Chapter 2

Review of Literature
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REVIEW OF LITERATURE

Review of literature is an important and integral part of a research work. It enlarges the vision of a researcher for the variable chosen and helps to discuss the result. An integrative literature review is critical to develop a substantial knowledge base about the concept (Broome, 2000). Moreover, it is a broader research review method, permitting the inclusion of various types of research and a more comprehensive understanding of the phenomenon (Whittemore & Knafl, 2005).

Present review of literature concentrates on studies related to spiritual distress and spiritual coping among people living with different stages of HIV/AIDS. This chapter reviewed past studies and literature related to theories of HIV/AIDS, models of coping and spirituality, studies on HIV/AIDS, studies on HIV/AIDS and psychosocial correlates, studies on spirituality and spiritual coping in HIV/AIDS, studies on spiritual distress and its diagnosis/assessment, studies on coping in HIV, studies on spiritual/religious coping and studies on gender differences and spiritual coping with HIV/AIDS.

2.1 Theories of HIV/AIDS

The brief discussion of four theories on HIV/AIDS can be described in the following heads:

Theory of Old Human Disease: According to this theory, the virus comes from a small and isolated ethnic group, which had acquired immunity to it, so that it had rarely caused death. When it spreads outside this group, and reached people who had no such immunity, it became a killer disease for them. This theory stated that, this disease common in one part of the world, when carried to virgin territory has often proved a mortal danger to the newly exposed population.

Simian Origin Theory: This theory stated that, the HIV has existed for a long time as an animal disease, and has recently managed to infect and trigger off epidemic in humans. The theory further stated that it originated among monkeys has in some cases given rise to the idea that the original transmission is from monkeys to human was via
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sexual relationship. The HIV I virus has evolved from the ‘Pan Triglodytes’ sub species of the chimpanzees. It was present in that species for centuries. It doesn’t cause any infection among the chimpanzees. HIV II is a less virulent form and less prevalent species. It is remarkably similar to a virus known as Simian immuno deficiency, which is epidemic among the monkeys.

Theory of Man-made Virus: This is quite unique as against the earlier two. According to this theory, HIV is a man-made virus, perhaps from germs warfare laboratory.

The Mutation Theory: The fourth theory is called the “Mutation theory”. According to this theory, viruses are continually changing and mutating into the new strains. It is possible that a mutation took place in a virus which produces a new virus with the deadly properties of HIV. The theory stated that the first recorded cases for the traces of HIV infection were from North America (1969) and Zaire (1959). So it is possible that there were other cases of HIV/AIDS in other countries of which we have no knowledge. It was believed that HIV was a virus that had undergone mutation or it was produced by combination of the viral particles.

According to medical science, there are two types of HIV i.e. HIV I and HIV II. Both are Zoo noses originated in sub-Saharan African. HIV I originated from Pan Trogloodytes family of Chimpanzees and HIV II from Sooty managabeys family of monkeys. HIV I is the cause of global pandemic of AIDS, while HIV II is mainly confined to West Africa- Both are cytopathic viruses belonging to the family of retrovirus. 11W is a RNA2 virus that contains the enzymes reverse transcriptase, integrate and protease. HIV I is its molecular heterogeneity which gives rise to groups and sub groups. There are three groups of HIV I i.e. M, N and 0 and the M group is further subdivided into a, b, c, f, g, h, j and e. In Asia the most common subtypes are e, c and b. The sub type ‘c’ is the most prevalent in India

2.2 Models of Coping and Spirituality

As previously mentioned, spirituality has the ability to act on all levels of the transactional model of coping simultaneously. It is for this reason that spirituality is viewed as a powerful coping resource.
The Primary Appraisal

The primary appraisal of a stressor is the evaluation of how threatening or harmful the stressor is to the individual, the primary appraisal of a stressor can be influenced by spirituality if the stressor is deemed more manageable because God is helping the person or if the stressor is deemed as a part of the path God has chosen for the individual (e.g. God intended for me to get HIV as part of a divine plan). These are positive ways in which a primary appraisal can deem a stressor less stressful. The primary appraisal of a stressor, however, can be negatively influenced by spirituality if the stressor is deemed a punishment from God. This is one way in which spiritual coping can be maladaptive.

The Secondary Appraisal

The secondary appraisal is the evaluation of the resources a person has readily available with which to handle a stressor. Spirituality can be seen as a resource for managing a stressor if God is viewed as providing the strength with which to handle the issue at hand. Feeling as though one is a vessel for spiritual energy or that one contains “the divine spirit within” (Ironson & Kremer, 2010) is another potential resource available for managing the stressor. In sum, spirituality can help a person to feel more capable of handling a stressful situation.

2.3 Studies on HIV/AIDS

HIV/AIDS is a major concern which has attracted the attention of psychosocial researchers, especially among subjects who were at higher risk. A number of clinical syndromes have been identified in relation with HIV infections which implies that the patient has to adapt to a set of disease specific factors such as medical, psychological and social as well as the general threat of death which may then often lead to various psychiatric conditions like spiritual distress, anxiety and depression. Many PLHIV may not recognize or report depressive symptoms, however, may present with behavioral changes, which may indicate the presence of underlying depression. This section attempts to present significant contributions by researchers in the sample of HIV/AIDS and socio demographic correlates. Studies are arranged in chronological order and reviewed in the past fifteen years.
The people infected with HIV may face profound psychological distress. Moreover, lack of proper understanding about the disease leads to social isolation and rejection. Fear of stigma and feeling of anxiety, hopelessness and depression were frequently reported among HIV positive patients. A study conducted in 1998 at NIMHANS in India among 51 HIV positive patients found that 30% of samples had anxiety and depression among 40% of subjects (Chandra, Ravi, Desai, & Subbakrishna, 1998).

The patients living with HIV/AIDS suffer from many psychological disorders which affect their life style. There are many stressful events such as fear of losing job, death due to disease and social withdrawal in economically weaker sections. These stressful events affect the emotional, developmental and social wellbeing of HIV/AIDS patients (Chippindale & French, 2001).

Feeney (2001) studied the role of HIV/AIDS in increasing the adult-mortality in Zimbabwe. He found that the age specific death rates and probability of death are increasing over the years’ substantiality. It is also described that the sharp rise and fall of death rates between age 20 and 60 departs radically from the normal age pattern of human mortality and in showing high mortality for young and middle aged adults. The increasing pace of probability of death among women is higher than men in Zimbabwe.

Patil (2003) investigated the demographic impacts of this epidemic on the population of AIDS which leads to reduced life expectancy. Higher female and child mortality rates are a distinct possibility. In many African countries the life expectancy has come down by an average 12-13 years infest and child mortality will also increase. Female mortality will substantially increase and adult mortality, which is normally stable will also, increase to a large extent because this is one disease which affects to adult age structure. The scenario for a state like Maharashtra is that life expectancy will come down by four years for males and by 3 years for female by 2016.

Singhal (2003) studied on a large scale on Combating AIDS: Communication, strategies in action. His book deals with various aspects of the HIV/AIDS in the world especially in the Africa, South East Asia and about other developing countries. The study found that the developing countries are more vulnerable due to the lack of communication and awareness. Enough examples are given from the developed as
well as developing nations. He discussed many strategies against the HIV/AIDS like targeting hotspots, workers, truck drivers, to spread awareness by education etc. the main theme of book is to synthesize critical lesson of this disease around the globe and propose strategies for meeting this problem.

Dyson (2003) studied on the relationship between urbanization and HIV/AIDS. The urban level of HIV infection was usually appreciably higher than the rural level within the country. There is significant variation between the urban and rural infection rates. Broadly, there is positive relationship between urbanization and prevalence rates. Higher migrant workers and urban tendency to marry later may work to augment the extent of sexual mixing in some contexts. The effect of HIV/AIDS on the urban crude birth rates in severely affected. To the extent that the birth rates are being reduced by HIV/AIDS the impact of this effect is likely to be higher in urban area because of their generally higher levels of infection lead to higher death rates in urban areas than rural areas. Morality will be raised through direct and indirect mechanism. Lower birth rate and higher death rates consequently, will reduce the natural increase of the urban population thus, finally reducing the speed of urbanization.

Mahal (2004) investigated the economic impacts of HIV/AIDS through household income, sectoral economies as well as national on the household income through the expenses associated with treatment of individual that are borne by the household to whom the individual belongs, HIV/AIDS affects individual in their most productive age, when they are likely to be members of the labor force or in a position to provide in king support to the household. The sectoral impacts are seen on insurance, tourism, agriculture, private, industries, transport etc. There is more public expenditure on health, decreasing number of tourists domestic as well as foreign due to the fear of HIV. There is need to give more attention for analyzing of the impact of HIV/AIDS of the transport sector, relating to railways and the trusting on the national economics by two ways. Firstly, on the national output or on the per capita output. Secondly, on the distribution of national income. These problem become more vulnerable in the poor counties of the world, where for capita output is already low.

Neumayer (2004) seeks the relationship between HIV/AIDS and life expectancy. AIDS now represents the fourth major cause of death worldwide and the leading cause of death in sub-Saharan Africa excess mortality result in large difference in the life expectancy. Botswana, which had one of the lowest child
mortality, in this area child mortality has increased from 63 to 104 per thousand. Life expectancy has lowered down 19.3 percent in sub-Saharan countries, 2.9 percent in Latin America etc. due to HIV prevalence. The author has given many reasons for this lowered process, such as highest rates are found in countries faced with widespread poverty, low income levels, and deficient health care systems. This leads to high mortality. The epidemic is more concentrated in countries that have low life expectancy and impact on high child survival rate. This prevents them from catching up with the high performance in population’s life expectancy.

