in which the person utilizes pathways thinking (the perceived capacity to find routes to desired goals) and agency thinking (the requisite motivation to use those routes). High hopers
Summary

have positive emotional sets and a sense of zest that stems from their histories of success in goal pursuits, where as low hopers have negative emotional sets and sense of emotional flatness that seems from their histories of having failed in goal pursuits. Lastly high-or-low hope people bring these overriding emotional sets with them as they undertake specific goal-related activities.

Hope is a belief in a positive outcome related to events and circumstances in one’s life. Hope implies a certain amount of perseverance i.e., believing that a positive outcome is possible even when there is some evidence to the contrary.

Positive human functioning is perhaps most remarkable when evident in context of significant life challenge and adversity. It is then, when individuals are being tested, that much becomes known about human strengths what they are, how they come about, how they are natured or undermined.

Resilience in psychology is the positive capacity of people to cope with stress and catastrophe. It is also used to indicate a characteristic of resistance to future negative events.

Resilience is defined as a dynamic process that individuals exhibits positive behavioral adaptation when they encounter significant adversity or trauma (Luther, Cicchetti & Becker, 2000). Resilience is a two-dimensional construct concerning the exposure of adversity and the positive adjustment outcomes of that adversity (Luther & Cicchetti, 2000). Adversity refers to any risks associated with negative life conditions that are statically related to adjustment difficulties, such as poverty, children of schizophrenic mothers, or experiences of 9/11 attacks. Positive adaptation, on the other hand, is considered in a demonstration of manifested behavior on social competence or success at meeting any particular tasks at a specific life stage, such as
the absence of psychiatric distress often the September 11th terrorism attacks on the United States (Luther & Cicchetti, 2000).

Some individuals may seem to prove themselves to be more resilient than others, it should be recognized that resilience is a dynamic quality, not a permanent capacity. In other words, resilient individuals demonstrate dynamic self-renewal, whereas less resilient individuals find themselves worn down and negatively impacted by life stressors. Psychological resilience has been described as an individual’s capacity for maintenance, recovery or improvement in mental health following life challenges (Ryff, Singer, Dienberg Love & Essex, 1998), and an individual’s capacity for transformation and change (Lifton, 1993). Closely related concepts which have received research attention include hardiness (Kobassa, 1979), resourcefulness (Rosenmbauhn, 1990) and mental toughness. Among these terms hardiness is mostly closely related to resilience. The concept of hardiness evolved from existential psychology. It is considered that human search for authenticity by creating personal meaning, and action that promote personal growth.

Resilience is the ‘process of capacity for, or outcome of successful adaptation despite challenging or threatening circumstances’ (Masten, Best & Garmezy, 1990, p. 426). Resilience is best viewed as a relatively stable personality trait characterized by both the ability to recover from negative experiences and the flexible adaptation to the ever-changing demands of life.

In recent years, psychological or subjective well-being (SWB) is the focus of intense research attention (Diener & Diener, 1995). Psychological well-being resides within the experience of the individual (Campbell et. al. 1976). It is a person’s evaluative reaction to his or her life—either in terms of life satisfaction (Cognitive evaluations) or affect (ongoing emotional reaction). Diener & Diener (1995),
however, held that little attention has been paid to whether the prediction of psychological well-being differ in various cultures. They further added, that variables that influence people’s evaluations of their do vary across culture. Well-being refers to the harmonious functioning of the physical as well as psychological aspects of the personality giving satisfaction to the self and benefit to the society. The person reporting low well-being means that he/she is not having complete and harmonious functioning of the whole personality in relation to physical and mental health.

According to Diener, Suh & Oishi (1997) subjective well-being (SWB) is a field of psychology that attempts to understand people’s evaluation of their lives. These evaluations may be primarily cognitive (e.g. satisfaction or marital satisfaction) or may consist of the frequency with which people experience pleasant emotions (e.g. joy as measured by the experience sampling technique) and pleasant emotion (e.g. depression). Psychological well-being is a somewhat unavailable concept which is to do with people’s feeling about everyday life activities. Such feelings may range from negative mental states or psychological strains such as anxiety depression, frustration, emotional, exhaustion, unhappiness, dissatisfaction, to a state which has been identified as positive mental health (Jahoda, 1958; Warr, 1978). Scanning many studies on the perceived quality of life, Campbell (1980) distinguished three types of well-being: affect, strain and satisfaction. The concept of psychological well-being and mental health, by and large, are used as interchangeable by majority of the researchers. It is widely recognized that the concept of mental health focuses on an ideal state emphasizing “positive well-being” of the WHO charter rather than on disease, statistical or conformity criteria. Negative components of psychological well-being are relatively easily accessed through self-reports of anxiety, depression, frustration, etc, but it is difficult to assess positive components of well-being.
Chapter II has been devoted to review of literature in relation to the variables of the proposed research study. Reviewed studies on hope among HIV patients showed that patients who were having high hope dealt with the disease more positively. Some studies also showed that patients having hope helped them to deal with the HIV diagnosis more positively; they were more likely to cope with the adversity. But some studies found opposite, that hope is independent of the HIV status.

