Chapter – I

INTRODUCTION
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Background of the Study

About two decades ago, the subject of HIV (human immunodeficiency virus), which has been found to be the source of AIDS (acquired immunodeficiency syndrome), would not have been the topic of a foremost and serious worldwide tragedy. Few years ago, people were not phased by the effects that would be caused by this ever so populating disease, and no one would have ever realized that this disease would not be helped without costly medicine. Like a simple exponential growth equation, the AIDS virus has increased casualty numbers by about forty million all over the world.

Global Summary of the AIDS Epidemic December 2008

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimate Range</th>
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<tbody>
<tr>
<td>Number of people living with HIV in 2008</td>
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<tr>
<td>Total</td>
<td>33.4 million [31.1 million – 35.8 million]</td>
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<tr>
<td>Adults</td>
<td>31.3 million [29.2 million – 33.7 million]</td>
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<td>Women</td>
<td>15.7 million [14.2 million – 17.2 million]</td>
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<tr>
<td>Children under 15 years</td>
<td>2.1 million [1.2 million – 2.9 million]</td>
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<tr>
<th>People newly infected with HIV in 2008</th>
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<tr>
<td>Total</td>
<td>2.7 million [2.4 million – 3.0 million]</td>
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<tr>
<td>Adults</td>
<td>2.3 million [2.0 million – 2.5 million]</td>
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<tr>
<td>Children under 15 years</td>
<td>430 000 [240 000 – 610 000]</td>
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<th>AIDS – related deaths in 2008</th>
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<tr>
<td>Total</td>
<td>2.0 [1.7 million – 2.4 million]</td>
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<tr>
<td>Adults</td>
<td>1.7 million [1.4 million – 2.1 million]</td>
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<tr>
<td>Children under 15 years</td>
<td>280 000 [150 000 – 410 000]</td>
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The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information (UNAIDS).

AIDS has also shown that it is not selective; it has infected all races and all heritages. 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. Last year alone (2009), the ailment killed 15 million people in Africa. One third of
these sufferers are between the ages of ten and twenty-four. The disease has been described as a development crisis; it is deeply disturbing the economic and social bases of families and entire nations at a rate of infection at 16,000 per day.

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.

Without immediate action, AIDS will surpass the effect of the Black Plague that killed forty million people in the late fourteen century. Although novel treatments are often booming in the slowing the progression from HIV to AIDS and from AIDS to death, they are unreasonable and unavailable in many of the countries where the disease hits the hardest. It is estimated that only ten percent of the death that this disease will cause has been seen. There are no known cures or affordable vaccines to prevent AIDS; the only option is for a program to prevent further spread of epidemic, minimize its impact and provide care and nurture for those affected.

**Statement of the Problem**

The topic of the present study is “A study of hope and resilience as related to the psychological well-being among HIV positive”. HIV/AIDS is a serious medical condition that can be paralyzing to sufferers. HIV is the major concern among social workers and many researchers. Receiving an HIV diagnosis can produce strong emotional reactions. More specifically hope, resilience and psychological well-being are the major matter of interest that leads to examine the present condition of the patients.
HIV

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: at the end of 2001, more than 40 million people worldwide were infected with HIV and living with the virus or AIDS. The World Health Organization estimates that about 20 million people have died from AIDS, since the infection was first described in 1981.

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. Previous names for the virus include human T-lymphotropic virus-III (HTLV-III), lymphadenopathy-associated virus (LAV) and AIDS-associated retrovirus (ARV) (Rick, 1999; Coffin et.al. 1986).

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.

Infection with HIV occurs by the transfer of blood, semen, vaginal fluid, pre-ejaculate, or breast milk. Within these bodily fluids, HIV is present as both free virus particles and virus within infected immune cells. The four major routes of transmission are unprotected sexual intercourse, contaminated needles, breast milk,
and transmission from an infected mother to her baby at birth. Screening of blood products for HIV has largely eliminated transmission through blood transfusion as infected blood products in the developed world.

HIV primarily infects vital cells in the human immune system such as helper T-cells (specifically CD4\(^+\)T cells), macrophages and dendritic cells. HIV infection leads to low level of CD4\(^+\)T-cells through three main mechanisms; firstly, direct viral killing of infected cells; secondly, increased rates of apoptosis in infected cells; and thirdly, killing of infected CD4\(^+\)T cells by CD8 cytotoxic lymphocytes that recognize infected cells. When CD4\(^+\)T cells numbers decline below a critical level, cell-mediated immunity is lost, and the body becomes progressively more susceptible to opportunistic infections.

Eventually most HIV-infected individuals develop AIDS (Acquired Immuno-deficiency Syndrome). These individuals mostly die from opportunistic infections or malignancies associated with progressive failure of the immune system (Lawn, 2004). Without treatment, about 9 out of every 10 person with HIV will progress to AIDS after 10-15 years. Many progress much sooner (Buchbinder, et al, 1994). Treatment with anti-retroviral increases the life expectancy of people infected with HIV. Without antiretroviral therapy, death normally occurs within a year (Schneider, Gange, et. al, 2005). People can become infected with HIV from other people who already have it and when they are infected they can then go no to infect other people. Basically, this is how HIV spreads. Someone who is diagnosed as infected with HIV is said to be ‘HIV+’ or ‘HIV-’ positive.

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 invades 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. The lymph tissue, the resting place for CD4 T cells, macrophages, and dendritic cells, becomes increasingly full of HIV, and viral particles are also released into the bloodstream.

As infected T cells die, the immune system generates more to take their place. As new T cells become infected, they are either actively killed or induced to commit suicide. HIV presents its protein to the immune system, which develops antibodies against it. This antibody production, however, is hampered by the fact that HIV mutates rapidly, changing the proteins it displays to the immune system. With each new protein, the immune system generates new antibodies to fight the infection. Thus, an HIV infection is a dramatic balance between a replicating, ever changing virus and replenishing stores of T cells are fighting it. Unfortunately, the immune system, without therapeutic intervention, eventually loses the battle. Once the CD4 T cells are depleted, the immune system can no longer ward off the daily bombardment of pathogens that all human organisms experience.

The immune system is a group of cells and organs that protect our body by fighting diseases. The human system usually finds and kills viruses fairly quickly. What makes HIV so dangerous is that it attacks the immune system itself— the very thing that would normally get rid of a virus. It particularly attacks a special type of immune system cell known as a CD4 lymphocyte. HIV has a number of tricks that help it to evade the body defenses, including very rapid mutation. This means that once HIV has taken hold; the immune system can never fully get rid of it. There isn’t any way to tell just by looking someone’s being infected by HIV. Infact a person
infected with HIV may look and feel perfectly well for many years and may not know that they are infected. But as the person’s immune system weakens they become increasingly vulnerable to illness, many of which they would previously have fought off easily.

The only reliable way to tell whether someone has HIV is for them to take a BLOOD TEST, which can detect infection from a few weeks after the virus first entered the body.

In order to be transmitted from one individual to another, the HIV virus generally needs to come into contact with cells with CD4 molecules on their surface. Such cells are found within the immune system and are called T-helper cells. These have CD4 molecules on their surface and are mainly found in the blood. The transmission of the HIV virus goes through the following stages:

1. HIV binds the CD4 molecule of a T-helper cell.
2. HIV virus is internalized into the cytoplasm of the cell.
3. The cell itself generates a pro-viral DNA which is a copy of the host cell.
4. This pro-virus enters the nucleus of the host cell.
5. The host cell produces new viral particles which it read off from the viral code of the viral DNA.
6. These viral particles but off and infect new cells.
7. Eventually, after replication, the host T-helper cell dies.

The progression from HIV to HIV disease and AID varies in time. AIDS reflects a reduction in T-helper cell and specifically those with CD4-positive T-cells. This causes immune deficiency and appearance of opportunistic infections. The stages in the progression from initial HIV seroconversion to AIDS are as follows:
• The initial viral seroconversion illness;
• An asymptomatic stage;
• Enlargement of the lymph nodes, onset of opportunistic infections;
• AIDS-related complex (ARC);
• AIDS

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.

