CHAPTER - I

INTRODUCTION

Human Immunodeficiency Virus (HIV) originated in west-central Africa during the early twentieth century. Acquired Immunodeficiency Syndrome (AIDS) was first recognized by the Center for Disease Control and Prevention (CDC) in 1981, and its cause HIV infection was identified in the early part of the decade.

HIV/AIDS Global report

United Nations programme on HIV/ AIDS (UNAIDS) global report (2010) says that there are 3.33 crore people worldwide and 49 lakh people in Asian continent infected with HIV. According to National Aids Control Organization (NACO) report 2010, India has 22.7 lakh, HIV-infected persons, the third highest in the world after South Africa and Nigeria. Children less than 15 yrs account for 3.5 percent of all infections, while 83 percent are the in age group 15-49 years. Of all HIV infections, 39 percent (9.3 lakhs) are women. The four high prevalence states of South India (Andhra Pradesh–5 lakhs, Maharashtra–4.2 lakhs, Karnataka–2.5 lakhs, and Tamil Nadu–1.5 lakhs) account for 55 percent of all HIV infections in the country. Karnataka State Aids Prevention Society (KSAPS) consolidated ART report July 2012 quotes, Karnataka state has 2.23 lakh infected adults.

What is HIV/AIDS?

HIV is a retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections. The most advanced
stage of HIV infection is AIDS. It may take 10-15 years for an HIV-infected person to develop AIDS.

How HIV is transmitted?

HIV is transmitted primarily via unprotected sexual intercourse (including anal and oral sex), contaminated blood transfusions, hypodermic needles and from mother to child during pregnancy, delivery, or breastfeeding.

HIV clinical stages

Following two clinical staging systems are used to classify HIV and HIV-related disease for surveillance purposes.

1. The World health organization (WHO) disease staging system for HIV infection and disease.

2. The CDC classification system for HIV infection.

The WHO first proposed a definition for AIDS in 1986. Since then, the WHO classification has been updated and expanded several times, with the most recent version being published in 2007. The WHO system uses the following categories;

Stage I: HIV infection is asymptomatic with a Cluster Designation (CD4+) T cell (helper cells) count also greater than 500 per microlitre (µl or cubic mm) of blood. May include generalized lymph node enlargement.

Stage II: Mild symptoms which may include minor mucocutaneous manifestations and recurrent upper respiratory tract infections. CD4 count of less than 500/µl.
**Stage III:** Advanced symptoms which may include unexplained chronic diarrhea for longer than a month, severe bacterial infections including tuberculosis of the lung, and a CD4 count of less than 350/µl.

**Stage IV:** AIDS Severe symptoms which include toxoplasmosis of the brain, candidiasis of the esophagus, trachea, bronchi or lungs and Kaposi's sarcoma. CD4 count of less than 200/µl.

The United States Center for Disease Control and Prevention also created a classification system for HIV and updated it in 2008. This system classifies HIV infections based on CD4 count and clinical symptoms and describes the infection in three stages;

**Stage 1:** CD4 count $\geq 500$ cells/µl and no AIDS defining conditions.

**Stage 2:** CD4 count 200 to 500 cells/µl and no AIDS defining conditions.

**Stage 3:** CD4 count $\leq 200$ cells/µl or AIDS defining conditions.

The CDC's classification system is more frequently adopted in developed countries. Since the WHO's staging system does not require laboratory tests, it is suited to the resource-restricted conditions encountered in developing countries, where it can also be used to help guide clinical management. Despite their differences, the two systems allow comparison for statistical purposes.

**HIV/AIDS treatment**

Prevention of HIV infection, primarily through safe sex and needle-exchange programs, is a key strategy to control the spread of the disease. There is no cure; however, antiretroviral treatment can slow the course of the disease and may lead to a near-normal life expectancy. While antiretroviral treatment reduces the risk of death
and complications from the disease, these medications are expensive and may be associated with side effects. There is currently no cure or effective HIV/AIDS treatment. The treatment consists of High Active Antiretroviral Therapy (HAART) which slows the progression of the disease. Treatment also includes preventive and active treatment of opportunistic infections. Following are the types of treatment/therapies for People Living With HIV/AIDS (PLWHA) followed across the globe.