Kadiala and Barnett (2004) focused on the impacts of HIV/AIDS in India and how it is affecting every human institution. The first case of HIV was reported in 1981 in USA and in India 1986. In short span of 18 years it has reached as high as $7 million in 2004 and if this rate lies unchecked it will be as high as 20 million in 2010 in India only literacy like of awareness and the role of NGO’s etc., are the important tools from combating HIV/AIDS.

Acharya and Das Gupta (2005) studied the tribal village of Uttarakhand (now Uttarakhand) for exploring the situation of health in the general view and HIV/AIDS in the particular view among adolescent boys and girls are likely to engage in high risk behavior due to lack of information about sexuality and the means to protect themselves from such infections. Adolescent boys in both the urban and rural areas seemed to be poorly informed about HIV/AIDS, contraception and other sexual health issues. Only five percent rural and 17 percent of urban peoples know at least one correct mode of transmission. Unmet needs of awareness among aware peoples are not uncommon. Therefore, preventing infection and creating awareness regarding the infection among young adults is very important and critical for showing the epidemic in rural as well as urban areas.

Srivastava and Katyal (2011) studied on HIV/AIDS: Concepts and Prospects. The cumulative AIDS diagnosis statistics can obscure current trends in new infection incidence. In view of this, there is a strong need for scrutinizing the statistics of VCTC by taking note of availability of health facility and public on HIV/AIDS among the high risk young population. It has recently been observed that number of new HIV infection occurring annually is among the younger population (18-24 years). The public efforts to contain this hazard are extremely inadequate. Although, the threat posed by HIV/AIDS is as great as it ever was, there has been little effort to use
the important new behavioral research developments in our understanding of how to help person particularly high risk population to protect themselves from contracting HIV infection. The studies conducted in this field suggest that most affected age group lies between the ages of 15-24 years. This raises question regarding the awareness and knowledge about HIV/AIDS related issues among younger generation.

Ahlawat and Kadian (2012) examined the awareness about HIV/AIDS among rural people: A case study of village Chimni. HIV/AIDS is a serious problem due to constantly increasing incidence and prevalence. In spite of various efforts and finds investment by government in India and international agencies, the problem does not seem to have reduced. It seems that regarding awareness a lot is yet to be done. In this paper the awareness of rural people about HIV/AIDS has been analyzed by taking hundred respondents as a sample size. Percentage and chi-square test were employed to find out the important findings about the awareness of the disease in rural area of Haryana.

Sirira and Rangaial (2011) studied empirically on cognitive impairment among HIV patients. There is belief regarding HIV/AIDS that it affects only the immune system but the underlying truth is the decline in mental process is another complication of HIV/AIDS infection. Their aimed to assess the reaction time and attention of individuals with HIV positive and to compare it with normal individuals. It was hypothesized that there would be individual difference between HIV positive and normal individuals on the measure of attention and reaction time. The neuropsychological tool trail making test and reaction time test were administered to 30 HIV positive patients and were contrasted with those of 30 control subject. Result of this study revealed that there was a significant difference between HIV positive and normal individuals on the measure of attention (P<0.01). The difference is more significant in simple reaction time (P<0.02) than in the choice reaction time (P<0.05). Reaction time is more found in HIV positive subjects as compared to normal individuals.

Nask, Sharam, and Kumar (2011) studied on the attitude towards the sexual behaviour among HIV case in a sample of 60 HIV positive person. The result revealed that attitude towards sexual behavior of HIV infected cases reported the significance difference with their counterparts. White enjoying the sexual, they put aside family and social norms like extra and premarital relation/heterosexuality. On
the other hand, normal individuals enjoy in the frames of restrictions prescribed down by the society. It confirms the messiness in their attitude towards sex as compared to normal. Sexual behavior attitude is measuring the help of sex behavior inventory by Singh (1997). Findings confirm the hypothesis.

Singh, Pandey, and Tripathi (2011) evaluated the impact of supportive psychotherapy in the attenuation of mental ill health and adjustment problems of recently diagnosed HIV/AIDS positive people. For this purpose, a total of 40 patients were selected, supportive psychotherapy was provided to the participants after base assessment and two follow up at 15 days interval each were taken. The tools which were used in present study were: Middle Hospital Questionnaire (MHQ) by Srivastava and Bhatt and Adjustment Inventory by Tripathi. A paired sample test was conducted and there was statistically significant decrease in mental ill health were from baselines assessment to first follow up and from first follow up to second follow up 26.63, and the same trend was found in the case of adjustment problems which compared with baseline assessment of first follow up and from first follow up to second follow up. They found that supportive psychotherapy is quite helpful for the HIV/AIDS positive people to cope with their mental ill health and adjustment related problems after the diagnosis of the disease and to improve their quality of life.

Kaur (2012) evaluates the difference in awareness between the pre-tutorial and post-tutorial in adolescents. It assessed knowledge and source of information about acquired Immune deficiency syndrome test. The most common sources are television, newspaper, magazine and friends but they did not hear of AIDS form parents, teacher and doctor which could be an extremely effective medium to reach people. It revealed that the knowledge of and information about HIV/AIDS amongst the adolescents is grossly inadequate. It needs to undertake intensive health education efforts at school level as this group is most vulnerable to get HIV infection due to lack of knowledge and misconception about the deadly virus. Implication for policy makers and educators are discussed.

2.4 Studies on HIV/AIDS and Psychosocial Correlates

Nathawat and Chandra (2002) studied on AIDS update and the emotional reactions associated with it. The epidemiology of HIV in the world and in India with special reference to all the state is provided. The magnitude of HIV/AIDS in Rajasthan with its 32 district had received the major attention. In addition to it, 15
AIDS patients (Males=10, Female=5), 20 cancer patients (10 each males and females), and 20 surgical patients (10 each male and female) were studied on worrying depression and self-efficacy through Tallis, Worrying Domain Questionnaire (WDQ), beck depression inventory (short scale) and Bandura’s self-efficacy scale. They found that high level of worrying and depression in AIDS patients as compared to their cancer and surgical counterparts. Furthermore, self-efficacy of AIDS patients was considerably reduced than the control.

Cook, Burke, Cohen, Gurtman, Richardson, and Hessol (2004) investigated the association between depressive symptoms and AIDS related mortality among HIV positive women. They found that AIDS related deaths were likely among women with chronic depressive symptoms. Moreover, depressive symptoms were more severe among women in the terminal phase of the illness. However, they observed that despite the depressive symptoms, women who received mental health services were less likely to die from AIDS related causes. They also pointed out that those who were on a HAART regimen for a year or more were less likely to experience AIDS related mortality. They highlighted the importance of identifying and treating depression using both pharmacological psychotherapeutic means as a prerequisite in the clinical care of women who have HIV.

Vyavaharkar, Moneyham, Tavakoli, Phillips, Murdaugh, Jackson, and Meding (2007) examined the relationships among sociodemographic factors, social support, coping, and adherence to antiretroviral therapy (ART) among HIV positive women with depression. They found that coping focused on managing HIV was negatively associated with reasons for missed medications and coping strategies that focused on avoidance or denial was positively associated with reasons for missed medications. Coping by spiritual activities and focusing on the present, mediated the effect of social support on missed medications. Further, they observed satisfaction with social support and coping focused on managing HIV disease were the best positive predictors of medication adherence. They posit that social support and coping can be modified through a variety of interventions including cognitive, behavioral, and social approaches.

Vosvick, Martin, Smith, and Jenkins (2010) examined gender differences with regard to depression as a part of HIV related coping. They found that men and women showed little differences while using various HIV related coping strategies. However,
there were gender differences by which specific coping strategies predict depression. In both gender symptoms, distraction, blame, and positive growth played a key role in predicting depression but when men were examined separately, expression also contributed to the variance in depression. Moreover, disease symptoms were significantly associated with depression for both men and women.

Singh and Saini (2012) conducted a study on a sample of 800 students with age range of (15 to 21). The basic objective of the study was to know the correlates of HIV risk perception among youth population. The test of HIV risk perception (Singh & Saini, 2010) HIV knowledge (Carey, Morrison-Beedy, & Johnson, 1997) impulsivity (Barratt, 1994), and sexual sensation seeking (Kalichman, & Rompa, 1995) were used in the study. It has been observed in the findings that HIV risk perception is significantly correlated with the variables of HIV knowledge (−.32) impulsivity (.18) and sexual sensation seeking behavior (.22)

Devi (2012) examine the body about the differences between the normal and HIV infected patients male as measured by Morey’s (1991) personality assessment inventory on the sub scale of mania, paranoia and schizophrenia. The samples are included fifty normal people and fifty HIV-infected patients; are randomly selected from the Manipur. HIV infected sample are those drug abuse (Heroin No. IV) And syringe sharing. All the selected sub scales are activity level, grandiosity, irritability, resentment, hyper vigilance, persecution, psychotic experiences social detachment and thought disorder. The present study is analyzed by finding out mean, standard deviation, test and sig. level (two-tailed) for both present study shows that the mean and standard deviation of grandiosity, resentment are more similar for both the samples. It means that they are slight non-significant differences between the both samples but the findings also show that activity level, irritability, hyper vigilance, persecution, psychotic experiences, social detachment and thought disorder have significance difference for both the samples. It means that HIV-infected have significance difference on these above variables as compared to the normal people.

Parashar, Kadu, and Mahto (2012) examined depression, suicidal ideation effect on quality of life in HIV/AIDS patients and normal population. Human immunodeficiency virus/Acquired Immunodeficiency syndrome (HIV/AIDS) is a global health problem which has brought new dimension to some of the already complex issues threatening India. We all know the impact HIV/AIDS has had on the
world but what people don’t realize is the impact, it is having on other serious health issues in the country. Depression is the most prevalent psychiatric co-morbidity and a common cause of significant morbidity among people with HIV infection. Sociality may be the direct physiological result of HIV, a reaction to chronic pain, on emotional reaction to having a chronic and life threatening illness. Quality of life is phrase used to refer to on individuals’ total wellbeing. The sample size of the study was 30 HIV/AIDS patients and 30 normal populations. The tools used for assessing the variables are Beck Depression Inventory, WHO Quality of Life (WHOOL-BRIEF) and Suicidal Ideation Scale (SIS).