AIDS is thought to have originated in sub-Saharan Africa during the 20th century. It was transferred to humans by a similar route as some classic Old World infectious diseases. The ancient Old World was the incubator of many diseases like smallpox because it had large human populations in close association with large animal populations, especially those that lived in herds or social group.
Researchers believe that back in 1930s two colonies of chimpanzees in the south east Cameroon is where the virus first jumped species from chimpanzees to human, way before HIV began its devastating spread among the people. The findings provides a crucial link between HIV, which causes AIDS in human, and the simian immunodeficiency virus (SIV), a strikingly similar virus that infects monkeys and chimpanzees.

Researchers announced in May 2006 that the HIV virus most likely originated in wild chimpanzees in the south eastern rain forests of Cameroon (modern East province). The researchers say that the transference from chimp to human most likely occurred when a human was bitted by a champ or was cut while butchering one, and the human became infected. After the initial transfer of HIV from a non-human primate to humans, the virus ultimately spread via contact among humans to the rest of the world.

India is one of the largest and most populated countries in the world, with over one billion inhabitants of this number, at least five million are currently living with HIV. According to some estimates, India has a greater number of people living with HIV than any other nation in the world (UNAIDS, 2006).

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide (Bureau of Hygiene & Tropical Diseases, 1986). India had no reported cases of HIV and AIDS (Ghosh, 1986). There was recognition, though, that this world not be the case for long, and concerns were raised about how India would cope once HIV and AIDS started to emerge.

In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening, and health
education (NACO, 2006). By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS.

At the beginning of the 1990s, as infection rates continued to rise, responses were strengthened. In 1992, the government launched a strategic plan for HIV prevention. This plan established the administrative and technical basis for programme management and also set up State AIDS bodies in 25 states and 7 union territories. It was able to make a number of important improvements in HIV prevention such as improving blood safety (NACO).

By this stage, cases of HIV infection had been reported in every state of the country. Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population.

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. Below is a list and explanation of some common misconceptions and their rebuttals.

- Sexual intercourse with a virgin will cure AIDS:

  Virgin cleansing is a myth that was occurred since at least the sixteenth century, when Europeans believed that they could rid themselves of a sexually transmitted disease by transferring it to a virgin through sexual intercourse (Meel, 2003: Groce et al., 2004). Doing so does not cure the infected person, but it will expose the victim to HIV infection, potentially spreading the disease further.
HIV is transmitted by mosquitoes:

When mosquitoes bite a person, they do not inject the blood of a previous victim into the person they bite next. Mosquitoes do, however, inject saliva into their victims, which may carry diseases such as dengue fever, malaria, yellow fever, thus infecting the person being bitten. However, HIV is not transmitted this way (Webb et al., 1989).

HIV cannot be transmitted through oral sex:

While it is agreed that oral sex is a very much lower risk activity than vaginal and anal sex, it has been established that HIV can be transmitted through both insertive and receptive oral sex (Rothenberg et al., 1998), when there is contact between the semen and mouth membranes.

AIDS can be spread through casual contact with an HIV infected individual:

One cannot become infected with HIV through day-to-day contact in social settings, schools or in the workplace. One cannot be infected by shaking someone’s hand, by hugging or “dry” kissing someone, by using the same toiled or drinking from the same glass as an HIV infected person, or by being exposed to coughing or sneezing by an infected person (Madhok et al., 1986; Courville et al., 1998).

An HIV-infected mother cannot have children:

HIV infected women are still fertile, although in late stages of HIV disease a pregnant woman may have a higher risk of spontaneous miscarriage. Normally, the risk of transmitting HIV to the unborn child is between 15-30%. However, this may be reduced to just 2-3% if patients carefully follow guidelines (Groginsky et al., 1998).
HIV is the same as AIDS:

This is false. HIV is an acronym for Human Immunodeficiency Virus, and AIDS (Acquired Immune Deficiency Syndrome) is the collection of symptoms, diseases and infections associated with an acquired deficiency of the immune system. While HIV is almost universally acknowledged as the underlying cause of AIDS, not all HIV positive individuals have AIDS, as HIV can remain in a latent state for many years.

There is a cure for HIV / AIDS:

Worryingly, surveys show that many people think that there's a cure for AIDS - which makes them feel safer, and perhaps take risks that they otherwise shouldn’t. These people are wrong, though there is still no cure for AIDS. Medication slows the progression from HIV to AIDS, and which can keep some people healthy for many years. But they have to take powerful medication everyday of their lives, sometimes with very unpleasant side effects. There is still no way to cure AIDS, and at the moment the only way to remain safer in not to become infected.

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.

Stigma is a powerful tool of social control. Stigma can be used to marginalize, exclude and exercise power over individuals who show certain characteristics. In many societies people living with HIV and AIDS are often seen as shameful. In some societies the infection is associated with minority groups or behaviors, for example, homosexuality. In some cases HIV/AIDS may be linked to ‘perversion’ and those
infected will be punished. Also, in some societies HIV/AIDS is seen as the result of personal irresponsibility. Sometimes, HIV and AIDS are believed to bring shame upon the family or community. And whilst negative responses to HIV/AIDS unfortunately widely exist, they often feed upon and reinforce dominant ideas of good and bad with respect to sex and illness, and proper and improper behaviors.

Factors which contribute to HIV/AIDS related stigma:

- HIV/AIDS is a life-threatening disease.
- People are scared of contracting HIV.
- The disease’s is associated with behaviors (such as sex between men and injecting drug use) that are already stigmatized in many societies.
- People living with HIV/AIDS are often thought of as being responsible for becoming infected.
- Religious or moral beliefs lead some people to believe that having HIV/AIDS is the result of moral fault (such as promiscuity or ‘deviant sex’) that deserves to be punished.

Following are the various forms of stigma attached to HIV:

- Women and Stigma:

  The impact of HIV/AIDS on women is particularly acute. In many developing countries, women are often economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. In a number of societies, women are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs). Together with traditional beliefs about sex, blood and the transmission of other diseases, these beliefs provide a basis for the further stigmatization of women within the context of HIV and AIDS.
Introduction

- **Families:**

  In the majority of developing countries, families are the primary caregivers to sick members. There is a clear evidence of the importance of the role that the family plays in providing support and care for people living with HIV/AIDS. However, not all family responses are positive. Infected members of the family can find themselves stigmatized and discriminated against within the home.

- **Employment:**

  While HIV is not transmitted in the majority of workplace settings, the supposed risk of transmission has been used by numerous employers to terminate or refuse employment. There is also evidence that if people living with HIV/AIDS are open about their infection status at work, they may well experience stigmatization and discrimination by others.

- **Healthcare:**

  Many reports reveal the extent to which people are stigmatized and discriminated against by health care systems. Many studies reveal the reality of witheld treatment, non-attendance of hospital staff to patients, HIV testing without consent, lack of confidentiality and denial of hospital facilities and medicines. Also fuelling such responses are ignorance and lack of knowledge about HIV transmission.

  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. It is therefore, to understand the impact of psycho-social factors (hope and resilience) on psychological well-being of the patients.
Since the purpose of the proposed study is to study hope and resilience as related to psychological well-being among HIV positive, it is therefore, useful at this point to discuss in brief about the concept of hope, resilience and psychological well-being. It has been assumed that greater hope and resilience would be associated with positive aspects of psychological well-being of these patients.

**Hope**

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 Menninger (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. Correspondingly, it was noted the hopelessness or lack of hope introduced significant risk not only of mental disorders generally but of depression, sociopathy and suicidal behaviours specifically (Beck, Rush, Shaw and Emery, 1979; Erikson, Post & Paige 1975; Frank; 1968; Hanna 1991; Melges & Bowlby 1969). Hope was also emphasized as moderator of stress on physical health outcomes (Chan, 1977; Gottschalk, 1985) and as a contributor to cancer patient’s psychosocial adaptation (Good, Good, Shaffer and Lind, 1990; Snyder, Harris et.al; 1991). The influence of hope on psychological and spiritual development was also observed (May, 1991; Merton, 1961; Miller and Power, 1988).