Antiviral therapy includes NARTI or NRTI. Current high active antiretroviral therapy options are combinations consisting of at least three medications belonging to at least two types, or "classes," of antiretroviral agents. Initially treatment is typically a non-nucleoside reverse transcriptase inhibitor plus two nucleoside analogue reverse transcriptase inhibitors. Typical NRTIs include: zidovudine (AZT) or tenofovir (TDF) and lamivudine (3TC) or emtricitabine (FTC). Combinations of agents which include protease inhibitors (PI) are used if the above regime loses effectiveness. The World Health Organization, European guidelines and the United States recommends antiretroviral in all adolescents, adults and pregnant women with a CD4 count less than 350/µl or those with symptoms regardless of CD4 count. This is supported by the fact that beginning treatment at this level reduces the risk of death. The United States in addition recommends them for all HIV-infected people regardless of CD4 count or symptoms; however it makes this recommendation with less confidence for those with higher counts. While the WHO also recommends treatment in those who are co-infected with tuberculosis and those with chronic active hepatitis B. Once treatment is begun it is recommended that it is continued without breaks or "holidays". Many people are diagnosed only after treatment ideally should have begun. The desired outcome of treatment is a long term plasma HIV Ribonucleic acid
count below 50 copies/mL. Levels to determine if treatment is effective are initially recommended after four weeks and once levels fall below 50 copies/mL checks every three to six months are typically adequate. Inadequate control is deemed to be greater than 400 copies/mL. Based on these criteria treatment is effective in more than 95% of people during the first year. Treatment recommendations for children are slightly different from those for adults. Both the World Health Organization and the United States recommend treatment for all children less than twelve months of age. The United States recommends treatment in those between one year and five years of age with HIV Ribonucleic acid counts of greater than 100,000 copies/mL and in those more than five years when CD4 counts are less than 500/µl.

**HIV treatment benefits**

Benefits of treatment include a decreased risk of progression to AIDS and a decreased risk of death. With treatment there is a 70% reduced risk of acquiring tuberculosis. Additional benefits include a decreased risk of transmission of the disease to sexual partners and a decrease in mother-to-child transmission. The effectiveness of treatment depends to a large part on compliance. Reasons for non-adherence include poor access to medical care, inadequate social supports, mental illness and drug abuse. The complexity of treatment regimens (due to pill numbers and dosing frequency) and adverse effects may reduce adherence.

People with HIV use various forms of complementary or alternative medicine, even though the effectiveness of most of these therapies has not been established. With respect to dietary advice and AIDS some evidence has shown a benefit from micronutrient supplements. Evidence for supplementation with selenium is mixed with some tentative evidence of benefit. There is some evidence that Vitamin A,
supplementation in children reduces mortality and improves growth. In Africa, nutritionally compromised pregnant and lactating women a multivitamin supplementation has improved outcomes for both mothers and children. Dietary intake of micronutrients at Recommended Dietary Allowance levels by HIV-infected adults is recommended by the World Health Organization. The WHO further states that several studies indicate that supplementation of Vitamin A, Zinc, and Iron can produce adverse effects in HIV positive adults. There is not enough evidence to support the use of herbal medicines.

**Side effects of treatment**

Specific adverse events are related to the antiretroviral agent taken. Some relatively common adverse events include: lipodystrophy syndrome (abnormal or degenerative conditions of the body's adipose tissue), dyslipidemia (condition where there are abnormal amount of lipids in the blood) and diabetes mellitus, especially with protease inhibitors. Other common symptoms include diarrhea, and an increased risk of cardiovascular disease. Newer recommended treatments are associated with fewer adverse effects. Certain medications may be associated with birth defects and therefore may be unsuitable for women hoping to have children.