Existing literature revealed that HIV diagnosis tends to provide the process of coping and positive attitude towards one’s illness that resulted in resilience in HIV patients. Some studies showed that social support and positive emotions played a crucial role in developing resilience among HIV positive patients. Some studies found significant positive and negative relationships between resilience and various risk-taking behaviors. From the above literature it can be said that resilience plays an important role in dealing with the HIV disease.

From the readily available literature on psychological well-being the researcher found that in certain studies social support and various coping styles were associated with psychological well-being. In some studies positive meaning was associated with higher level of psychological well-being among HIV patients. But some showed people with HIV had poorer psychological well-being. In all from the above literature, it can be said that positive well-being had a favorable effect on both diseased and healthy population.

Chapter III deals with the method and procedure opted for the investigation. The current research is casual research. As the name indicates, causal design investigates the cause and effect relationship between two or more variables. This design measures the extent of relationship between the variables. Casual research
designs attempts to specify the nature of functional relationship between two or more variables. In the present study psychological well-being is dependent variable and hope and resilience are independent variables. The study aims to find out the relationship between hope, resilience and psychological well-being.

The study was conducted on 160 people. Of these 80 people were HIV positive patients and the remaining 80 people were HIV negative people. The sample of HIV patients were selected from Jawaharlal Nehru Medical College (JNMC) Aligarh and sample of HIV negative people were drawn from general population. The sample of HIV patients consisted of 50 males and 30 females and sample of HIV negative people consisted of 37 males and 43 females. The upper age limit of the sample was 60 years. The general information (demographic information) of HIV patients is that 52.5% of them belonged to joint family while 47.5% belonged to nuclear family. In case of HIV negative people 42.5% had joint family system and 57.5% belonged to nuclear family. In case of area of living 38.75% HIV patients belonged to rural area and 61.25% belonged to urban area whereas 10% of HIV negative people live in rural area and 90% in urban area. As far as education profile is concerned it was found that 63.75% of HIV patients got their primary and secondary education, 12.5% did their graduation and 19% of them were uneducated. In case normal people 23.75% were primary and secondary educated and 76.25% of them did higher studies (i.e. masters, PhD).

In the present study the researcher used several tools to measure hope, resilience and psychological well-being. Hope scale developed by Snyder (Snyder et al., 1991) was used to measure hope (8-point Likert scale). This scale measures the disposition of hope. Internal reliability for the total scale ranged from alpha .74 to .84, for the agency subscale it range from .71 to .76 and for the pathway subscale it
ranges from 0.63 to 0.8. To measure resilience, the Resilience Scale was used. The Resilience Scale (RS), originally created by Waglind and Young (1993) is a 25 items scale of 7-point Likert type. Wagnild and Young (1993) reported internal consistency reliabilities for the instrument ranging from .76 to .91 from several of their prior studies. In the present study Psychological Well-Being Scale developed by Bhogle and Prakash (1995) was used. The instrument seems to be most suitable as it contains the items which provide the general information about the psychological well-being of the respondents. When put on test, PSW questionnaire (Bhogle & Prakash, 1993) shows an internal consistency of 0.84 and split half coefficient of 0.91, in retest using the same questionnaire after three months 0.72 correlation was observed. The data collected were analyzed statically by using SPSS package. Tests of correlation, t-test and Regression analysis were used.

Chapter IV and V are devoted to result and discussion. The correlation analysis was carried out to examine relationship among hope, resilience and psychological well-being. The intercorrelation among variables shows that there was a strong and positive relationship between hope, resilience and psychological well-being among HIV patients. 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. Results indicate that hope emerged as significant predictor in explaining 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, Edward & Alberta, 2008). In another words, they deal with disease positively that enhanced their psychological well-being.

In the present investigation, resilience did not emerge as a significant predictor of psychological well-being among HIV positive. 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 has not that much effect on psychological well-being as compared to the effect of hope.

The reason behind the finding that resilience did not emerged 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 case of HIV negative people, the intercorrelation among variables showed that significant correlation was not found between hope, resilience and psychological well-being. 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. The explanation behind the results that hope did not emerged as
a significant predictor of psychological well-being, 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.

In the present investigation resilience emerged as a non 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.

The results also showed 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 more 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, have better psychological well-being in comparison to HIV positive patients.

It was also found that there was no significant difference between HIV positive male and HIV positive female on hope and resilience. It seems because as both male and female 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 male and HIV positive female 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 male and female differ significantly on psychological well-being.

Results also highlight that HIV negative male and HIV negative female did not differ significantly on hope, resilience and psychological well-being. 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 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.

In the light of the research experience it is suggested that further research is required for assessing other factors which influence psychological well-being among HIV positive patients. Personality of HIV patients and HIV negative people can be studied in more detail by taking a large sample to draw more fruitful generalization.