McIntosh and Rosselli (2012) investigated the effects between stressors and coping mechanisms on behavioral health outcomes among women living, with HIV using a meta analytic approach. They found that acute and chronic forms of psychosocial stress had a strong effect on the development of psychopathology as did the physical burden of disease management. Further, they found that physical stress resulting from HIV related symptomology was a significant predictor of adverse psychological consequence in women. Functional impairment was also found to significantly predict negative effect. Moreover, coping by avoidance and social isolation predicted more severe and negative mental health outcomes in women living with HIV/AIDS. Spirituality and positive reappraisal’ predicted greater psychological adaptation. They posit that positive reframing appeared to promote psychological ad4ptation which in turn may lead to positive health outcomes in women living with HIV/AIDS.

Dalmida, Koenig, Holstad, and Wirani (2013) examined correlates of depressive symptoms, particularly the role of religious coping (RCOPE), among people living with HIV/AIDS (PLWHA). The study also examined social support as a possible mediator of the proposed association between religious coping and depressive symptoms and the impact of depressive symptomatology on health outcomes such as HIV medication adherence, immune function, and health-related quality of life (HRQOL) among PLWHA. PLWHA with depressive symptomatology reported significantly poorer health outcomes, including poorer HIV medication adherence, lower CD4 cell count, and poorer HRQOL. Social support partially mediated the relationship between religious coping and depressive symptoms. They found that high rates of depressive symptoms are present in PLWHA, which negatively impact health
outcomes. Religious coping, perceived stress, and social support satisfaction serve an important role in depressive symptomatology among PLWHA. These findings underscore the need for healthcare providers to regularly screen PLWHA for and adequately treat depression and collaborate with mental health providers, social workers, and pastoral care counselors to address PLWHA’s mental, social, and spiritual needs and optimize their HIV-related outcomes.

Szaflarski (2013) studied on spirituality and religion among HIV-infected individuals. Spirituality and religion are important to many people living with HIV. Recent research has focused on special populations (ethnic-minorities, women, and youth), spirituality/religion measurement, mediating/moderating mechanisms, and individual and community level interventions. Spirituality/religion in PLWH has been refined as a multidimensional phenomenon, which improves health/quality of life directly and through mediating factors (healthy behaviors, optimism, social support). Spirituality/religion helps people to cope with stressors, especially stigma/discrimination. Spiritual interventions utilizing the power of prayer and meditation and addressing spiritual struggle are under way. Faith-based community interventions have focused on stigma and could improve individual outcomes through access to spiritual/social support and care/treatment for people living with HIV/AIDS. Community engagement is necessary to design/implement effective and sustainable programs. Future efforts should focus on vulnerable populations; utilize state-of-the-art methods (randomized clinical trials, community-based participatory research); and, address population-specific interventions at individual and community levels. Clinical and policy implications across geographic settings also need attention.

Shittu, Issa, Olanrewaju, Mahmoud, Odeigah, Salami, and Aderibigbe (2013) assessed the prevalence of depressive disorders and its correlates among PLWHA. They found that more than half of the sample satisfied the criteria for a depressive disorder. Further, they found that depressive symptoms were strongly related to gender, below average year of schooling, unemployment, poor economic status, low social cohesion, and stressful life events. They posit that clinicians should assess PLWHA for depression, to ensure early detection and treatment and failure to recognize depression at the early stages may endanger both the individual and others in the community.
Giri, Neupane, Pant, Koirala, Timalsina, and Sharma (2013) investigated the effect of HIV/AIDS diagnosis on PLWHA’s quality of life. They reported older individuals with HIV/AIDS had lower levels of perceived lower quality of life and women in particular were found to perceive lower quality of life in the social and psychological domains. Further, they found that higher level of CD4 counts and being married were strongly associated with higher quality of life in the environmental domain while advanced clinical stage of the disease had a negative influence on quality of life. They observed that psychological quality of life was the worst affected which might be due to negative feelings, and low self-esteem due to the perception of acquiring an incurable disease. They posit that psychotherapy as an adjunct to the treatment of HIV/AIDS, besides antiretroviral therapy can enhance the quality of life PLHIV.

2.5 Studies on Spirituality and Spiritual Coping in HIV/AIDS

2.5.1 Coping style used by people living with HIV

Active Coping is sometimes referred to as positive, engagement, approach or involvement coping and relates to most problem focused and certain emotion focused coping. Active coping generally includes coping strategies such as acceptance, direct action, planning, problem solving, involvement, positive reframing, goal setting, information seeking, religion, meaning making, social support, helping others and humour.

2.5.1.1 HIV/AIDS and Active Coping: Active coping strategies have been associated with the following:

- Enhanced quality of life (Vosvick, Gore-Felton, Koopman, Thoresen, Krumboltz, & Spiegel, 2002; Vyawahakar, Moneyham, Murdaugh, & Tavakoil, 2011)
- High positive affect (Deichert, Fekete, Boarts, Druley, & Delahanty, 2008)
- High self-esteem (Stein & Rotheram-Borus, 2004; Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin, & Tsevat, 2007)
- Less symptoms of psychological distress, depression and anxiety (Chan, Au, Li, Chung, Lee, & Yu, 2006; Kraaij, Van der Veek, Garnefski, Schroevers,
Witlox, & Maes, 2008; Moneyham, Hennessy, Sowell, Demie, Seals, & Mizuno, 1998; Prado, Feaster, Schwartz, Pratt, Smith, & Szapocznik, 2004

- Lower frequency of substance use (Pence, Thielman, Whetten, Ostermann, Kumar, & Mugavero, 2008)
- Disclosure of HIV-positive status (Simoni, Demas, Mason, Drossman, & Davis, 2000)
- The utilization of social support resources (Deichert, Fekete, Boarts, Druley, & Delahanty, 2008)
- Greater satisfaction with social support (Simoni, Demas, Mason, Drossman, & Davis, 2000)
- Adherence to ARV treatment (Vervoort, Grypdonck, de Grauwe, Hoepelman, & Borleffs, 2009)

Active coping focused specifically on eight types of active coping strategies, namely, direct action, acceptance, positive reframing, emotional and instrumental social support, information seeking, helping others and religion. A brief discussion of each of coping strategy now follows.

2.5.1.2 Direct action as a coping strategy entails taking active steps to address the stressor and its effects (Carver, Scheier, & Weintraub, 1989). Direct action is therefore a problem-solving way of coping and implies that one takes responsibility of one’s stressful circumstances (Skinner, Edge, Altman, & Sherwood, 2003). Furthermore, direct action is more likely to be used in response to stressful situations that are still perceived to be changeable or controllable (Carver, Scheier, & Weintraub, 1989). Using direct action to cope with HIV-infection has been linked to perceived control, suggesting that someone who is using direct action has a sense of mastery and sees the self as capable to exercise control over her/his life and stressful situations (Coetzee & Spangenberg, 2003). It can also be said that direct action has an element of confrontation and goal-orientation, as it is aimed at confronting the stressor in an often goal-directed manner (Coetzee & Spangenberg, 2003). Direct action is considered to be emotionally constructive, as it not only deals with the stressor but also relates to improvement in emotional well-being (Skinner, Edge, Altman, & Sherwood, 2003).
2.5.1.3 **Acceptance:** According to Carver, Scheier, and Weintraub. (1989), acceptance implies an acknowledgement of reality and an attempt to deal with the stressful situation. Acceptance of one's HIV-positive status can be seen as the preparedness to recognize the impact HIV will have on one's life (Vervoort, Grypdonck, de Grauwe, Hoepelman, & Borleffs, 2009). People living with HIV may not necessarily achieve acceptance of their HIV-status immediately after diagnosis, but may steadily develop a sense of acceptance as time progresses. Acceptance is often conceptualized as a secondary control or accommodative way of coping and is as a result more likely to be used in stressful situations where the stressor is not changeable and must be accommodated (Carver, Scheier, & Weintraub, 1989; Skinner, Edge, Altman, & Sherwood, 2003). In some instances, acceptance can take the form of passive, resigned or even fatalistic acceptance which is associated with negative affect and faster disease progression in people living with HIV. However, healthy acceptance should ultimately empower the person living with HIV to deal with the challenges of their illness in a realistic and proactive way (Coetzee & Spangenberg, 2003).

2.5.1.4 **Helping others** as a coping strategy is at times referred to as altruism (Skinner et al., 2003). Helping others entails purposefully reaching out to other people with the aim of supporting them either emotionally, physically or financially. Relatively little research has been conducted on helping others within the context of coping with HIV. Pittiglio and Hough (2009) found that as mothers living with HIV gained more knowledge about HIV and AIDS, they were more eager to help other people living with HIV. To this end, the mothers found great delight in reaching out to others by sharing their personal experiences of being HIV-positive and being sources of support to other people living with HIV.

2.5.1.5 **Avoidant Coping** is sometime referred to as maladaptive, detachment, disengagement, negative or passive coping and is linked to most of Lazarus and Folkman’s (1984) emotion focused coping strategies. Avoidant coping generally include coping strategies such as denial, repression, substance use, emotional venting, self-blame, distraction, self-isolation, escape, avoidance, feeling out of control, rumination as well as behavioral and mental disengagement.