**HIV/AIDS psycho-social problems**

The treatments/therapies, treat the body and support the physical well being for people living with HIV/AIDS but they do little about psychological (mental) and social issues. Not only they face several challenges in terms of the medical management of their disease, they also face stigma, discrimination and psychosocial issues associated with HIV infection.
HIV/AIDS has had a great impact on society, both as an illness and as a source of discrimination. The disease also has significant economic impacts. There are many misconceptions about HIV/AIDS such as the belief that it can be transmitted by casual non-sexual contact. The disease has also become subject to many controversies involving religion, region, color and race of people. It has attracted international medical and political attention. The UNAIDS programs have attracted large-scale funding towards controlling and eradication of AIDS.

Psychologists and researchers have explained the role of stigma on HIV infection. Herek (2002) says that HIV and AIDS related stigma is socially shared knowledge about the devalued status of people living with HIV that means treating someone as unimportant. Bharat, Aggleton and Tyrer (2001) reports that stigma is manifested in prejudice, discounting, discrediting and discrimination directed at people perceived to have HIV, along with the groups and communities to which they are associated. Naranjo (2004) also says that people living with HIV/AIDS (PLWHA) struggle with numerous social problems such as stigma, depression, substance abuse. He also concludes that this can affect their Quality of life not only from the physical health aspect, but also from mental and social health point of view and cause numerous problems. Henderson and Thornicroft (2009) reports that people living with HIV/AIDS (PLWHA) suffer physically, mentally, psychologically and such persons are most of the times discriminated on the basis of stigma attached to the means of acquiring HIV. They may be ill treated and isolated from family members and face discrimination from society, which affect their quality of life detrimentally. Ravikumar and Sampathkumar (2013) reports about Psycho social problems in children with HIV, result indicated girls and rural children have highly adjustmental
problems, low self esteem and lower emotional competency then boys and urban children.

From all of the above there has been a conclusion globally, that there is a need for attention from psychologists and counsellors to guide PLWHA on coping skills. It is also clear that stigma plays a key role in the mental health of PLWHA. This ascertainment the study of Stigma and Quality of Life.

STIGMA

The term stigma originates from the concept of stigmata that was used by the Ancient Greeks to refer to a physical marking on an individual to expose a moral flaw in their character. Goffman (1963) described stigma as “an attribute that is deeply discrediting within a particular social interaction”. He is widely credited for conceptualizing and creating a framework for the study of stigma. His work was seminal in creating an environment for ongoing academic research on stigma.

Stigma is often described as the negative labels or stereotypes used when talking about something or somebody, people sometimes associate stigma with being isolated, abused or discriminated against.

Stigma has been defined as a social process that is characterized by exclusion, rejection, blame or devaluation that results from an adverse social judgment about a person or group based on kind of health problem he face.

UNAIDS (2010) defines HIV-related stigma and discrimination thus a process of devaluation of people either living with or associated with HIV and AIDS. AIDS stigma and discrimination exist worldwide, although they manifest themselves
differently across countries, communities, religious groups and individual perceived HIV status.

People who are stigmatized are marked out as being different and stigma is often attached to things which are seen as embarrassing or a danger. Stigma can be used as a way of denying dignity, respect and rights to some members of society, and can result in people being isolated or abused. It can lead to discrimination, where people are treated less well because of a characteristic they have.

From the various studies and observations it is seen that people with HIV infection carry a high level of stigma. Brimlow, Cook and Seaton (2003) have reported that people with HIV infection fits the profile of a condition that carries a high level of stigmatization. First, people infected with HIV are often blamed for their condition and many people believe HIV could be avoided if individuals made better moral decisions. HIV/AIDS has historically been linked with behaviors considered by some to be immoral and/or questionable, i.e. homosexuality, drug use, and promiscuity. Second, although HIV is treatable, it is nevertheless a progressive, incurable disease. Third, HIV transmission is poorly understood by some people in the general population, causing them to feel threatened by the mere presence of the disease. Finally, although asymptomatic HIV infection can often be concealed, the symptoms of HIV-related illness cannot.

In most part of India, it is still unfortunate that even till date HIV is perceived as a disease of people whose lifestyles are considered perverted and sinful. Discrimination, Stigmatization, and Denial are the expected outcomes of such values, affecting life in families, communities, workplaces, schools, and health care settings. Because of HIV/AIDS-related, appropriate policies and models of good practice
remain undeveloped. PLWHA continue to be burdened by poor care and inadequate services, while those with the power to help do little to make the situation better.