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. There are differences in conceptualizations with regard to whether hope has both state and trait components, whether it exists on a continuum with hopelessness, and whether it is an antecedent, a strategy, or an outcome of coping (Raleigh & Boehm, 1944).

Hope is rarely discussed without considering hopelessness and vice 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 behaviour (Alloy, Abramson, Metalsky & Hartlage, 1988; Beck, Kovacs & Weissman, 1975; Beck, Weissman, Lester & Terxler, 1974; Minkoff, Bergman, Beck & Beck, 1973).

In fact, Bernard (1977) hypothesized that hope, like depression, may originate from “heredity, physiology and health, environment, and personal and individual orientation - especially the orientation of responsibility”. Other authors consider hope and hopelessness to be related but non linear concepts (Farran, Herth & Popovich, 1995) and to exist simultaneously in the same individual (Duault & Martocchio, 1985). Still other think hope and hopelessness are on a continuum (McGee, 1984; Stotland, 1969). As Seligman and Csikszentmihalyi (2000) pointed out, research suggests that certain human strengths such as courage, hope and optimism, can act as buffer against psychological disorder.

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). An increasing number of empirical studies have found hope to be related to adjustment, both
physical and psychological. For example, Synder et al. (1991) found that college students high in hope utilized more active, approach-related coping strategies, even after controlling for negative affectivity. Similarly, Chang (1998) found that level of hopefulness in college students related negatively to wishful thinking, self-criticism, and social withdrawal. Furthermore, hope appears to be related to grade point average in college students and also to athletic performance in college athletes (Curry, Snyder, Cook, Ruby & Rehm, 1997). In a study of Veterans with visual impairment (Jackson, Taylor, Palmatier, Elliott & Elliott 1998), hope related positively with functional ability (r=.31), sociable and confident coping styles (r=.43 and .45, respectively) and negatively to the use of avoidant coping styles (r=-.46). Hope has been found to be negatively related to general maladjustment (Cramen & Dyrkacz, 1998), suicidal ideation (Range & Penton, 1994), and symptoms of depression (Chang, 2003). The impact of hope on depression and psychosocial adjustment was also studied in a group of adults with traumatic spinal cord injuries. Higher hope was associated with less depression and greater overall psychosocial adjustment, even after controlling for the amount of time since injury (Elliott, Witty, Herrick, & Hoffman 1991). Kwon (2000) also found that hope was negatively correlated with severity of depressive symptoms and the relationship was moderated by mature defense styles.

Before preceding further lets take a quick look on history of hope. Hope was personified in Greek mythology as Elpis. When Pandora opened Pandora’s Box, she led out all the evils expect one: hope. Apparently, the Greeks considered hope to be as dangerous as all the world’s evils. But without hope to accompany all their troubles, humanity was filled with despair. It was great relief when Pandora revisited her box and let out hope as well. It may be worthy to note that in the story, hope is represented as weakly leaving the box but is in effect far more potent than any of the major evils.
It should be noted that Western European civilization does not have a monopoly on the idea of hope. In every civilization and historical period, there have been hopeful belief and activities. But hope often does not appear into be as significant a deriving belief in all cultural perspectives. For example, hope may not be as prominent a motivational force within the Native American tradition as has been the case for other peoples in Western civilization.

The idea of hope has served as an underpinning for thinking in Western civilization. As Bronowski (1973) has noted in regard to the Industrial revolution, hope helped to make our world ours. Where hope will talk as, in turn, is perhaps the most important question about the unfolding 21st century.

Given below are some of the theories of hope:

**Stotland** (1969) explored the role of expectancies and cognitive schemas and described hope as involving important goals for which there is a reasonably high perceived probability of attainment. Stotland developed a theory that portrays hope as an expectation of future goal attainment that is mediated by the importance of the goal for the individual and motivates action to achieve the goal. Expectation of goal attainment and importance of the goal are determinants of motivation. The greater the importance of the goal to individual, the greater will be the effort to achieve the goal. If the goal is important and the individual perceives a low probability of attaining it, anxiety will be experienced. Because there is motivation to avoid anxiety, the greater the anxiety, the more the individual will motivated to escape it. Hope is a component of adaptive action in a difficult situation, and hopelessness is a factor in maladaptive behaviours. Using Stotland's (1969) model, Erickson, Post and Paige (1975) designed the hope scale, which consists of 20 general and common (i.e., not situation-specific) goals. This Hope scale yields scores of average importance and average
probability across these goals. There is little reported research, however, using this scale.

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).

Only those goals with considerable value to the individual are considered applicable to hope. Also, the goals can very temporally – from those that will be reached in the next few minutes (short-term) to those that will take months even years to reach (long-term). Likewise, the goals entailed in hoping may be approach oriented (that is, aimed at reaching a desired goal) or preventive (aimed at stopping an undesired event) (Snyder, Feldman, Taylor, Schroeder & Adams, 2000). Lastly, goals can vary in relation to the difficulty of attainment, with some quite easy and others extremely difficult. Even with purportedly impossible goals, however, people may join together and succeed through supreme planning and persistent efforts. Pathways thinking has been shown to relate to the production of alternate routes when original ones are blocked (Snyder; Harris, et al., 1991) as has positive self-talk about
finding routes to desired goals (e.g., “I’ll find a way to solve this”; Snyder, LaPointe, Crowson & Early, 1998). Moreover, those who see themselves as having greater capacity for agency thinking also endorse energetic personal self-talk statements, such as “I will keep going” (Snyder, LaPointe, et al., 1998), and they especially likely to produce and use such motivational talk when encountering impediments.

High hopers 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.

The various components of hope theory can be viewed in fig. with the interactive relationship of pathways and agency thoughts on the far thoughts, one can see the emotional sets that are taken to specific goal pursuit activates. Next in fig, are the values associated with specific goal pursuits. As noted previously, sufficient value must be attached to a goal pursuit before the individual will continue the hoping process. At this point, the pathways and agency thoughts are applied to the desired goal. Here, the feedback loop entails positive emotions that positively reinforce the goal pursuit process, or negative emotions to curtail this process.

Fig shows how, along the route to the goal, the person may encounter a stressor that potentially blocks the actual goal pursuit. Hope theory proposes that the successful pursuit of desired goals, especially when circumventing stressful impediments, results in positive emotions and continued goal pursuits efforts (i.e., positive reinforcement). On the other hand if a person’s goal pursuit is not successful (often because that person cannot navigate around blockage), the negative emotions
should result (Ruehlman & Wolchik, 1988), and the goal pursuit process should be undermined (i.e., punishment).

Furthermore, such a stressor is interpreted differently depending on the person’s overall level of hope. That is to say, high hoppers construe such barriers as challenges and will explore alternate routes and apply their motivations to those routes. Typically having experienced successes in working around such blockages, the high hoppers are propelled onward by their positive emotions. The low hopper however, becomes stuck because they cannot find alternate routes; in turn, their negative emotions and ruminations stymie their goal pursuits.
Figure: The Feedforward and Feedback Functions in Hope
Averill, Catlin, and Chon (1990) define hope in cognitive terms as appropriate when goals are (1) reasonably attainable (i.e., an intermediate level of difficulty), (2) under control, (3) viewed as important, and (4) acceptable at social and moral values.

Brezntiz (1986) proposed five metaphors to capture the operations of hope in response to stressors, with hope as (1) a protected area, (2) a bridge, (3) an intension, (4) performance, and (5) an end in itself. He also cautioned that hope may be illusion skin to denial.

Erikson (1964) defined hope as “the enduring belief in the attainability of fervent wishes” and posed dialectics between hope and other motives, one of the strongest and most important being trust/hope versus mistrust, which is the infant’s first task. Another broad dialectic, according to Erikson (1982), pertains to the generativity of hope versus stagnation.