**HIV/AIDS and avoidant coping:** Avoidant coping strategies have been found to be associated with negative psychosocial and health outcomes. In this regard, avoidant coping strategies have been associated with the following:
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- Increase in HIV-and AIDS-related symptoms (Chida & Vedhara, 2009; Vervoort, Grypdonck, de Grauwe, Hoepelman, & Borleffs, 2009)
- Decreased physical functioning (Griswold, Evans, Spielman, & Fishman, 2005)
- Poor quality of life (Weaver, Antoni, Lechner, Duran, Penedo, Fernandez, & Schneiderman, 2004)
- Low self-esteem (Stein & Rotheram-Borus, 2004)
- More frequent substance use (Pence, Thielman, Whetten, Ostermann, Kumar, & Mugavero, 2008)
- Non-disclosure of HIV positive status (Makin, Forsyth, Visser, Sikkema, Neufeld, & Jeffery, 2008; Simoni, Demas, Mason, Drossman, & Davis, 2000)
- Non-adherence to ARV treatment (Vervoort, Grypdonck, de Grauwe, Hoepelman, & Borleffs, 2009)

2.5.1.6 Denial: It is characterized by efforts to block, blunt and not accept a stressful situation and its consequences (Hackl, Somlai, Kelly, & Kalichman, 1997). Denial thus creates distance between the stressor and the individual, which provides temporary relief from negative thoughts and emotion. To this end, failing to disclose one's HIV-positive status and living as if one is HIV-negative can be seen as an attempt to distance oneself from the reality of being HIV-positive. However, denial prevents the individual from confronting the stressor directly (Lazarus, 1999). (Denial is frequently reported in studies on coping with health-related stress and is generally believed to be used in the initial stages shortly after diagnosis (Taylor, 2003)

2.5.1.7 Self-Blame: Self-blame involves blaming and criticizing oneself for being in a stressful situation and may include rumination and negative introspection (Skinner, Edge, Altman, & Sherwood, 2003). Self-blame is closely associated with internalized
stigma, which refers to the internalization of AIDS-related stigmatic beliefs about being HIV-positive into one's self-concept (Visser, Kershaw, Mskin, & Forsyth, 2008). A meta-analysis done by Maskowitz, Hult, Acre, and Bussolari (2009) advocates that self-blame in people living with HIV is associated with negative affect as well as improved health-related behaviour. It is suggested that, despite self-blaming being an unkind way to deal with oneself, it involves taking responsibility for the stressful situation one is facing. (Consequently, self-blame may contribute to people living with HIV becoming more actively involved in improving their health and taking care of themselves (Maskowitz, Hult, Acre, & Bussolari, 2009).

2.5.1.8 Substance use: Using alcohol and drugs as a way to cope with a stressful situation is viewed as an avoidant coping style. Substance use coping involves using alcohol and drugs to escape a stressful situation. Moreover, substance use is considered to be risk behavior, as it may cause further health risks to the person living with HIV and contribute to the spread of HIV-infection (Pence, Thielman, Whetten, Ostermann, Kumar, & Mugavero, 2008).

In a study by Reeves, Merriam, and Courtenay (1999) the coping strategies used over time by 18 women and men living with HIV in the USA were qualitatively explored. The participants were diagnosed between 18 months and 13 years prior to the study. It was found that the coping strategies used by the participants changed markedly from immediately after diagnosis to later on in their lives. They found three main coping stages that people living with HIV go through.

The first stage occurs immediately after diagnosis. In this stage the coping strategies were found to be highly emotionally as well as behaviourally focussed and participants reported the experience of intense emotional reactions to the diagnosis including fear and anger. In addition, some participants reported attempting to continue their lives as if nothing had happened and engaged in risky behaviour such as substance abuse and unsafe sexual acts. Although some participants tried to blunt the diagnosis out, others actively searched for information to help them prepare for their future. Coping strategies used within the first stage after diagnosis included denial, behavioural and mental disengagement, substance use and information seeking (Reeves, Merriam, & Courtenay, 1999).
The second stage can be described as a stage of transition, during which time the participants came to the realisation that the coping strategies that they had been using up until that point had not been effective. This stage became a time of regaining control over their lives and purposefully confronting their situation. During this stage, people living with HIV may use more active coping strategies, such as direct action, helping others and social support (Reeves, Merriam, & Courtenay, 1999).

The third stage can be described as the stage in which the participants purposefully lived with their HIV-status with greater acceptance. This stage was characterised by five prominent coping strategies, namely, humour, religion, altruism, maintaining balance and seeking the support of other people. Humour was used to cope with the changes in their lives and sometimes a darker kind of humour was used to deal with particularly threatening health-related issues. Religion was used in the form of faith and trust in God, prayer and meditation. Altruism was the most frequently reported coping strategy. Participants indicated that they had the desire to make a difference and help other people. Moreover, the participants aimed to maintain as much balance in their lives as possible, so that HIV would not rule their lives.

The psychological help through spiritual exercise and Islamic principles for AIDS patients has been emphasized by Kirmani and Husain (2002). The importance of Islamic principle such as confession, remembrance of God and spiritual exercise has been brought out for management of AIDS patients. They may psychologically help themselves by confessing their own weakness and guilt feelings and surrender before God for down guidance in order to lead their right way of life and make them to achieve the goal of existence. The value of concentrative and religious meditative technique has also been focused to improve quality of life of AIDS patients.

In a large, nationally representative sample (Lorenz, 2005), 85 percent of PWH identified spirituality as being “somewhat” or “very” important to them while only 65 percent of the same population identified religion as being of the same importance. These findings not only demonstrate that PWH tend to identify as more spiritual than religious, but also show that the majority of PWH consider spirituality to be an important part of their lives. Study findings have demonstrated that many PWH find turning to their spirituality to be an effective coping method (Coleman, Eller, Nokes,
Spirituality is also an efficacious method for coping with the HIV diagnosis itself. Ironson, O’Cleirigh, Kumar, Balbin, Schneiderman, & Fletcher, (2006) found that 45% of PWH in their sample experienced an increase in spirituality and/or religiousness in the year following their HIV diagnosis while only 12% experienced a decrease in spirituality. For some, this increase actually transformed their spirituality and, in turn, their global belief system (Kremer & Ironson, 2009).

### 2.6 Studies on Spiritual Distress and its Diagnosis/Assessment

Spiritual distress is a subjective phenomenon, and researches on its diagnosis or assessment have increased in the last two decades.

According to Callister, Bond, Matsumura, and Mangum (2004), there is paucity in the literature on spirituality in nursing programs. Addressing the dimensions of spiritual nursing interventions is critical in nursing education. Nursing education and clinical practice should facilitate the development of sensitivity and capability of nurturing the human spirit in clinical practice. Participants in this study described their perception of the nursing diagnosis *spiritual distress*: “There are lots of opportunities to use the nursing diagnosis with spiritual distress, but we concentrate too much on the physical.” “It is important to diagnosis people who are in spiritual distress, who are suffering from it, it will help them later on, and then they can help themselves a little bit more.” “Some people don’t get better until their spiritual distress becomes better.”

O’Brein (2004) stated that a patient who questions the reason for suffering may be experiencing spiritual distress and identified seven nursing diagnosis involving spiritual issues: spiritual alienation, spiritual anger, spiritual anxiety, spiritual despair, spiritual guilt, spiritual loss and spiritual pain. Characteristics indicating appropriateness of the diagnosis include questioning the meaning and purpose of life and one’s relationship with God; expressing guilt feelings and anger toward God; refusing to participate in usual religious practices; regarding illness as God’s punishment and seeking spiritual assistance.

Moskowitz and Wrubel (2005) studied on illness appraisals of gay men who were living with HIV in the United States of America (USA) were qualitatively explored. Most men appraised losing control of one’s life, one’s present and future
health, the loss of a friend, damage to self-worth, stigma and one’s own mortality as some of the most threatening aspects associated with being HIV-positive. Other aspects of living with HIV that were appraised as either harmful, threatening or a challenge included financial loss, experiencing constant stress, the health of one’s partner and the disruption of work-related goals.

Mitchell, Bennett, and Manfrin-Ledet (2006) reported nurses spent more time with their patients than other health care workers. Therefore, the spiritual needs of patients must be recognized as a domain of nursing. One component of being a nurse is identifying spiritual distress and providing spiritual care at the end of life. Participants described perceptions of providing spiritual care at end of life: “It is about helping people that are suffering to move on, either through death or something.” “I helped prepare a body of an oncology patient who passed away.” “If he had been my patient and I spoke to the family, may be that would have provided an opportunity to talk about their spirituality.”

Karimollahi, Abedi, and Yousefi (2008) examined antecedents of spiritual distress experienced by Irani Muslim patients. The World Health Organization (WHO) has proclaimed that the definition of health includes four domains of well-being: Physical, mental, social and spiritual. It is therefore suggested, that nurses should prepare themselves to assist individuals and families not only to cope with illness and suffering, but also to find meaning in these experiences. The purpose of this investigation was to explore antecedents of spiritual distress experienced by Muslim patients in the Islamic context of Iran. Qualitative descriptive research was conducted using unstructured Interviews. Three main categories were found: failure in communication, non-holistic care and inability to worship. The results showed that the patient’s satisfaction could depend on good communication, good listening and good information. In ending, it can be said that staff members have a great deal of responsibility for assuring that the patient feel good as possible, facilitating relative’ involvement based on the family’s wishes and limiting the stress and difficulties experienced by the family.