**Reasons for stigmatization**

Ever since the first case of AIDS was reported in the early 1980s, people with HIV have been stigmatized. There are a number of reasons for this like;

- HIV is a serious, life-threatening illness. There is a long history of illnesses being stigmatized, even when such illnesses don’t pose a health risk to others, like cancer, or can be prevented and treated, such as tuberculosis (TB).
- HIV is often transmitted through sex or drug use. Many people make moral judgments about these kinds of behavior.
- HIV particularly affects certain groups that already experience discrimination. In the United Kingdom this includes gay men, Africans and injecting drug users, India it includes the sex workers, daily wage workers and slum dwellers. Additionally people with HIV from other groups also experience stigma.
  
  Parker and Aggelton (2003) reports that there are several underlying factors that determine HIV/AIDS stigma. These include lack of knowledge on HIV/AIDS transmission, lack of a preventative vaccine for HIV/AIDS, serious life threatening illness, cultural norms of silence regarding sexuality and sexual practices, moral beliefs about sexual risk behaviors (such as sex outside marriage and having multiple sex partners), as well as linkages between HIV/AIDS and other stigmatized behaviors such as substance use, commercial sex work, and homosexuality.
Several authors divide stigma into felt or perceived stigma and enacted stigma. Malcolm (1998) defines ‘Felt stigma’ refers to real or imagined negative societal attitudes and potential discrimination arising from HIV/AIDS. ‘Felt stigma’ can affect the behaviors and outcomes of people living with HIV/AIDS. ‘Enacted stigma’ refers to the real experience of discrimination.

**Effect of stigma**

HIV/AIDS stigma and discrimination can adversely affect the exercise of virtually every human right, not only the right to be free from discrimination. The right to privacy, the right to health, freedom of movement, the right to education, housing, freedom from inhuman or degrading treatment, the right to life, liberty and security, and freedom from arbitrary arrest can all be denied or violated due to HIV related stigma and discrimination.

Radcliffe, et.al (2010) says that theories of layered stigma suggest that when multiple forms of stigma are present, there are additive, cumulative effects on an individual’s well-being. As external stigma increases, the internalized effects of stigma are often manifested in various sexual and emotional behaviors. Studies indicate that individuals experiencing high HIV stigma were significantly more likely to engage in unprotected sex while high or intoxicated and they also reported more receptive anal intercourse. Stigma was associated with increased levels of anxiety, loneliness, depressive symptoms, engaging in avoidant coping strategies, and history of suicidal ideation.

The ever presence of stigma and its persistence even in areas where HIV prevalence is high makes it an extraordinarily important yet difficult attitude to eradicate. One would expect stigma to decrease with increased visibility of HIV, but
this is not the case. Given the fact that AIDS stigma caused enormous barriers to public health programs from the denial and silence, to problems associated with disclosure, health seeking behavior, and to the communal violence, it would be fitting for the public health community and psychologists to begin to use more creativity in designing AIDS stigma interventions and to implement them on a significant scale.

Avert (2011) reports that the practical and psychological burdens of stigma create formidable obstacles to effective HIV prevention. Individuals at risk, particularly those who are members of marginalized and at-risk groups, may internalize stigma; with an associated impact being self stigmatizing beliefs and actions. CDC (2010) points that Homophobia, stigma, racism, and discrimination negatively affect the health and well-being of gay Men and other men who have Sex with Men (MSM), other members of the LGBT community, and result in the added burden of stress and health disparities. Pardasani, Moreno and Forge (2010) says that Stigma has the effect of leading some people to believe they are not at risk, as they discount their actual personal risk because they do not identify with a particular group or community. Sometimes stigma can also lead to a form of denial that deters some people from testing for HIV or otherwise seeking treatment.