For Gottschalk (1974), hope involves positive expectancies about specific favorable outcomes, and it impels a person to move through psychological problems. He developed a hope scale to analyze the content of 5-minute segments of spoken words. This hope measurement has concurrent validity in terms of its positive correlation with positive human relations and achievement, and its negative relationships to higher anxiety, hostility and social alienation.

Basing his definition on the coping of prisoners of war, Marcel (1978) concluded that hope gives people the power to cope with helpless circumstances.

Mowrer (1960) proposed that hope was an emotion that occurred when rats observed a stimulus that was linked with something pleasurable. Mowrer also
described the antithesis of hope, or fear, which he said entailed a type of deread in which the animal lessened its activity level and that, as such, fear impedes their goal pursuits.

Staats (1989) defined hope as “the interaction between wishes and expectations”. Staats and colleagues developed instruments for tapping the affective and cognitive aspects of hope. To measure affective hope, the Expected Balance Scale (EBS, Staats, 1989) entails 18 items, for which respondents use a 5-point Likert continuum. To measure cognitive hope, the hope index (Staats & Stassen, as cited in Staats, 1989) focuses on particular events and their outcomes and contains the subscales of Hope-Self, Hope-Other, Wish and Expect.

More details on the developmental antecedents of the hope process can be found in Snyder (1994) and Snyder, McDermott, Cook and Rapoff (2002). In brief, however, Snyder (1994) proposes that hope has no hereditary contributions but rather is entirely a learned cognitive set about goal-directed thinking. The teaching of pathways and agency goal-directed thinking is an inherent part of parenting, and the components of hopeful thought are in place by age two. Pathways thinking reflect basic cause and effect learning that the child acquires from caregivers and others. Such pathways thought is acquired before agency thinking, with the latter being posited to begin around age one year. Agency thought reflects the baby's increasing insights as to the fact that she is the causal force in many of the cause-and-effect sequences in her surrounding environment.

In general, Hope Scale scores have predicted outcomes in academics, sports, physical health, adjustment, and psychotherapy. For e.g., in the area of academics, higher Hope scale scores taken at the beginning of college have predicted better
cumulative grade point averages and whether students remain in school (Snyder, Shorey, et al., 2002). In the area of sports, high Hope scale scores taken at the beginning of college track season have predicted the superior performances of male athletes and have done so beyond the coach’s rating of natural athletic abilities (Curry, Snyder, Cook, Ruby, & Rehm, 1997). Additionally, hope has been advanced as the common factor underlying the positive changes that happen in psychological treatments (Snyder, Ilardi, Cheavens, et al., 2000).

Scheier and Carver (1985, 1992) developed another construct similar to hope, that of optimism. Scheier and Carver defined optimism as a generalized expectancy that one will experience good outcomes of life. Their definitions make no distinction regarding the agency through which outcomes occur, whether through individual’s effort, the efforts of others or outside forces. According to Scheier and Carver (1992) optimism leads to persistence in goal directed striving. Parallel to Bandura’s characterization of self-efficacy, Scheier and Carver (1992) have characterized optimism as the most powerful predictor of behavior. There would appear to be a contradiction between Scheier and Carver’s (1985) definition of optimism which broadens its focus to outcome regardless of how they occur and their postulate that optimism is the mechanism that leads the individual to persist in goal directed striving.

Snyder et al. (2000) have listed some of the characteristics of person with high hope and such a person is:

1) More likely to have a fairly consistent pattern of high hope thought across time.

2) Probably has had a major positive adult role model to look up to as adult.

3) Is certain of his/her goals and challenged by them.
4) Is likely to consider relevant external standards set to other, but attends primarily to his/her own standards in setting goal.

5) Value progress towards goals as much as the goals themselves.

6) Easily establishes friendship in childhood and later.

7) Enjoy interacting with people and listening to perspective of others.

8) Has given and take relationship in which both partners join things from the interchange.

9) Is more likely to have higher grades throughout school, is less likely to dropout and is more likely to graduate from college.

10) To less anxious, especially in evaluative test taking circumstances.

11) Exhibits more positive affectivity and is higher in well-being, perceived self worth’s self esteemed and confidence (in several areas).

12) Exhibits better recovery from physical injuries.

13) Is less likely to have thought about suicide.

Although it may be obvious to all but the casual observer that hope and coping are interrelated concepts, the literature does not consistently address the existence or nature of this relationship. Often, hope is described as a coping strategy (Bruhn, 1984; Korner, 1970; Lazarus & Folkman, 1984; Raleigh & Boehm, 1994), but it may also be described as an antecedent to coping (Dufault & Martocchio, 1985; Owen, 1989; Weisman, 1979) or as an outcome of coping (Engel, 1968; Farran & McCann, 1989). In fact, hope may have a role in all three aspects of coping. As an antecedent, hope influences how the individual perceives the situation as a challenge rather than a threat and to muster problem-focused or emotional-focused resources (Farran, Herth, et al., 1995). Finally, as an outcome, hope results from the use of coping strategies,
such as prayer and interpersonal interaction (Raleigh 1992). Hopelessness, however, occur when coping becomes ineffective (Farran, Herth, et al, 1995; Stotland, 1969).

Some research supports hope as a coping strategy. In a study of adolescents with cancer, Hinds (1988b) found that participant reported using two strategies, forgetting cancer and hopefulness, to achieve cognitive comfort, which is part of larger coping process. Other research suggests that hope is an outcome of using coping mechanisms, for example, Raleigh (1992) found that participants reported using strategies to maintain hope such as physical activity, religious activities, mental distraction, or interaction with others. Herth (1989) found that hope and coping responses were related in a study of 120 cancer patients and suggested that fostering hope in the cancer patient is important for the coping responses. These findings suggest that additional discussion of and research on the relationship between hope and coping are essential.

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.

In some faiths and religious of the world, hope plays a very important role. Buddhists and Muslims for instance, believe strongly in the concepts of free will and hope. Hope is passive in the sense of a wish or a prayer-or active as a plan or idea, often against popular belief, with persistent, personal action to execute the plan or prove the idea.

More recently, psychologist Scioli (2006) has developed an integrative theory of hope that consists of four elements: attachment, mastery, survival and spirituality. This approach incorporates contributions from psychology, anthropology, philosophy and theology as well as classical and contemporary literature and the arts.
There is some evidence to suggest that in adverse situations, hope may be worse than hopelessness for overall well-being. For example, people sentenced to life imprisonment without the possibility of parole adjust better to their situation than prisoners who retain the possibility of parole. Similarly, patients who underwent a permanent colostomy showed higher life satisfaction six months after the operation than those who underwent a potentially reversible colostomy.

Positive thinking and variants of positive psychology have demonstrated associations with healthy functioning in numerous life domains (e.g., Nunn, 1996; Snyder, 1995, 2002; Snyder et al., 1991). Snyder's (Snyder et al., 1991) cognitive theory presents hope as a dispositional construct that examines the degree to which individuals believe that they can achieve their goals for the future. Hope consists of two related aspects, the degree to which one can overcome goal-related obstacles. Emotions, according to hope theory, arise in part as a result of hope (Snyder, 2002). Perceived failure or blocked goal results in negative emotions, whereas perceived success or goal attainment results in positive emotions (Snyder, 2002).

Resilience

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. The growing literature on human resilience addresses this juxtaposition of being well in the face of difficulty.

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).

Following are two definitions of resilience cited by Greene (2002)

- Resilience is the act of rebounding or springing back after being stretched or pressed, or recovering strength, spirit and good human. (Webster’s new Twentieth century dictionary of the English language).

- The term “resilience” is reversed for unpredicted or markedly successful adaptation to negative life events, trauma, stress and other forms of risk. If we understand what helps some people to function well in the context of high adversity, we may be able to incorporate this knowledge into new practice strategies. (Fraser, Richman, & Galinsky, 1999, p. 136).