Monod, Rochat, Bula, Jobin, Martin, and Spencer (2010) developed the spiritual distress assessment tool: an instrument to assess spiritual distress in hospitalised elderly persons. Although spirituality is usually considered a positive resource for coping with illness, spiritual distress may have a negative influence on
health outcomes. Tools are needed to identify spiritual distress in clinical practice and subsequently address identified needs. This study describes the first steps in the development of a clinically acceptable instrument to assess spiritual distress in hospitalized elderly patients. A three-step process was used to develop the Spiritual Distress Assessment Tool (SDAT): 1) Conceptualisation by a multidisciplinary group of a model (Spiritual Needs Model) to define the different dimensions characterizing a patient’s spirituality and their corresponding needs; 2) Operationalisation of the Spiritual Needs Model within geriatric hospital care leading to a set of questions (SDAT) investigating needs related to each of the defined dimensions; 3) Qualitative assessment of the instruments acceptability and face validity in hospital Chaplains. The SDAT appears to be a clinically acceptable instrument to assess spiritual distress in elderly hospitalised persons. Studies are ongoing to investigate the psychometric properties of the instrument and to assess its potential to serve as a basis for integrating the spiritual dimension in the patient’s plan of care.

Kandasamy, Chaturvedi, and Desai (2011) examined the influence of spiritual well-being (SWB) on symptoms of distress, depression, and other dimensions of quality of life in advanced cancer patients receiving palliative care. The study was cross-sectional in nature. Fifty patients with advanced cancer from a hospice were assessed with the following instruments: the visual analog scale for pain (VAP), M.D. Anderson symptom inventory (MDASI), Hospital Anxiety Depression Scale (HADS), Functional assessment of cancer therapy - Palliative Care (FACT-pal), and Functional assessment of chronic illness therapy-spiritual well-being (FACIT-sp). We studied the correlations between spirituality and other variables on these scales. They found that depression and anxiety were negatively correlated with spiritual well-being (SWB). The SWB was significantly correlated with fatigue (r = -0.423, P <0.002), symptom distress (r = -0.717, P < 0.001), memory disturbance (r = -0.520, P < 0.001), loss of appetite (r = -0.399, P <0.004), drowsiness (r = -0.400, P < 0.004), dry mouth (r = -0.381, P <0.006), and sadness (r = -0.720, P < 0.001). Spiritual well-being was positively correlated with all the other aspects of QOL measures. Predictors such as palliative care well-being (t = 2.840, P <0.008), distress (t = -2.582, P <0.015), sadness (t = -2.765, P <0.010), mood (t = 2.440, P <0.021), and enjoyment in life (t = -3.586, P <0.001) were significantly correlated with SWB, after regression analysis. This study suggests that spiritual well-being is an important component of the quality of life of advanced cancer patients, and is closely related to the physical and psychological symptoms of distress.
Khan (2012) evaluates the impact of counseling on depression and other behaviors manifesting psychological distress among HIV/AIDS patients. AIDS is a chronic, life threatening condition caused by the human immunodeficiency virus (HIV). Beck's depression inventory (BDI) was administered to study depression, stage of HIV infections was also used to facilitate clinical evaluation. Twenty persons with HIV/AIDS (16 men and 4 women) participated in the study. The subjects were administered B.D.I before counselling and after counselling programme was completed; pre and part counseling scores were compared. Certain behavior like negative emotions, body postures, eye contact, hesitant and unnatural speech, and negative attitude towards others were observed systematically by the researcher and status of these behaviors at pre and part counselling stage was compared. It was found that at the post counselling condition scores on depression were significantly lower. Marked improvement was also seen in the behavioral symptoms of psychological distress.

Caldeira, Carvalho, and Vieira (2013) have made an attempt to identify the definition and defining characteristics (DCs) of spiritual distress based on integrative literature review. Thirty-seven articles and 35 DCs were identified. Spiritual distress as a response to health problems in the context of nursing care is different from an impaired ability to experience and integrate meaning in life. They found that diagnosis misses some DCs that emerged from the literature review and lacks comprehensiveness. The domain and the class are reductionist toward its meaning. The taxonomy lacks a spiritual domain to include this and other diagnoses currently dispersed in other domains. Further content and clinical validation is needed, as well as an assessment, to determine the diagnosis, class and domain.

Taylor and Mamier (2013) examined nurses’ responses to patient expressions of spiritual distress. This secondary analysis of data from 200 practicing registered nurses’ and student nurses’ responses to 3 vignettes depicting patient spiritual distress were evaluated qualitatively and quantitatively (using the Empathic Response Scale). Findings showed wide variation in these nurses’ ability to respond empathically; while some responses would be healing, others were potentially hurtful.

Yusha’u, David, and Zuwaira, (2014) assessed the impact of psychological distress and coping strategies among PLWHA. They found that the major coping strategies employed by PLWHA were turning to religion, active coping, and
acceptance all of which were positive coping strategies which lead to adaptation and hastened recovery from distress. They reported that women with HIV/AIDS tend to be more hostile and had higher paranoid ideation than men.

Simano, Chaves, and Lunes (2015) have made an attempt to understand the concept of spiritual distress and existing methods to identify it. It is an integrative literature review conducted in LILACS, MEDLINE, BDENF, CINAHL, IBECS, PUBMED, using the terms “spiritual distress”, “spiritual suffering”, together with the descriptor: nursing. After analysis of 30 articles, nine were selected, and only four (44.4%) conceptualized spiritual distress, some using more than one concept, with the deficiencies in the constructs of transcendence, connection, beliefs/values systems, sense of meaning and purpose in life that most prevailed. Strategies to identify the phenomenon range from close observation of the patient to the application of psychometric assessment instruments. They suggest that combined use of all methods will enable healthcare professionals to have the means to identify and assess spiritual distress and thus offer care that meets the spiritual needs of the patient.

2.7 Studies on Coping in HIV

Not only is a diagnosis of HIV considered to be a significant life stressor but also the implications of the diagnosis impose a series of subsequent stressors onto the patient with which he or she is then required to cope. Similar to other chronic diseases, differences in coping methods in PWH have been related to differences in HIV progression, mortality, mental health, and health behaviors. Coping research in HIV has largely focused on the relationship between coping and mortality and HIV progression as measured by immune markers such as CD4+ cell and viral load counts.

Sikkema, Kalichman, Hoffmann, Koob, Kelly, and Heckman (2000) investigated the prevalence of AIDS related bereavement and psychosocial predictors of grief severity and reported that AIDS influenced the psychological coping not only of the individual with the disease but also those close to the individual. They found that bereavement related grief was most closely associated with emotional suppression and avoiding coping strategies. They further posit that interventions for AIDS related bereavement that reduce distress and maladaptive ways of coping were needed to address the secondary prevention needs of bereaved people living with HIV/AIDS.
Simoni and Ng (2000) investigated the association of retrospective self-reports of sexual and physical abuse, current coping strategies and depressive symptoms. They reported that individuals who had experienced childhood physical abuse tend to use more adaptive coping strategies while those who experienced childhood sexual abuse tend to use avoidant coping strategies. Those individuals who experienced adult abuse used adaptive coping strategies and those who had some sort of trauma in their recent past used avoidant coping strategies. Additionally, they identified that individuals with more education, higher income and who were employed used avoidant coping less frequently in comparison to adaptive coping strategies. They posit that childhood physical or sexual abuse has long standing effects and a direct impact on current depressive symptomatology than adult abuse.

DeGenova, Patton, Jurich, and McDermid (2001) investigated the relationship of emotion focused coping strategies and problem focused coping strategies with depression and physical illness among HIV infected individuals. They found that those who employed emotion focused coping strategies experienced more depression symptoms in contrast to those individuals who employed problem focused coping strategies. They posit that problem focused coping is usually more effective than emotion focused coping for generating positive mental health outcomes during stressful events. Moreover, they elaborated that those who used emotion focused coping strategies might have more depression symptoms, which may then in turn decrease the availability and use of problem focused coping strategies.

Turner-Cobb, Gore-Felton, Marouf, Koopman, Kim, Israeliski, and Spiegel (2002) explored the psychosocial correlates of adjustment to HIV/AIDS among HIV positive individuals. They reported that adjustment was significantly associated with greater satisfaction with social support related to HIV/AIDS, secure attachment styles, and less use of behavioral disengagement in coping with HIV/AIDS. They reported that those PLHIV who were more satisfied with their relationships, securely engaged with others, and more directly engaged with their illness experienced positive adjustment. Further, they posit that individuals who coped with their HP/AIDS by dealing directly with stressors associated with their chronic illness experienced better adjustment.
Sikkema, Kochman, DiFranceisco, Kelly, and Hoffmann (2003) explored the association between AIDS related grief and coping among individuals with HIV. They reported that severity of grief reaction was associated with escape/avoidance and self-controlling coping strategies, type of loss and depressive symptoms. They suggested that interventions are needed to enhance coping and reduce psychological distress associated with bereavement and grief experienced.

Coetzee and Spangenberg (2003) documented that problem-focused, active coping styles were superior to emotion-focused, passive coping styles, such as avoidance, in reducing psychological distress.

Ashton et al (2005) examined the influence of social support and maladaptive coping strategies on HIV related health symptoms. They reported, after controlling for demographic characteristics, CD4 cell Count, and baseline HIV related health symptoms, that individuals who resorted to less venting or expressing emotional distress as a way of coping with HIV had a lower rate of increase in HIV related health symptoms. Further, they reported that individuals reporting more satisfying social support had a lower rate of increase in their HIV related health symptoms, suggesting that social support predicted better health outcomes over time, independent of coping style and baseline medical sterns. They posit that social support can buffer deleterious health outcomes among individuals with a chronic illness.

Gore-Felton, Koopman, Spiegel, Vosvick, Brondino, and Winningham (2006) examined the effect of maladaptive coping strategies and psychological quality of life on depression among PLWHA. They found that engaging in various kinds of avoidant behaviors was strongly associated with greater depression at baseline and increased depression at three months. They identified Quality of Life as the single most important predictor of depression. They posit that improving Quality of Life and adaptive coping strategies can alleviate depression among adults living with HIV.