UNAIDS (2010) noted that stigma isolates families and can discourage households from registering affected children in national support programs, and further limits access to information, prevention, care, and treatment. Globally, support for adults and children affected by the epidemic are provided by underfinanced civil society groups, with limited government support. This results in gaps in funding and services, as well as discrimination in laws and/or policy.
For people who are infected with HIV/AIDS, Stigma continues to be a growing issue or an obstacle effecting the quality of life and access to health care. It is as important to combat the stigma as it is to develop medical cures to prevent or control the spread of HIV. Changing people’s mindsets and attitudes are not that easy. Eliminating stigma completely remains at this stage a big challenge. But an overview of previous researches and studies does suggest that something can be done through a variety of interventions, such as focused information dissemination, counseling, coping skills acquisition and direct contact with someone that is living with HIV/AIDS.

Ogden and Nyblade (2005) reports that PLWHA experience stigma in numerous forms, as illustrated in Social stigma excludes PLWHA from family and community events, resulting in their loss of respect in the community. Physical stigma includes isolation and violence, verbal stigma includes insults, taunts, blame, gossip and rumors. Institutional stigma includes job loss due to HIV status, eviction from housing, loss of educational opportunities and substandard health care.

Suggestions from researches

- PLWHA need to be educated on their basic human rights.
- Their rights will enable them to enforce it through the legal process.
- In order to mitigate the effects of discrimination and stigma, institutions should implement their HIV/AIDS policies based on sound information and taking into account the rights of everybody.
- HIV negative people as well as common people also need to be educated, in order to create an environment free of fear of HIV biased social attitudes and no stereotypes towards HIV/AIDS.
Several researchers gave suggestions to overcome stigma. Nilsson (2002) suggests that there is a need to bring an understanding between the rights of the individual, who is at risk of exposure and condemnation because of stigma which is potential threat to the individual’s wellbeing and quality of life, and the rights of the rest of the society for the effective development of large scale effective public health programs. Bezuidenhoudt, et.al. (2004) say that all diseases have psychological effects on people; those infected and those affected. It is most important to create an optimistic mind-set in PLWHA. The stigma about dying can be minimized so that people can realize than they can continue to live productive lives. Mass advertising and campaigning should be done in order to educate. Through this, more people will feel comfortable about getting tested and they suggest that Psychotherapy and education are the keys. Brown, Trujillo and Macintyre (2003) suggest that AIDS stigma can be reduced through intervention strategies including information, counseling, coping skills and acquisition, and contact with affected groups.

The overwhelming stigma of living with a disease such as HIV has a significant negative impact on quality of life. PLWHA public health officials and health care providers play a key role in the improvement of quality of life. PLWHA must be educated on reducing stigma by finding healthy ways to deal with their diagnosis. Hence the role of Psycho-education becomes key in PLWHA.

The survival of PLWHA has been increased with the recent advances in clinical tests and treatments. Hence their QOL has become an important focus for researchers and healthcare providers. Quality of life is often regarded in terms of how it is negatively affected, on an individual level, a debilitating weakness that is not life-threatening.
QUALITY OF LIFE

Quality of life (QOL) is a term that is popularly used to convey an overall sense of well-being and includes aspects such as happiness and satisfaction with life as a whole. WHO (1998) has defined QOL as "Individuals perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, standards, expectations and concerns." The Constitution of the WHO defines health as "A state of complete physical, mental, and social well-being not merely the absence of disease. Researchers at the University of Toronto's Quality of Life Research Unit define quality of life as "The degree to which a person enjoys the important possibilities of his or her life". People living with HIV/AIDS Quality of Life Model is based on the categories "being", "belonging", and "becoming", respectively who one is, how one is not connected to one's environment, and whether one achieves one's personal goals, hopes, and aspirations.

Rajeev, Yuvaraj, Gowda and Ravikumar (2012) say that QOL is a complex and multidimensional concept that is difficult to define and measure. Assessment of QOL in individuals living with HIV/AIDS is becoming crucial to research and evidence based practice in some areas. Additionally the study of psychosocial factors those are likely to influence health outcomes in HIV - infected individuals can increase the understanding of this disease and allow to design more efficient interventions.