Resilience literature generally affirms that the concept encompasses not merely surviving: but in addition it includes both thriving and having benefited from the stressor experience.
Resilience emerged as a major theoretical and research topic from the studies of children of schizophrenic mothers in the 1980s (Luther, Cicchetti & Beckar, 2000; Masten, Best & Garmezy, 1990). In Masten’s (1989) study, the results showed that children with a schizophrenic parent may not obtain comforting care-giving compared to children with healthy parents and such situation had an impact on children’s development. However, some children of ill parents thrived well and were competent in academic achievement, and therefore led researchers make efforts to understand such responses to adversity. In the onset of the research on resilience, researchers have been devoted to discovering the protective factors that explain people’s adaptation to adverse conditions, such as maltreatment (Cicchetti & Rogosch, 1997), catastrophic life events (Fredrickson, Tugade, Waugh & Larkin, 2003), or urban poverty (Luther 1999). The focus of empirical work then has been shifted to understand the underlying protective processes. Research endeavor to uncover how some factor (e.g., family) may contribute to positive outcomes (Luthar, 1999). Emmy Werner was one of the first scientists to use the term resilience. She studied a cohort of children from Kauai (Hawaiian Island). Kauai was quite poor and many of the children in the study grew up with alcoholic or mentally ill parents. Many of the parents were also out of work. Werner noted that of the children who grew up in these every bad situation, two-thirds exhibited destructive behaviors in their later teen years, such as chronic unemployment, substance abuse, and out-of-wedlock births (in use of teenage-girls). However one-third of these youngsters did into exhibit destructive behaviors. Werner called the latter group resilient. Resilient children and their families had traits that made them different from non-resilient children and families.
Psychological resilience refers to an individual's capacity to withstand stressors and not manifest psychological dysfunction, such as mental illness or persistent negative mood. This is the mainstream psychological view of resilience, that is resilience is defined in terms a person's capacity to avoid psychopathology despite difficult circumstances.

Psychological stressors or "risk factors" are often considered to be experiences of major acute or chronic stress as death of someone else, chronic illness, sexual, physical or emotional abuse, fear, unemployment and community violence.

The central process involved in building resilience is the training and development if adaptive coping skills. The basic flow model (called the transactional model) of stress and coping is: A stressor (i.e. a potential source of stress) occurs and cognitive appraisal takes place (deciding whether or not the stressor represents something that can be readily dealt with or is a source because it may be beyond one's coping resources). If a stressor is consider to be a danger, coping responses are triggered. Coping strategies are generally either be outwardly focused on the problem (problem-solving), inwardly focused on emotions (emotion-focused) or socially focused such as emotional support from other.

In humanistic psychology, resilience refers to an individual's capacity to thrive and fulfill potential despite or perhaps even because of such stressors. Resilient individuals and communities are more inclined to see problems as opportunities for growth. In other words, resilient individuals seem not only to cope well with unusual strains and stressors but actually to experience such challenges as learning and development opportunities.

Following are some of the characteristics of resilient people:

- Ability to "bounce back" and "recover from almost anything"
• Have a “where there’s a will, there’s away” attitude
• Tendency to see problems as opportunities
• Ability to “hang though” which things are difficult
• Capacity for seeing small window of opportunity and making the most of them
• Have a healthy social support network
• Has the wherewithal to competently handle most different kinds of situations
• Has a wide comfort zone
• Able to recover from experiences in the pain zone or of a traumatic nature.

Whilst 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.

Resilience is some kind dynamic quality that is very private. If rooted firmly in the inner sanctum, resilience can hibernate but remain alive during times of difficulty and oppression, then when flower circumstances become more favorable. It is the inner voice that is most prevalent in the human psyche; the inner voice is constantly chattering away. Human psychological experience is fundamentally shaped by what happens in the inner sanctum or core beliefs. When events become overwhelming, when adrenalin surges, when things go wrong, resilience emerges as a the capacity to still find the wherewithal, determination and reason into cope with situation, regardless, despite all odds and more often than not, to find ways through.

Psychological resilience has been described as an individual’s capacity for maintance, 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 (Rosenmbaun, 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. Stressful life events are inevitable challenges that provide opportunities for growth and the development of authenticity (Kobasa, 1979; Maddi & Kobasa, 1984). Drawing from previous work in the field (e.g; Antonovsky, 1979), Kobasa conceptualized hardiness as a constellation of three personality characteristics-control, commitment, and challenge - that were fundamental to authentic living. The control component of hardiness relates to a person's belief in his or her ability to influence or to manage life events. The opposite of control is powerlessness. The second component, commitment refers to active engagement in daily living and having a clear purpose in life. The opposite of commitment is alienation. For the final component, challenge, change is considered as a normal part of living and an opportunity for growth and development. The opposite of challenge is threat. When combined, these three qualities from a personality style of stress resistance that Kobasa called hardiness (Kobasa, 1979, 1982; Maddi & Kobasa, 1984).

Relevant psychological literature on resilience hasn't always used the term 'resilience' or psychological resilience'. Following words are closely related keywords or synonyms:

- Adaptive Coping
- Adversity Quotient
Introduction

- Emotional Intelligence
- Learned Optimism
- Learned Resourcefulness
- Life Orientation
- Resourcefulness
- Self-concept, Self-confidence, Self-efficiency
- Self-healing personality
- Sense of Coherence
- Sense of Meaning
- Thriving

Two factors are found to modify the negative effects of adverse life situations. The first factor is vulnerability which includes any indices aggregating the negative effects of difficult circumstances. For example, children with low intelligence are more vulnerable than those with high intelligence when both groups experience severe adversities (Rutter, 2000). Another factor, protective, on the other hand, is related to moderating the negative effects of environmental hazards or a stressful situation in order to direct vulnerable individuals to optimistic paths, such as external social support. More specifically, Werner (1995) distinguished three contexts protective factors existed in; (1) personal attributes including outgoing, bright, and positive self-concepts; (2) the family such as having close bonds with at least one family members or a emotionally stable parents; and (3) the community, like receiving support or counsel from peers. Besides the above distinction on resilience, research has also been devoted to discovering the individual differences on resilience. Self-esteem, ego-control, and ego-resiliency are related to behavioral adaptation (Cicchetti, et.al 1993). Demographic information (e.g., gender) and resource (e.g., social support) are also
used to predict resilience. In terms of examining people’s adaptation after 9/11 attacks (Bonanno, Galea, Bucciarelli & Vlahov, 2007), women were less involved in affinity groups and organizations showed less resilient.

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. Early studies of resilience tended to regard this construct as a rare trait held by extraordinary individuals, yet more recent work suggests that resilience is a common trait and that it is a part of basic human adaptation system.

Most of the research on resilience has focused on the individual in a western model of developmental psychology. Most of such studies investigated the manners in which individuals cope with adverse circumstances, such as a history of child abuse, facing a diagnosis of terminal illness, or even terrorist attack. It is likely that, “resilient people have optimistic, zestful, and energetic approaches to life, are curious and open to new experiences, and are characterized by high emotionally” (Fredrickson, Tugade, Waugh, & Larkin, 2003). These individuals have adopted strategies such as distancing themselves from negative messages or situations, and also have cultural flexibility and strong connectedness. However, the notion of resilience goes beyond the focus on the individual by also including the community level (Sonn & Fisher, 1998).

Much of the literature, on resilience has emphasized the avoidance of negative outcomes (e.g.; psychological, social, emotional or physical problems), rather than the presence of the positive outcomes. Alternatively, the study of resilience brings to the
literature on flourishing greater insight about how human strengths come to be, including the observation that they are sometime forged in trail and tribulation. At the extreme end, in fact, is the proposition that particular heights of the human experience, what some call thriving are known only by those who have run the gunlet. Whether ultimate human strengths emerge from extremes of human suffering is an open and controversial question. We do not invoke the necessity that one must know pain to find the essence of what is good in life; rather, we see research on resilience as a valuable realm of balance. That is it draws on the negative in human experience by articulating the many ways in which life can be hard, but it also emphasized the positive in describing how some despite (or because of) their travail, are able to love, work, play-in short embrace life. Such a combination avoids the something excessively upbeat tone that overdone darkness characterizing research on human maladies.