Additional coping tools and methods have been investigated as possible factors in HIV progression. Some of these include longstanding personality features, emotional expression, interpersonal coping, and spiritual coping. Longstanding personality features related to slower HIV progression include conscientiousness, openness, and extroversion (Ironson, O’Cleirigh, Weiss, Schneiderman, & Costa, 2008).
Chapter 2: Review of Literature

Kabbash, E1-Gueneidy, Sharaf, Hassan, and Al-Nawawy (2008) explored the psychosocial, health care needs and investigated the coping strategies employed by PLWHA. They found that a vast majority of PLWHA used emotion focused coping strategies and there were no gender differences. Additionally, they also found that age did not influence the coping style adopted. They found that HIV diagnosis induced a number of bio psychosocial changes in the life of the infected person such as informing the spouse about the infection, acceptance, changing the pattern of sexual behavior, fear of stigmatization, feelings of anxiety, hopelessness, isolation, loneliness, depression and despair, which in turn left a negative psychosocial impact on the infected person. Moreover, these feelings compelled PLWHA not to engage in problem focused coping and hence they engage in emotion focused coping.

Kraaij, Van der Veek, Garnefski, Schroevers, Witlox, and Maes (2008) explored the relationships between coping strategies, goal adjustment, and symptoms of depression and anxiety among HIV positive men. They found that cognitive coping strategies had a stronger influence on well-being than other coping strategies. Less use of positive refocusing, positive reappraisal, putting into perspective and increased use of catastrophizing, and blaming others were related to symptoms of depression and anxiety. Additionally, they reported that, withdrawing effort and commitment from unattainable goals, and reengaging in alternative meaningful goals where preexisting goal was not achievable were effective while coping and facilitated good quality of life. They posit that intervention programs aimed at people with HIV should pay attention to both cognitive coping strategies and goal adjustment.

Moskowitz, Hult, Acree, and Bussolari (2009) found that the effectiveness of certain coping strategies to improve physical and psychological well-being changed over time. It was found that direct action became increasingly less effective in improving physical health as time progressed since HIV diagnosis. Furthermore, social support and distancing were found to become less effective in improving psychological well-being over time. In contrast, self-control as a form of coping with HIV was found to become more effective in improving psychological well-being as time progressed.

Ironson and Kremer (2010) thoroughly reviewed the literature on different coping methods in HIV progression and mortality. In the studies reviewed, avoidance coping predicted faster progression to AIDS symptoms or mortality, including one
study which (Ironson, O’Cleirigh, Fletcher, Laurenceau, Balbin, & Klimas, 2005) was conducted after the widespread availability of HAART and controlled for medication adherence. Approach-oriented coping was related to fewer symptoms, slower HIV progression, and longer time to an AIDS diagnosis or death.

Bishwas (2010) examined clinical hypnotherapy in people living with HIV/AIDS: A study of disease progression and coping strategies. This research focused on the effect of positive thought induction (e.g., package of relaxation, guided imagery, symptom management, etc.) on the well-being, quality of life coping strategies, clinical and immune parameters, disease progression in terms of symptoms management in people living with HIV/AIDS in a controlled clinical research. Data were collected from 18 adult HIV + patient having CD4 count above 250 and plasma viral load less than 5000 screened from a large group of HIV + patients who had countered for the study. A pre-test/ post-test/ follow up design of research was adopted for the present study. Result indicated that post and follow up test for positive brought induction through hypnotherapy had gelded significant positive changes in several dimension of coping strategies e.g., active coping, alcohol drug abuse denial, planning reinterpretation and growth. Similarly, it had to significant increase in different immunological parameters of CD4 count, absolute CD4 count absolute CD8 count proportion of CD4 to CD8 count and absolute CD3 count. These results are discussed in the light of recent theoretical developments in the area of clinical hypnotherapy.

Kyajja, Mullira, and Ayebare (2010) explored the side effects of Anti Retroviral Treatment (ART) experienced by PLWHA and further identified strategies used by them to cope with the side effects. They found that the most reported common adverse effects of ART were tiredness, nightmares, mood swings, nausea, poor appetite, insomnia, vomiting and dizziness. Further, the most common strategies employed by PLWHA for coping with side effects were categorized as information seeking, social support seeking and positive emotion focused coping. Approximately one fourth of the sample reported non adherence to their ART medications as a strategy to cope with the side effects. They further reported that a strong relationship existed between side effects burden and a patient’s age as well as patient’s level of education. They posit that after initiating ART generally PLWHA were able to cope with the high burden of side effects through appropriate strategies, but a significant
proportion of PLWHA tend not to cope appropriately and thus resort to non-adherence. They suggested that clinicians should assist patients with continuous health education and counseling that focuses on appropriate strategies to cope with the side effects of ART.

Malhotra, Nair, and Nair (2010) studied on coping with HIV in relation to personality. Living with the diagnosis of HIV can be frightening and anxiety-producing experience, including the uncertainty of future, fear of death and disfigurement. This general strategy that people living with HIV/AIDS may use emotion focused coping and problem focused coping. Personality characteristics and coping style effect difference on appraisal and response to stressors that may influence immune function. With the understanding that the role of personality in coping can broaden the person centered change efforts to encompass simultaneous growth in personal resources the present study aimed to find out whether HIV positive people’s choice of coping response is a function of their more general personality disposition (Extraversion, neuroticism and psychoticism). Correlational design was adopted for relating the coping strategies adopted by the HIV positive persons and their personality characteristics. The target population of the present study was HIV infected people in the reproductive age group of 15 to 49 years. The subjects were contacted through networks of positive people community care centers drop in centers informal groups etc. measure used in the present study were brief COPE scale and Eysenck’s personality questionnaire R. Pearson product moment correlation was used to analyze the data.

Bagri (2011) compared women who were diagnosed with HIV/AIDS patients, Hepatitis C as well as matched controls suffering from Liver Failure or Liver Disease with regard to depression, self-efficacy, and coping strategies. The results of the study indicated that women with HIV/AIDS had significantly more depressive symptoms than women with Hepatitis C. Women with HIV/AIDS had significantly lower levels of self-efficacy in comparison to women having Hepatitis C. Further, Hepatitis C patients engaged in more behavioral coping than AIDS patients, in the form of seeking information, seeking guidance or support and taking action to deal directly with the problem. Moreover, Hepatitis C patients tend to engage in avoidance coping strategies rather than AIDS patients indicating that they resorted to cognitive and behavioral attempts to avoid thinking about their stressor and its implications.
However, significant differences with regard to cognitive coping strategies and approach coping strategies were not observed.

McIntosh and Rosselli (2012) investigated the effects between stressors and coping mechanisms on behavioral health outcomes among women living, with HIV using a meta-analytic approach. They found that acute and chronic forms of psychosocial stress had a strong effect on the development of psychopathology as did the physical burden of disease management. Further, they found that physical stress resulting from HIV related symptomology was a significant predictor of adverse psychological consequence in women. Functional impairment was also found to significantly predict negative effect. Moreover, coping by avoidance and social isolation predicted more severe and negative mental health outcomes in women living with HIV/AIDS. Spirituality and positive reappraisal predicted greater psychological adaptation. They posit that positive reframing appeared to promote psychological adaptation which in turn may lead to positive health outcomes in women living with HIV/AIDS.

Skalski, Sikkema, Heckman, and Meade (2013) investigated the prevalence of drug use and psychosocial predictors of drug use among HIV infected adults. They found that self-destructive avoidance was positively associated with drug use and spiritual coping was negatively associated with drug use. They pointed out that depression, poorer quality of life, less use of spiritual and solution focused coping, frequent alcohol consumption and greater use of self-destructive avoidance were associated with drug use among HIV adults. They posit that the use of illicit drugs may be a variant of self-destructive avoidance indicative of relying on drugs to escape their problems since they do not know how to manage stress in more adaptive ways. Further, they suggested that assessment of drug abuse should be a routine part of care for older patients in HIV clinics and interventions designed to increase spiritual coping and decrease self-destructive avoidance may be particularly efficacious for HIV infected adults.

Tahri and Zarimoghadam (2013) compared PLWHA and healthy controls with regard to psychiatric disorders and coping strategies. They found that there were significant differences with regard to Obsessive Compulsive Disorder and fear. They further reported significant differences between PLWHA and healthy controls with regard to problem oriented coping strategies, emotional coping strategies and avoidant strategies. They observed that problem oriented strategies and emotional strategies
were adopted less by PLWHA in comparison to healthy subjects, while avoidant coping strategies were more frequently employed by PLWHA in comparison to healthy controls. They posit a biopsychosocial approach is more appropriate for dealing with the problems encountered by PLWHA.

Jyanthi and Reddy (2014) explored the coping mechanisms used by PLWHA to overcome their stressful conditions and whether coping to stress was influenced by gender. They found that male patients were using more of emotion focused coping strategies followed by appraisal focused coping strategies, problem focused coping strategies and defense strategies. Female patients were using more of emotion focused coping strategies followed by problem focused coping strategies, appraisal focused coping strategies and defense mechanisms. They found a predominance of emotion focused coping strategies among men and women PLWHA. They reported significant gender differences with regard to problem focused coping strategies and defense strategies however, there were no gender differences with regard to appraisal focused coping strategies and emotion focused coping strategies.

Udobong, Udonwa, Charles, Adat, and Udonwa (2015) investigated the relationship between family support and coping strategies of women living with HIV/AIDS. They observed strong relationships between care giving, favorable social attitudes, and effective communication and coping strategies of women living with HIV/AIDS. They posit that families are important care givers providing emotional and instrumental support for PLWHA. Moreover, this support helps to buffer stress, improve adherence, reduce symptoms of depression, and fast tracts restoration of quality of life. Consequently, it will reduce the sense of shame, anxiety, guilt, discrimination and stigmatization experienced by women with HIV.