Watchel, et,al. (1992) reports that “Quality of life relates both to adequacy of material circumstances and to personal feelings about circumstances. It includes overall subjective feelings of well being that are closely related to morale, happiness and satisfaction". Further as health is generally cited as one of the most important
determinants of overall quality of life, it has been suggested that quality of life may be uniquely affected by specific disease process such as AIDS. QOL has recently been scientifically-defined and it has been considered synonymous with health status, functional status, psychological well-being, happiness with life, satisfaction of needs, and assessment of one’s own life. According to ecological economist Robert Costanza While QOL has long been an explicit or implicit policy goal; adequate definition and measurement have been elusive. Diverse "objective" and "subjective" indicators across a range of disciplines and scales, and recent work on subjective well-being surveys and the psychology of happiness have spurred renewed interest.

Everyday issues such as finances, living circumstances, health care, and employment can improve or damage quality of life. For PLWA the everyday issues are compounded and can be overwhelmingly difficult. The diagnosis of a HIV test can result over time in both external and internal stigma, which may then be multiplied depending on mode of transmission, race, gender, and socioeconomic status. We understand from studies and observation that social support for people living with HIV/AIDS has shown a strong potential to influence QOL. Monger (2011) reports three major components of social support are emotional, tangible, and informational support. Distinction among the different types of social support is relevant. Naranjo (2004) reports that many of the people living with HIV struggle with numerous social problems such as stigma, poverty, depression, substance abuse, and cultural beliefs which can affect QOL in PLWA not only from the physical health aspect, but also from mental and social health point of view and cause numerous problems in useful activities and interests of the People living with HIV/AIDS.
Various studies have examined the relationships between Quality Of Life and depression, social supports, HIV infection stage, functioning in daily living, employment, perceived health status, severity of HIV infection symptoms, stress and adverse effect of treatments for HIV infection among subjects living with HIV infection. Also living with HIV can impact upon many of the factors that affect our quality of life; not only our physical health, but also our mental and social well-being. HIV is not simply a virus that causes disease, but also a social and historical event that impacts how others react towards PLWHA. Issues including personal safety and human rights as well as other aspects of the political and social infrastructure can radically affect quality of life in PLWHA.

A clinic based study reported that internalizing of stigma had a significant negative correlation with QOL in the psychological domain and environmental domain says that PLWHA experiencing higher stigma obtained lower scores in the psychological, environmental and Spirituality/Religious/Personal belief domains of QOL. Another clinic based study reported that each type of stigma was associated with each domain of QOL. In India, the educational level of PLWHA was significantly associated with the psychological domain of QOL; occupation and better family support of PLWHA were significantly associated with the environmental domain of QOL. Among PLWHA, women were reported to have the poorest QOL. HIV/AIDS stigma can severely compromise the QOL of people living with this condition by reducing access and quality of care. This affects adherence to therapy and thereby potentially increases the risk of transmission. PLWHA experiencing higher stigma obtained lower scores in the psychological, environmental and Spirituality/Religious/Personal belief domains of the quality life.
There are only few studies from India which have explored the association between stigma and QOL in PLWHA. Interventions to facilitate HIV positive persons to effectively cope with HIV associated stigma are required. Nevertheless, there is a general feeling that there is dearth of information that specifies the need to develop such interventions.

Intervention program with proper information can be used to facilitate HIV positive persons to effectively cope with HIV stigma and enhance quality of life. However, none of the studies have explored the Psycho-education intervention on Stigma, and QOL in PLWHA. Therefore, it seemed appropriate to implement Psycho-education intervention to the People living with HIV/AIDS to develop coping skills for reducing their stigma and improve quality of life.

**PSYCHO-EDUCATION**

The concept of psycho-education was first noted in the medical literature, in an article by Donley “Psychotherapy and re-education” in the journal of Abnormal Psychology, published in 1911. It wasn’t until 30 years later that the first use of the word psycho-education appeared in the medical literature in title of the book “The psycho educational clinic” by Tomlinson, New York. This book was published in 1941. In French, the first instance of the term psycho-education is in the thesis “La stabilité du comportement” published in 1962. The popularization and development of the term psycho-education into its current form is widely attributed to the American researcher Anderson in 1980 in the context of the treatment of schizophrenia. Anderson’s research concentrated on educating relatives concerning the symptoms and the process of the schizophrenia. Also, her research focused on the stabilization of social authority and on the improvement in handling of the family
members among themselves. Anderson’s research included more effective stress management techniques.