Being resilient does not mean, that an individual will "bounce back" and return to the same position after experiencing difficulties, but it does not mean that equilibrium will be re-established. Resilient persons experience the same difficulties and stressors as everyone else; they are not immune or hardened to stress, but they have cleared how to deal with life inevitable difficulties and this ability sets them apart.

In the last two decades, many researchers have become interested in identifying factors associated with resilience in high-risk children. To have a better understanding of resilience, many studies of risk and protective factors in high-risk samples were conducted. Garmezy (1983), in his review, indicates that resilient children shared three categories of protective factors in almost all their experiences. The first one is the dispositional attributes of the child, in this category the children
themselves, believed they were in control of their lives, and were self-reliant. The second factor is family cohesion and warmth. For this category, a child experienced a warm relationship with at least one adult family member, the family felt close, and order and organization were in evidence. The third factor is the availability and the use of external support systems by parents and children, in the neighborhood or elsewhere in the community. There was a support system available to help the child move towards self-defined goals, and there were role models with whom the youngster could identify (Garmezy, 1983).

Seligman (1992) identified certain personality traits that contributed to resilience: optimism, sense of adventure, courage, self-understanding, humor, a capacity to work hard, and an ability to endure and find outlets for emotions. In her review of the literature, Henry (1999), proposes that resilience is defined as the capacity for successful adaptation, positive functioning, or competence despite high risk, chronic stress, or prolonged on severe trauma. Henry suggests that resilience is best understood in terms of transactional processes that assume that developmental outcomes are determined by the interaction of genetic, biological, psychological and sociological factors in the context of environmental support. Gilligan (2000) underlines that the qualities of the child are important in understanding resilience, so also are the experiences as that the child encounters and how they process those experiences (Gilligan, 2000). Resilience provides us with a different approach, that motivates us to promote children’s normal development under the most persistent adverse circumstances. Resilience is normal development under difficult circumstances (Gilligan, 2000).

Gilligan (2000) identifies three important areas or components of resilience. One is having a sense of a secure base a young person’s sense of secure bases
cultivated by a sense of belonging within supportive social networks, by attachment type relationship to reliable and responsive people, and by routines and structures in their lives. Gilligan argues for the importance of the little things of routines and structures and of daily activities at home, familiar routines around meals, bed time stories, getting up, family outings, can be important sources of a sense of order and structure.

A second component is self-worth and self esteem. Self-esteem is made up of two important experiences, (a) secure and harmonious love relationship, and (b) success in accomplishing tasks that are identified by individuals that are central to their interests. Self-esteem is a secondary effect of positive life conditions and experiences.

And finally, a third component is the sense of self-efficacy. A child and youth must at some point start exerting some self-control, responsiveness and decision making capacity within his own life. Of course, this must be viewed developmentally and of course it must be nurtured through consistency, warmth/praise, support, and encouragement to the child to engage in his or her environment.

Resilience is most likely different from one person to the next. But it seems to be made up of different mixtures of dispositional and situation characteristics.

Theoretical descriptions of psychological resilience indicate that resilient people are able to “bounce back” from stressful experiences quickly and efficiently (Carver, 1998). Accordingly, resilient individuals should exhibit faster cardiovascular recovery from negative emotional arousal, compared to their less-resilient counterparts. Together with work on the undoing hypothesis (Fredrickson & Levenson, 1998; Fredrickson et al., 2000), the broaden-and-build theory suggests that this ability to “bounce back” to cardiovascular baseline may be fueled by experiences
of positive emotion. Theoretical writings on resilience have indicated that resilient individuals are characterized by high positive emotionality (e.g., Block & Kremen, 1996; Klohnen, 1996; Wolin & Wolin, 1993) and by the capacity to rebound from negative circumstances despite threats to the individual (e.g., Block & Block, 1980; Lazarus, 1993; Masten, 2001).

According to Dyer and McGuinness (1996), there are four critical attributes that define the parameters of resilience. Malleability and pliancy are present in that there is a sense of rebounding toward a direction in life. A sense of self that surpasses self-esteem and shows a crystal clear clarity on one’s unique path in life in another attribute. This sense of self is a balanced perspective and appreciation of one’s life and experiences, sometimes referred to as equanimity (Wagnild & Young, 1990). The resilient individual possesses the quality of “stick-to-it-iveness”, a value of fortitude with conviction, tenacity with resolve. Armed with this determination, there is a clear acknowledgement that the difficulties in life are to be expected and dealt with. An amiable, benign attitude encourages attachment to others who may support the development of resilience. It is these prosocial behaviors, or the ability to draw people into one’s life during times of adversity, that can help individual faced with adversity bounce back and go on with life.

Resiliency and resilience have merged as intriguing areas of inquiry that explore personal and interpersonal gifts and strengths that can be accessed to grow through adversity. Resiliency inquiry did not emerge from academic grounding in theory, but rather through the phenomenological identification of characteristics of survivors, mostly young people, living in high-risk situations. The first wave of resiliency inquiry was in response to the question, what characteristics mark people who will thrive in the face of risk factors or adversity as opposed to those internal and
external resilient qualities represented the outcome of the first wave of resilient inquiry.

From a historical view, the first wave of resiliency inquiry focused on the paradigm shift from looking at the risk factors that led to psychological problems to the identification of strengths of an individual (Benson, 1997). The character, trait, or situational premise of resiliency is that people possess selective strengths or assets to help them survive adversity. These resilient characteristics have been reformed to as protective factors or development assets.

Werner (1982) and her colleague, Smith (Werner & Smith, 1992), longitudinal findings of a community after studying their children. Werner categorized the resilient qualities that helped these young people to be competent in the face of high-risk environments. Werner’s phenomenology included personal characteristics such as being female, robust, socially responsible adaptable, tolerant, achievement oriented, a good communicator, and having good self-esteem.

More recently, resilient qualities have been identified in the field of positive psychology (Seligman & Csikszentmihalyi, 2000). Articles have emerged that described the strengths, characteristics, and virtues indicative of states of mental health, vitality, and resilience. A special issue of the American Psychologist described optimal characteristics and states or what is termed in this article, resilient qualities. The resilient qualities described with rich detail included happiness (Buss, 2000), subjective well-being (Diener, 2000), optimism (Peterson, 2000), faith (Myers, 2000), self-determination (Ryan & Deci 2000; Schwartz, 2000), wisdom (Baltes & Staudinger, 2000), excellence (Lubinski & Benbow, 2000), and creativity (Simonton, 2000). More recently, the Journal of Social and Clinical psychology has a special issue that focused on strengths, virtues and positive characteristics (McCullough &
Snyder, 2000). The resilient qualities described included morality and self-control (Baumeister & Exline, 2000), gratitude (Emmons & Crumpler, 2000), forgiveness (McCullough, 2000), dreams (Snyder & McCullough, 2000), hope (Snyder, 2000), and humility (Tangney, 2000).

The invaluable contribution of the first wave of resiliency inquiry helped identify resilient qualities that help people recover from adversity.

The second wave of resiliency inquiry was a pursuit to discover the process of attaining the identified resilient qualities. Resiliency then became defined as the process of coping with adversity, change, opportunity in a manner that results in the identification, fortification, and enrichment of resilient qualities or protective factors. The second wave of resiliency inquiry was an attempt to answer the question, how are the resilient qualities acquired? Flach (1988, 1997) suggested that resilient qualities are attained through a low of disruption and reintegration. A more detailed process of accessing resilient qualities as a function of conscious or unconscious choice was proposed by Richardson et al. (1990). Resilient reintegration refers to the reintegrative or coping process that result in growth, knowledge, self-understanding and increased strength of resilient qualities.