Sreelekshmi (2015) studied on anxiety and coping mechanisms among HIV positive patients and the study showed that 50 % of samples were between 36-50 years of age, 53.3% were males, 63.3% of samples had only secondary education, 44% were unskilled workers and 50.3% of samples had only family income of Rs.<5000. Mean anxiety level was 42.68% and overall mean percentage of problem focused coping strategy was high (56.8%) as compared to emotion focused coping strategy. Among emotion focused coping strategies, acceptance (65.75%) was the most frequently used coping mechanism. Anxiety and acceptance coping strategy was
significantly negatively correlated (p=0.000). It shows that identification of anxiety levels and coping strategies are of extreme importance because care of People living with HIV/AIDS (PLWHA) must be individualized and prioritized.

2.8 Studies on Spiritual/Religious Coping

Since spirituality has been found to play a large part in the lives of PWH, it has also been identified as a potentially powerful coping resource for this population.

Draper (2001) studied that spiritual coping strategies involving relationship with self, others, Ultimate other/God or nature were found to help individuals to cope with their ailments. This may be because of finding meaning, purpose and hope, which may nurture individuals in their suffering. Spirituality is often referred by literature as being synonymous with religiosity. Thus the use of spiritual coping strategies is restricted to individuals who hold religious beliefs. However, the definition of spirituality indicates that this concept is broader than religiosity.

Touhy (2001) defines spirituality as broader than being religious, although for some people spirituality is expressed and developed through formal religious activities such as prayer and worship service. In addition, spirituality could be defined in terms of personal views and behaviors that express a sense of relatedness to a transcendent dimension or to something greater than self. Students in Touhy’s study identified the importance of having personal faith. “Personal faith helps me understand how it impacts other people.” “Having a belief and being a spiritual person will help you continue with your job.”

Pesut (2003) studied on students who viewed God as loving and just could experience spirituality quite differently than a student who associates God with guilt and judgment. These views could influence how the nurse interacts with others in a spiritual context. Quotes obtained from students in this dissertation study suggested that spirituality is significant in their lives. “My spirituality helps me and hopefully gives me a positive attitude to help families experiencing loss with their families.” “It’s having that belief that helps with understanding the beliefs of patients.” “I believe that God is guiding my life and does help with my nursing activities.” “My spiritual beliefs give me purpose in life.” “I think I am pretty comfortable with my spirituality.”

Young and Koopsen (2005) emphasized that spirituality is a highly subjective, personal, and individualistic concept. O’Brien (2003) defines spirituality as a personal
concept which is generally understood in terms of an individual’s attitudes and beliefs related to transcendence (God). Quotes by students in this study illustrated how personal beliefs impacted nursing care: “My spirituality helps me and hopefully gives me a positive attitude to help families experiencing loss with their families.” “It’s having that belief that helps with understanding the beliefs of patients.” “My spiritual beliefs give me purpose in life.” “I believe in a higher power, and my family and I call that higher power God.” All participants (N=12) stated that they believe in God or a Higher Power.

Cotton, Tsevat, Szaflarski, Kudel, Sherman, Feinberg, and Holmes (2006) found that, after the HIV diagnosis, 25 percent of their sample of PWH felt alienated by their place of worship and 10 percent changed worship locations all together. They reported that spirituality also plays an important role in the lives of PWH.

Pargament, and Raiya (2007) studied that the field of psychology has begun to display a growing interest in religious coping methods and their implications for health and well-being. Empirical studies have yielded an interesting picture of the relationship between religious coping and physical and mental health. In this paper, they review some of the foundational assumptions on which the theory of religion and coping rests. Then, they summarize recent advances in research in the area of religion and coping. They conclude by highlighting some of the exciting new directions for research in the psychology of religion and coping.

Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin, and Tsevat (2010) examined the relationship between spiritual coping and health outcomes in PWH. They found that those who engaged in positive spiritual coping had better quality of life and better well-being over time than those who exhibited spiritual struggle. Those who exhibited spiritual struggle had faster HIV progression and lower quality of life. Therefore, positive spiritual coping is related to more positive outcomes in PWH.

Carpenter Laney, and Mezulis (2011) examined prospective associations between religious coping, stress, and depressive symptoms in a community sample of 111 adolescents (80 female). Study hypotheses were tested in a prospective 12-week study. Youth self-reported their use of positive and negative religious coping strategies and personal religious commitment at baseline and then reported stressors and depressive symptoms weekly for eight weeks with an additional assessment at 12 weeks. Data were analyzed using hierarchical linear modeling. Results indicated that, as expected, negative religious coping significantly moderated the effects of stress on
depressive symptoms across the 12-week study, with depressive symptoms being highest among youth with high stress exposure and high negative religious coping. The exacerbating effects of negative religious coping on the stress-depression relationship were strongest for youth with high personal religious commitment. Positive religious coping only marginally buffered the effects of stress on depressive symptoms. The results confirm and extend previous findings on the association between religious coping strategies and stress in predicting depressive symptoms.

Awasthi, Koolwal, and Gehlot (2012) examined positive and negative religious coping and quality of life in patients suffering from cancer. The cancer experience inspires fresh or renewed interest in religion. Religiosity and religious coping have been found to be significantly associated with better quality of life and improved adjustment of cancer. The present study attempts to assess the religious coping and quality of life of patients suffering from cancer. Objective of the study was to study socio-demographic profit of cancer patients and to assess their religious coping and its association with their quality of life. Patients with different cancer type showed little variation in religious coping scale. A strong correlation was found between positive religious coping scores and subjective wellbeing inventory scores. Present study conclude that greater use of positive religious coping was related to better overall quality of life, while greater use of negative religious coping was associated with worse overall quality of life.

Gaudette and Jankowski (2013) studied spiritual coping and anxiety in palliative care patients. Patients often rely on spirituality to cope with anxiety, yet it is not known if spiritual coping actually helps patients deal with anxiety. A series of patients who were referred to the palliative care team at New York University, Langone Medical Center (N = 44) were interviewed about their spiritual coping and anxiety. Anxiety was measured using the first three items of the GAD-7. Fourteen items, which were adapted from existing scales, were used to create the “Beliefs and Activities Spirituality Scale” (BASS), having two subscales: Activities (alpha = .79) and Beliefs (alpha = .82). Anxiety had a significant negative correlation with the total BASS (r = -.56), and the Activities (r = -.52) and Beliefs (r = -.42) subscales. The salubrious association of spiritual coping and anxiety remained for the BASS and the Activities subscale, after controlling for demographic variables.
Reynolds, Mrug, and Guion (2013) studied on spiritual coping and psychosocial adjustment of adolescents with chronic illness: the role of cognitive attributions, age, and disease group. Spiritual coping is an important determinant of adjustment in youth with chronic illness, but the mechanisms through which it affects outcomes have not been elucidated. It is also unknown whether the role of spiritual coping varies by age or disease group. This study evaluated whether general cognitive attributions explain the effects of spiritual coping on internalizing and externalizing problems in adolescents with cystic fibrosis and diabetes and whether these relationships vary by age or disease group. In this cross-sectional study, adolescents (N = 128; M = 14.7 years) diagnosed with cystic fibrosis or diabetes completed measures of spiritual coping and attributional style. Adolescents and their caregivers reported on adolescents' internalizing and externalizing problems. Overall, positive spiritual coping was associated with fewer internalizing and externalizing problems. Negative spiritual coping was related to more externalizing problems, and for adolescents with cystic fibrosis only, also internalizing problems. Optimistic attributions mediated the effects of positive spiritual coping among adolescents with diabetes. The results did not vary by age. An optimistic attribution style may help explain the effects of positive, but not negative, spiritual coping on adjustment of youth with diabetes. Youth with progressive, life-threatening illnesses, such as cystic fibrosis, may be more vulnerable to the harmful effects of negative spiritual coping. Future research should examine whether addressing spiritual concerns and promoting optimistic attributions improves adolescents' emotional and behavioral functioning.

Thune-Boyle, Stygall, Keshtgar, Davidson, and Newman (2013) studied on religious/spiritual coping resources and their relationship with adjustment in patients newly diagnosed with breast cancer in the UK. This paper reports the cross-sectional data of a longitudinal study examining the beneficial and harmful effects of religious/spiritual coping resources on adjustment in the first year after a breast cancer diagnosis. One hundred and fifty-five patients newly diagnosed with breast cancer were assessed after surgery. Several aspects of religiousness/spirituality in relation to anxiety and depression were examined: religiosity/spirituality, strength of faith, belief in God, private and public practices, spiritual involvement, perceived spiritual support and positive and negative religious coping strategies. Non-religious coping, social support and optimism were also assessed. ‘Feeling punished and abandoned by God’ significantly explained 5% of the variance in increased levels of anxiety but was
partially mediated by denial coping. It was also partially mediated by acceptance coping, lowering levels of anxiety. Feeling punished and abandoned by God was a significant independent predictor of depressed mood, explaining 4% of the variance. Using religious/spiritual resources in the coping process during the early stages of breast cancer may play an important role in the adjustment process in patients with breast cancer. Patients may benefit from having their spiritual needs addressed as experiencing some form of religious/spiritual struggle may serve as a barrier to illness adjustment. Implications for research and clinical practices are discussed.