**What is Psycho-education?**

The term psycho-education comprises systemic, didactic psychotherapeutic interventions, which are adequate for informing PLWHA and their relatives about the illness and its treatment, facilitating both an understanding and personally responsible handling of the illness and supporting those afflicted in coping with the disorder. The roots of psycho-education are to be found in behavioral therapy, although current conceptions also include elements of client-centered therapy in various degrees. Within the framework of psychotherapy, psycho-education refers to the components of treatment where active communication of information, exchange of information among those afflicted and also involve imparting knowledge, facilitating understanding and application, developing psychomotor skills, or bringing about affective or attitudinal change. Psycho-education is also often provided to a client's significant others to, at the minimum, help them to cope with the individual's problem, and enable them to be effective components of the treatment and recovery process. Psycho-education in behavior therapy has its origin in the patient's relearning of emotional and social skills. In the last few years increasingly systematic group programs have been developed, in order to make the knowledge more understandable to patients and their families.
Therapeutic elements of psycho-education

- Information transfer (symptomatology of the disturbance, causes, treatment concepts, etc).
- Emotional discharge (understanding to promote, exchange of experiences with others concerning, contacts, etc).
- Support of a medication or psychotherapeutic treatment, as cooperation is promoted between the mental health professional and patient (compliance, adherence).
- Assistance to self-help (e.g. training, as crisis situations are promptly recognized and what steps should be taken to be able to help the patient).

Psycho-education is not necessarily psychotherapy as it does not exclusively deal with psychological or mental illness but rather any condition you or a relative or a friend is experiencing. For example breast cancer is not a mental illness however a person with breast cancer may feel anxious, disheartened and scared about their condition and therefore it is said that the cancer is bringing about psychological stressors. Research has shown that the more a person is aware of their illness and how it affects their own lives and that of others, the more control that person has over their illness. This means that, with appropriate knowledge and techniques, episodes of mental illness occur less often and are usually less severe in intensity and duration.

Format of Psycho-education

Psycho-education can be implemented in a number of different formats and settings. The format depends entirely on the disorder, the developmental age of the individual and their individual needs. Psycho-education can be as follows;
1. Individual based

2. Family based

3. Group based

Psycho-education most commonly involves the individual with the disorder, the patient or client, but in some situations psycho-education is implemented only to the people who deal with the patient on a day to day basis such as family, friends, teachers or caretakers.

**Application of Psycho-education in different set ups**

Psycho-education can be implemented in many areas some of them are schools and colleges, clinical set up, and social set up, which are discussed briefly.

1. Schools and colleges: Psycho-education can be implemented in schools as a preventative measure for teenage pregnancy, anger management and bullying. Psycho-education can be used for educating children and adolescents in schools about relevant issues like social competency, eating disorders, body image and healthy eating and the like.

2. Clinical set up: psycho-education focused in a clinical set up is usually the medical aspects of the condition by identifying and defining the diagnosis, the prognosis, the biology and psychology. How the condition may affect a person’s future in terms of physical limits, how this will affect his mind set and how to think positively.

There are some other issues where we can apply Psycho-education, they are;

- The stigma attached to diagnosis, how this is affected by the media and what can be done to combat and manage the stigma. The stigma associated with many physiological and psychological conditions can
impact significantly on self-esteem and self-worth. Educating on healthy lifestyle behaviors that will help to manage the condition.

- Stress management, why there is a need to manage our stress levels and how does high stress lead to the worsening of symptoms? Can be educated.
- Understanding and enhancing self-esteem, self-image and self-efficacy.
- Treatment, for many disorders adherence to medication is a very important factor in maintaining and managing the condition. The information will answer questions about the medication that includes: What it does? How does it work? What are the benefits? What are the side effects or adverse effects? When and how often it must be taken?

3. Social factors: Along with education about the psychological factors of condition the therapist and doctor may also discuss the social factors. These include the influence of social stigma as well as social support and the importance of recognizing the social support you have, this is called social psycho-education. When people feel they have the support of the community they are more likely to manage the distress associated with their condition more effectively. However the people who are experiencing hardships are more likely to perceive they have no support.