To cope with life prompts, human cultivate, through disruptions, resilient qualities so that most events become routine and less likely to be disruptive. People learn to drive, make a living, make a meal, and take care of personal needs without significant disruptions. Disruptions mean that an individual's intact world paradigm is changed and may result in perceived negative or positive outcomes. Disruptions result in primary emotions that potentially lead to introspection. Hurt, loss, guilt, fear, perplexity, confusion and bewilderment are some common primary emotions that surface in the immediate wake of disruption.
Resilient reintegration is to experience some insight or growth through disruption. The process is an introspective experience in identifying, accessing, and nurturing resilient qualities. Resilient reintegrations result in the identification or strengthening of resilient qualities.

The third wave of resiliency inquiry resulted in the concept of resilience. It became clear that in the process of reintegrating from disruption in life, some form of motivational force within everyone that drives them to pursue wisdom, self-actualization, and altruism and to be harmony with a spiritual source of strength. Both resilience and resiliency are metatheories providing an umbrella for most psychological and educational theories.

Resilient reintegration requires energy to grow, and the source of the energy, is a spiritual source or innate resilience. The questions that led to the third wave of resiliency inquiry were what and where is the energy source or motivation to reintegrate resiliency.

A statement of resilience theory is that there is force within everyone that drives them to seek self-actualization, altruism, wisdom and harmony with a spiritual source of strength. This force is resilience, and it has a variety of names depending upon the discipline. Werner and Smith (1992) referred to resilience as an innate “self-righting mechanism” and Lifton (1994) identified resilience as the human capacity of all individuals to transform and change - no matter their risks. Spiritual people said that resilience is about discovering motivational centers in clients, and form a client’s paradigm; most believe that their strength comes from their God or a creative force.
Summary of three wave of Resiliency Inquiry

<table>
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<tr>
<th>Wave</th>
<th>Description</th>
<th>Outcome</th>
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<tr>
<td>First Wave: Resilient Qualities</td>
<td>Phenomenological descriptions of resilient qualities of individuals and support systems that predict social and personal success.</td>
<td>List of qualities, assets, or protective factors that help people grow through adversity (i.e., self-esteem, self-efficacy, support systems, etc.)</td>
</tr>
<tr>
<td>Second Wave: The Resiliency Process</td>
<td>Resiliency is the process of coping with stressors, adversity, change, or opportunity in a manner that results in the identification, fortification, and enrichment of protective factors.</td>
<td>Describe the disruptive and reintegrative process of acquiring the desired resilient qualities described in the first wave; A model that helps clients and students to choose between resilient reintegration. Reintegration back to the comfort zone or reintegration with loss.</td>
</tr>
<tr>
<td>Third Wave: Innate Resilience</td>
<td>Postmodern multidisciplinary identification of motivational forces within individuals and groups and the creation of experiences that foster the activation and utilization of the forces.</td>
<td>Helps clients and students to discover and apply the force that drives a person toward self-actualization and to resiliently reintegrate from disruptions.</td>
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The term resiliency encompasses a breath of experiences, but is commonly, understood as the display of positive adaptation in the face of adversity (Luther & Cicchetti, 2000). Resilience is not a static characteristic or attribute of an individual (Brooks, 1994), but is a dynamic process successfully adapting to stressful life events. Resilience may be detected in individuals who have had a confiding relationship in early life, and whose temperament and psychological characteristics are expressed in their coping styles.
Psychological well-being

Health, be it mental and/or physical, has been found, to be culturally anchored concept. Culture often defines what mental health is and, as clinical psychologists have come to agree, mental illness or abnormality varies in its definition along the dimension of society and culture. Similarly, this concept has inter-individual and intra-individual variations. That is, while the idea of well-being varies from person to person, it changes within the same individual with age, information (knowledge) and personality variations.

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.

The concept of well-being suffers from definitional problems. In their systematic review of the definitions, Pollard and Lee (2003) describe well-being as a "complex, multi-faceted construct that has continued to elude researchers' attempts to define and measure it". Well-being has been defined as a dynamic state characterized by a reasonable amount of harmony between an individual’s abilities, needs and expectations and environmental demands and opportunities (Levi, 1987). It is connotative as a harmonious satisfaction and individual conditions.

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. Diener, Suh, Lucas and Smith (1999) conceptualized subjective well-being as a broad construct, encompassing four specific and distinct components including (a) pleasant or positive affect of well-being (e.g., joy, elation, happiness, mental health), (b) unpleasant affect or psychological distress (e.g., guilt, shame, sadness, anxiety, worry, anger, stress, depression) (c) life satisfaction (a global evaluation of one's life) and (d) domain or situation satisfaction (e.g., work, family, leisure, health, finance, self).

Well-being is the opposite of depression (Joseph & Lewis, 1998). Well-being is the admixture of affective, cognitive and somatic state of affairs. It presents an overall view of subjective well-being (Joseph & Lewis, 1998). It also includes motivational experiences of life with subjective feeling of satisfaction. Terms like happiness, hope, optimism or satisfaction are invariably used as synonyms of well-being. Happiness and satisfaction are the steps to the goal of well-being. They involve multiple life situations as belongingness, creativity, education, familial responsibilities, financial complexities, health (all mental, physical and social health), matrimony, opportunities, self-esteem and trust in others.

Different terms such as happiness, satisfaction, morale and positive affect etc. has been used in literature synonymously with well-being (Chekola, 1975; Culberson 1977; Jones 1953; Tatarkiewicz, 1976; Wessman, 1957; and Wilson, 1960).

‘Well-being’ has been defined by a number of scholars. Diener (1984) grouped these definitions into three categories. The first category defined well-being on the basis of external criteria such as virtue or holiness. These are normative definitions because a particular value framework is considered as standard to judge
the well-being and only the observer or society can judge a person as experiencing or not experiencing well-being. As per this approach, difference in different cultures should produce a varying standard for well-being.

The second category of definitions describes well-being as a person's subjective evaluation about what he considers desirable and good and involves how he evaluates himself on his own life standards. Here, well-being is considered to be a harmonious satisfaction of one's desires and goals.

The third category of definitions mention well-being as it is used in everyday life. Bradburn (1969) describe it as a preponderance of positive affect over negative affect. Current pleasant emotional experiences are thought to be important, or the person is predisposed to such emotion, whether or not he is experiencing them currently. In other words well-being is the amount of positive and negative affect experienced by an individual.

Verma, Mahajan and Verma (1989) defined well-being as subjective feelings of contentment, happiness, satisfaction with life experiences and one's role in the world or work, sense of achievement, utility, belongingness with no distress, dissatisfaction and worry.

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 unpleasant emotions (e.g. depression). Researchers in the field strive to understand not just undesirable clinical states, but also difference between people in positive levels of long-term well-being.
Most of the scholars see well-being as a combination of the components like happiness, satisfaction, hope, optimism, proper perception of means and ends, faith in absolute truth, values, standards and potentiality for achievement (Lu, L, 1995). Veenhoven (1991) stated that the satisfaction of an individual, after his judgment of his overall quality of life indicates well-being.

Well-being can be represented into two forms such as objective well-being and subjective well-being. Objective well-being deals with the feeling of the "well off" character that is, the satisfaction one attains after having comfort like good housing, stable financial status, employment etc. The subjective well-being (psychological well-being) on the other hand, is the ability to maintain balance between one’s needs and the environmental demands. It is the congruence between the individual and group expectations and perceived reality. Bradburn (1969), Campbell (1976), Warr (1978) and others have defined subjective well-being as people’s feelings about their life activities. Such feelings fall on the continuum of negative mental states (anxiety, depression, unhappiness, dissatisfaction etc) to the other end of positive outlook of life (good health, satisfaction, happiness etc) with the second end indicating well-being. Most of the time it has been observed that an increase in the objective standards of living can enhance one’s subjective well-being.

Well-being is much more than just an absence of disease. Johoda (1958) suggested that health is not merely absence of illness, rather it is physical, social, mental and spiritual well-being, a state which has been identified as an attribute of positive mental health. This idea was further supported by WHO (1987CF) and Verma et al (1989). It is also the essence of the humanistic model.