Baldacchino (2013) explains spiritual coping, which may or may not contain religiosity, may enhance adaptation of clients with chronic illness. Part 1 of this article presented the research methodology of this cross-sectional comparative study, which explored the spiritual coping of clients with chronic illness receiving rehabilitation services in Malta (n=44) (lower limb amputation: n=10, chronic heart disease: n=9, osteoarthritis in an institution: n=10 and in the community: n=15) and Norway (n=16) (post-hip/shoulder surgery: n=5; chronic heart disease: n=5; chronic pain: n=6). Data were collected from seven purposive samples by focus groups. Roy's adaptation model (1984) and Neuman's Systems Model (2010) guided the study. Part 2 discusses the findings, which consist of one main spiritual coping theme and three sub-themes: ‘adopting religious coping strategies, relationship with God, and time for reflection and counting one's blessings’. Commonalities were found in the findings except in one dimension, which was found only in the Malta group that is, being supported by others with a similar condition. This difference may be a result of the environment in the rehabilitation centers, cultural, and geographical differences between the two countries. While considering the limitations of this study, recommendations are proposed to the rehabilitation and education sectors and further trans-cultural comparative longitudinal research with mixed method approach on various clients with acute, chronic and life-threatening illness.

Henry (2013) examined whether spiritual coping (SC) was related to health behaviors, specifically medication adherence, safer sex practices, and substance use as well as depression levels in an HIV+ population over a two year period. In addition, the present study examined whether spiritual coping predicted changes in medication adherence and depression levels over time. This longitudinal study assessed 177 HIV+ and diverse men and women in the midrange of illness as indicated by a CD4 number
between 150 and 500 and no previous AIDS defining symptom. Spiritual coping data and safer sex data were assessed from interviews conducted at baseline assessment and at each follow-up assessment every 6 months for a period of 2 years. Linear Regression was used to examine the relationship between spiritual coping and baseline medication adherence, safer sex practices, substance use, and baseline depression levels. Hierarchical Linear Modeling was used to examine whether spiritual coping change over time in medication adherence and depression controlling for age, gender, ethnicity, education, anti-HIV medication and baseline values for each outcome. Result shows that spiritual coping was not significantly related to medication adherence, substance use, safer sexual practices, or depression. Spiritual coping did not significantly predict changes in medication adherence or depression over time. However, subcodes showed that spiritual conflict, spiritual struggle and spiritual guilt were related with less marijuana use, less cocaine use, and to less use of protection in participants reporting sexual activity with more than one partner, respectively.

Kremer and Ironson (2014) examines how people with HIV use spirituality to cope with life's trauma on top of HIV-related stress (e.g., facing death, stigma, poverty, limited healthcare) usual events. Spirituality, defined as a connection to a higher presence, is independent from religion (institutionalized spirituality). As a dynamic adaptive process, coping requires longitudinal studying. Over time, 65% used spiritual coping positively, 7% negatively, and 28% had no significant use. Spirituality was mainly beneficial for women, heterosexuals, and African Americans ($p<0.05$). Results suggest that spirituality is a major source of positive and occasionally negative coping (e.g., viewing HIV as sin). We discuss how clinicians can recognize and prevent when spirituality is creating distress and barriers to HIV treatment, adding a literature review on ways of effective spiritual assessment. Spirituality may be a beneficial component of coping with trauma, considering socio-cultural contexts.

Reynolds, Mrug, Hensler, Guion, and Madan-Swain (2014) examine longitudinal relationships between spiritual coping and psychological adjustment among adolescents with chronic illness. Adolescents ($N = 128; M = 14.7$ years) with cystic fibrosis or diabetes completed measures of spiritual coping and adjustment at 2 time points 2 years apart; parents also reported on adolescent adjustment. Prospective relationships between spiritual coping and adjustment were evaluated with an autoregressive cross-lagged path model. Positive spiritual coping predicted fewer
symptoms of depression and less negative spiritual coping over time, whereas negative spiritual coping predicted more positive spiritual coping. Depressive symptoms predicted higher levels of negative spiritual coping and conduct problems over time. The results did not vary by disease. Positive spiritual coping may buffer adolescent patients from developing depression and maladaptive coping strategies. Results also highlight the harmful role of depression in subsequent behavior difficulties and maladaptive coping. Addressing spiritual beliefs and depressive symptoms in pediatric medical care is warranted.

2.9 Studies on Gender Differences and Spiritual Coping with HIV/AIDS

Gender differences in coping strategies are the ways in which men and women differ in managing psychological and spiritual stress. There is evidence that males often develop stress due to their careers, whereas females often encounter stress due to issues in interpersonal relationships (Davis, Matthews, & Twamley, 1999). Early studies indicated that there were gender differences in the sources of stressors, but gender differences in coping were relatively small after controlling for the source of stressors (Billings & Moos, 1981); and more recent work has similarly revealed small differences between women's and men's coping strategies when studying individuals in similar situations (Brannon, Linda, Feist, & Jess, 2009).

Olley, Gxamza, Seedat, Theron, Taljaard, Reid, and Stein (2003) found only a few differences in coping between women and men living with HIV. They found that HIV-positive women used planning and religion more as compared to men.

Olley, Seedat, Nei, and Stein (2004) investigated gender differences with regard to psychiatric morbidity, coping responses, and disability among PLWHA. They reported no significant gender differences with regard to mood disorders such as major depression and dysthymic disorder. However, males tend to meet diagnostic criteria for alcohol abuse or dependence, and tend to engage in certain risky sexual behaviors. Women were more likely to suffer from post-traumatic stress disorder, and to employ planning and practice religion as coping strategies to deal with the illness. They did not observe significant gender differences with regard to disability. They posit that clinicians should be aware, of the high prevalence of mood disorders in both men and women, and the prevalence of gender differences with regard to alcohol and substance use and risky sexual behavior.
Chapter 2: Review of Literature

In general, gender differences exist which indicates that women tend to employ emotion-focused coping and the “tend-and-befriend” response to stress, whereas men tend to use problem-focused coping and the "fight-or-flight” response, perhaps because societal standards encourage men to be more individualistic, while women are often expected to be interpersonal. An alternative explanation for the aforementioned differences involves genetic factors. The degree to which genetic factors and social conditioning influence behavior, is the subject of ongoing debate (Washburn-Ormachea, Jill, Hillman, Stephen, Sawilowsky, & Shlomo 2004).

Sharma (2005) studied the reason, why the women are more vulnerable than men to HIV/AIDS and analyzed various date on the AIDS situation in India with special reference to women. She shows that women are doubly victimized by the AIDS epidemic. It explores the existing gender relations in the context of AIDS, and how the gender imbalance makes the situation worse for women by analyzing the risk and vulnerability of the women population in the gender context due to gender in equalities, biological and social economic conditions. The author suggests that the existing gender imbalance and women’s status are most responsible factors. The power dynamics in the individual and in the society makes it difficult particularly for the women to initiate or negotiate for the safer sex. In the India scenario, social construction of veracity, male dominant gender power relations in the sexual life, negotiations and decision making myths and misunderstanding about sex and sexuality, cultural silences and take of formal education are the contributing factors.

Myint and Mash (2008) found religion to be used more by HIV-positive women than by men in their South African sample. Ultimately, there is no clear consensus on the nature of gender differences with regard to coping with HIV.

Vosvick, Martin, Smith, and Jenkins (2010) examined gender differences with regard to depression as a part of HIV related coping. They found that men and women showed little differences while using various HIV related coping strategies. However, there were gender differences by which specific coping strategies predict depression. In both genders symptoms, distraction, blame, and positive growth played a key role in predicting depression but when men were examined separately, expression also contributed to the variance in depression. Moreover, disease symptoms were significantly associated with depression for both men and women.
Chapter 2: Review of Literature

Haruna and Ago (2014) explored whether there were gender differences in the choice of coping strategies for HIV/AIDS. They investigated whether ‘males tend to use problem focused coping than their female counterparts and more of the females would use emotion focused coping than the males. They found that there were no gender differences with regard to problem focused coping strategies for HIV’AIDS. However, they observed significant gender differences with emotion focused coping strategies for HIV/AIDS. They posit that clinicians have to be the dynamic and proactive in their attempts to help the HIV/AIDS patients develop healthy coping strategies.

Jyanthi and Reddy (2014) explored the coping mechanisms used by PLWHA to overcome their stressful conditions and whether coping to stress was influenced by gender. They found that male patients were using more of emotion focused coping strategies followed by appraisal focused coping strategies, problem focused coping strategies and defense strategies. Female patients were using more of emotion focused coping strategies followed by problem focused coping strategies, appraisal focused coping strategies and defense mechanisms. They found a predominance of emotion focused coping strategies among men and women PLWHA. They reported significant gender differences with regard to problem focused coping strategies and defense strategies however, there were no gender differences with regard to appraisal focused coping strategies and emotion focused coping strategies.

Reflecting the Research Gap

An extensive review of literature suggests that spiritual distress and spiritual coping have been extensively studied in cancer patients. The main aim of the present study research is to explore spiritual distress and spiritual coping among PLWHIV.

Based on the existing literature, there is a gap in knowledge regarding spiritual distress and spiritual coping among people living with HIV/AIDS. There is a need to develop measures. By doing so we can understand the role of spiritual distress and coping among them. Studying the role of spiritual coping is to determine how to improve the capacity of PLWHIV/AIDS which will reduce their distress. The quality of coping is an important aspect of spiritual development. It is an important because it is a combination of self and God’s effort.
This study will examine the influence of gender and stages on spiritual distress and spiritual coping among people living with HIV/AIDS.

Based on this there is need to develop models on spiritual distress and spiritual coping for HIV/AIDS people. In a nutshell, this literature review has identified a research gap and the need for a comprehensive study of the role of spiritual distress and spiritual coping in people living with HIV/AIDS. Further research is needed to identify the spiritual distress and spiritual Coping strategies used by PLWHIV.

Therefore, this study will fill the knowledge gap by standardizing quantitative research instruments for the assessment of spiritual distress and spiritual coping.

Chapter Summary

The studies mentioned above are general and brief in nature. This literature review provided the background concerning the significant role of spiritual distress and spiritual coping which will be observed in the people living with HIV/AIDS. Reviewing the literature showed that spiritual coping has a significant role in the lives of PLWHA.