Toselan, Rossitera and Labrecque (1989) conclude that interventions in groups are more effective than individual treatments with regard to improving care receiver symptoms. The group setting may promote the exchange of experiences and techniques in how to influence the care recipient's behavior this enables mutual learning. In addition, other studies have shown that interventions in groups have the
added advantage of building up supportive social networks. Therefore present study used group Psycho-education on people living with HIV/AIDS.

**Effectiveness of Psycho-education**

The effectiveness of psycho-education like any psychotherapy depends entirely upon what you put into it. If you believe in the therapy and do your best to actively learn the material, by asking questions and engaging in the activities, psycho-education will benefit you. That said, psycho-education is not a standalone treatment option. Although knowing about your condition is very important without the concurrent psychotherapy or medications your condition will not improve. Psycho-education is the basis for dealing and managing your condition, once you have that basis you are more likely to benefit from the advantages of other treatments as you will have more faith in them and you will have a higher sense of control over your situation. Education and knowledge feeds into self-efficacy which is essential in treatment for any problem.

Bajaj, Kalia and Mann (2004) says that combining counseling and information-based approaches that break the "culture of silence" associated with HIV/AIDS and promote a culture of openness and support, can have a catalytic effect-starting a chain reaction that reduces stigma and discrimination and eventually also prevalence of HIV in the community. So, the current study introduces Psycho-education intervention based on findings and lessons from previous studies on Stigma and QOL. Corrigan and Watson (2007) list three main avenues for addressing the stigma discrimination associated with any mental disturbance: protest, education, and contact. Interventions based on any of these principles leave much to be desired.
Psycho-education main theme is education offered to people who live with a psychological disturbance which helps to reduce ignorance, prejudice, and discrimination which enhance QOL. However, none of the studies from India have explored the Psycho-education intervention on Stigma, and QOL in PLWHA. In the current research the researcher has explored the possibility of extending the successful Psycho-education intervention strategy on families to the group of PLWHA, towards the effort of improving QOL and reducing stigma.

SIGNIFICANCE OF THE STUDY

India has 22.7 lakhs HIV-infected persons and the third highest in the world after South Africa and Nigeria. Therapies, treat the body and support the physical well being of PLWHA but they do little about psychological (mental) and social issues. PLWHA may be ill treated and isolated from family members and face discrimination from society, which affect quality of life in people living with HIV/AIDS. It is also clear that stigma plays a key role in the mental health of people living with HIV/AIDS. This ascertains the study of Stigma and quality of life. An intervention program with proper information can be used to facilitate HIV positive persons to effectively cope with HIV stigma and enhance QOL. In this research the researcher has explored the possibility of extending the successful Psycho-education intervention strategy to the PLWHA towards the effort of improving QOL and reducing stigma.

The study has implications for the public health approach to the care and prevention of disease. It directly targets the population affected by HIV/AIDS to solicit information that can be useful in improving the care of both infected and affected populations. The study also has significance for psychological counselors,
social workers and policy makers. Psycho-education intervention can be used by specialists to design their intervention programs aimed at sustaining people with HIV/AIDS in good health and at supporting them in their adherence to HIV/AIDS treatment and prevention. Study results also can enable counselors, social work practitioners to educate not only people with HIV/AIDS but also their families on how to cope with HIV-related stigma and quality of life. Overcoming stigma, associated with their HIV infection may lead to further empowerment. Hence, the people with HIV/AIDS may subsequently feel that they can improve their general well-being as well as their QOL. Thus, they may be able to live longer and healthier lives, while at the same time preventing further HIV transmission to self and others.

PLWHA suffer physically, mentally, psychologically and even from economic criteria. Such people are usually discriminated on the means of acquiring HIV and they may be ill treated and isolated from family members and society, from which they develop stigma and which also affects quality of life. There is a need for attention from psychologists and counsellors to guide PLWHA on coping skills. However, none of the studies have explored the Psycho-education intervention on Stigma, and QOL in PLWHA. Therefore, it seemed appropriate to implement Psycho-education intervention to the People living with HIV/AIDS to develop coping skills for reducing their stigma and improve quality of life.