Well-being is a complex construct that concerns optimal psychological functioning and experience. In part, this reflects the increasing awareness that just as
positive affect is not opposite of negative affect (Cacioppo & Bernston 1998), well-being too is not the absence of mental illness.

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 assessed through self-reports of anxiety, depression, frustration, etc, but it is difficult to assess positive components of well-being.

Psychological well-being is not a new concept for human race. Psychological well-being fathers happiness for mankind. Psychological well-being or subjective well-being deals with people’s feelings in their day to day life (Bradburn, 1969; Campbell, 1976; Warr, 1978).

Before moving further, let us take a quick glimpse of historical antecedent of the concept of psychological well-being. Since times immemorial, psychological well-being is a part and parcel of man’s lifestyle. Basically it was studied in philosophy, under the name of ‘Eudoemonics’. This can be clearly studied in Aristotle’s ‘Ethica nicomachea’. Later, with the sheer development of human race, socially, the compartmentalization or more precisely specialization began. This led
the concept of psychological well-being to creep into the discipline of psychology too. Since then, it has become a topic of psychology as well as philosophy and theology.

Theology deals with study of religion. Analyzing theologically the concept of well-being, one can conclude that by the grace of people’s devoted faith in the respective religion or religions, walking with love on the righteous path should lead to their true well-being to true worthiness of life (Nishizawa, 1998).

Buddhism preaches love and well-being for all that is not only for the believers of their faith, but also for the followers of other religions. Christianity’s mission is to bring about true well-being from mankind. Hinduism starts with “Sarve Bhavantu Sukhin” (let all enjoy well-being). Geeta claims well-being to be most important features of life. This well-being can be attained by emancipation from anxiety producing fixation and attachments.

In Islam, The Holy Quran states “Saber Tawakkul” that is to have patience and to have faith in God. It implies that having faith in God and observing patience lead to real well-being.

Subjective or psychological well-being is a new field of research that focuses on understanding the complete range of well-being from utter despair, to elation and total life satisfaction. It is a field of psychology that attempts to understand people’s evaluation of their lives. These evaluation may be primarily cognitive (e.g.; life satisfaction or merital satisfaction) or may consist of the frequency with people experience pleasant emotions (e.g., joy as measured by the experience sampling technique) and unpleasant emotions (e.g; depression).

Subjective well-being refers to people how people evaluate their lives and includes variables such as life satisfaction and marital satisfaction, lack of depression and anxiety, positive moods and emotions. The idea of SWB or happiness has
interest for millennia. In the recent years it has been measured and studied in a systematic way. A person's evaluation of his or her may be in the form of cognitions (e.g., when a person gives conscious evaluate judgments about his or her satisfaction with life as a whole, or evaluative judgments about specific aspect of his or her life such as recreation). An evaluation of one's life also may be in form of affect (people experiencing unpleasant or pleasant moods and emotions in reaction to their lives). Therefore, a person is said to have high SWB (subjective well-being) if she or he experiences life satisfaction and frequent joy, and only infrequently experience unpleasant emotions such as sadness and anger. If a person is said to have low SWB than he or she is dissatisfied with his life, experiences little joy and affection and frequently feels anxiety. The cognitive and affective components of SWB are highly interested.

There are several cardinal characteristics (domains) in the study of SWB (Diener, 1984). First, the field covers the entire range of well-being from agony to ecstasy. It does not focus only on undesirable state such as depression or hopelessness. Individual differences in levels of positive well-being are also considered important. The field is concerned not only with the causes of depression and anxiety but also with the factors that differentiate slightly happy people from moderately happy people and extremely happy people.

Second, SWB is defined in terms of the internal experience of the respondent when assessing SWB an external frame of references is not imposed. Many criteria of mental health are dictate from outside by researchers and practitioner (e.g. maturity, autonomy, realism) SWB is measured from the individuals own perspective.

This approach has both advantages and disadvantage. Although it gives ultimate authority to our respondents, it also means the SWB cannot be consummate
definition of mental health because people may be disordered even they are happy. Thus, a psychologist will usually consider measures in addition to SWB in evaluating a person’s mental health.

Hallmark of SWB is that the field focuses on longer term states, not just momentary moods, although a person’s moods are likely to fluctuate with each new event, the SWB researcher is most interested in the person’s mood over time. Momentary happiness cannot be related to SWB is a wide term in which momentary happiness has an iota place.

Psychological well-being is the subjective feeling of contentment, happiness, satisfaction with life’s experiences and of one’s role in the world of work, sense of achievement, utility, belongingness and no distress, dissatisfaction or worry etc. It emphasizes positive characteristics of growth and development.

There are six distinct components of psychological well-being:

- Having a positive attitude towards oneself and one’s past life (self-acceptance)
- Having goals and objectives that give life meaning (purpose in life)
- Being able to manage complex demands of daily life (environmental mastery)
- Having a sense of continued development and realization (personal growth)
- Possessing caring and trusting ties with others (positive relations with others)
- Being able to follow one’s own convictions (autonomy).

OBJECTIVES

The present research is systematically designed in accordance with the following main research objectives:

1. To examine whether hope and resilience predict psychological well-being among HIV positive patients.
2. To examine whether hope and resilience predict psychological well-being among HIV negative people.

3. To examine whether HIV positive patients differ from HIV negative people with respect to hope, resilience and psychological well-being.

4. To examine whether HIV positive males differ from HIV positive females on hope, resilience and psychological well-being.

5. To examine whether HIV negative males differ from HIV negative females on hope, resilience and psychological well-being.

6. To examine the relationship of hope, resilience and psychological well-being among HIV positive patients.

7. To examine the relationship of hope, resilience and psychological well-being among HIV negative people.

**RESEARCH QUESTIONS**

The following research questions have been framed for the present study:

1. Do hope and resilience predict psychological well-being of HIV positive patients?

2. Do hope and resilience predict psychological well-being of HIV negative people?

3. Do HIV positive patients differ from HIV negative people with respect to hope, resilience and psychological well-being?

4. Do HIV positive males differ from HIV positive females on hope, resilience and psychological well-being?

5. Do HIV negative males differ from HIV negative females on hope, resilience and psychological well-being?
6. Does a significant relationship exist between hope, resilience and psychological well-being among HIV positive patients?

7. Does a significant relationship exist between hope, resilience and psychological well-being among HIV negative people?

HYPOTHESIS

The researcher summarized the various aspects of the proposed study in the form of the following hypothesis:

1. Hope will predict psychological well-being among HIV positive patients.
2. Resilience will predict psychological well-being among HIV positive patients.
3. Hope will predict psychological well-being among HIV negative people.
4. Resilience will predict psychological well-being among HIV negative people.
5. There is no difference between HIV positive patients and HIV negative people on hope, resilience and psychological well-being.
6. There is no difference between HIV positive males and HIV positive females on hope, resilience and psychological well-being.
7. There is no difference between HIV negative males and HIV negative females on hope, resilience and psychological well-being.
8. There is no relationship between hope, resilience and psychological well-being among HIV positive patients.
9. There is no relationship between hope, resilience and psychological well-being among HIV negative people.

Significance of the study

The researcher has opted the present research to study the relationship of hope, resilience and psychological well-being among HIV positive patients. Individuals
with a positive HIV diagnosis are at major risk for mental health issues. Most common are feelings of acute emotional distress, depression, anxiety, a sense of hopelessness and coping problems which can often accompany adverse well-being and adverse life-events. Not only adverse well-being likely following a positive diagnosis, living with HIV disease is a content source of stress due to changes in work status, the experience of acute illness, and adherence to complicated medication regimes. HIV disease is also highly stigmatizing, and can result in discrimination and outright ostracism. Individuals often lose their social support systems when they are most needed. While HIV disease can be managed with medications, there is still likelihood to early death which can result in reckless behavior and higher risk for suicide. In total HIV diagnosis can affect an individual’s total personality.

The interest of various social science disciplines in this area is rapidly growing. This is the reason for selecting HIV with reference to hope, resilience and psychological well-being for the present investigation.