Chapter 1
Introduction
1.1 Background of the Study

The history of the lethal epidemic of HIV is not that much longer. It is believed, widely, that HI virus emerged in Democratic Republic of Congo in 1920, approximately. In its beginning, HI virus was anonymous and was feared too much. And at the same time it was untreatable and deadly (AIDS Virus Education Research Trust, n.d). The beginning and the source of HIV is so hard to pin down. In 1999, there was an international bunch of researchers who claimed that they identified a SIVcpz which was similar to HIV-1 (Gao et al., 1999). The SIVcpz had come from the iced up sample that was taken from imprisoned chimpanzee. Later on, it was doable that scientists could take SIVcpz faecal sample taken from the chimpanzees that were wild, and that made it clear that they for sure were source of SIVcpz (Keele et al., 2006). The same year, some associates of the same team claimed that a type of HIV-1 was possibly drawn from the gorilla SIV (SIVgor) (Heuverswyn et al., 2006). A latest subtype of HIV-1 was recently proposed (Plantier et al., 2009). And it’s assumed that damage is drawn from the gorilla SIV. Bailes et al. (2003) suggested HIV-1 is drawn from SIVcpz while many researchers mentioned that SIVcpz is the fusion of two monkey SIVS.

In past more than three decades science has strived a lot to comprehend everything about HI virus. And right now science has understood that how this virus has evolved and what preventive measures must be taken to control it. Advancement in medical science is now touching its heights and they have successfully made drugs to treat HI virus. Since the beginning of this fatal epidemic, approximately 78 million have so far fallen prey to HI virus and among them around 35 million people have lost their lives because of the illnesses cause by AIDS. Only in 2016, more than one million people died because of the diseases caused by
AIDS (World Health Organization, n.d). In 2016, 19.5 million people infected with HIV had been receiving antiretroviral treatment (ART). As per the statistics, in 2010 only, 7.5 million people living with HIV/AIDS were receiving ART. It’s believed that by 2020 around 30 million people living with HIV/AIDS will be receiving ART.

HIV/AIDS can infect a person independent of his/her age. In Namibia, an orphan refers to a child who has lost his one or sometimes both his parents because of AIDS related illness and is yet to reach the age of 18 years (Mallmann, 2002). HIV/AIDS patients vary that how they perceive the psychological challenges they face because of their illness. No HIV/AIDS patient resembles another; rather every single one of them is unique. Some patients not only experience shattering changes in their professional life but their physical and psychological health deteriorates as well (Watstein & Chandler, 1998). People who are infected are frightened, for they have to strive to adjust with other people. If parents are infected that affects the psychology of their children. Parents infected with HIV/AIDS have abrupt mood swings and that directly and indirectly affects the psychological health of children. Children usually do not understand that what is happening with their parents. And they are inclined to respond with dread and anxiety and may sometimes blame themselves (Mallmann, 2002).

Ammassari et al. (2004) stated that death anxiety is the most frequently symptom reported by the people living with HIV/AIDS. Baer, Dwyer, and Lewitter-Koehler (1988) suggest that people living with HIV/AIDS have higher level of anxiety, depression, fear and suicidal thoughts. Hintze, Templer, Cappelletty, and Frederick (1993) claimed that higher level of death anxiety and death depression are greatly correlated with the rate of anxiety, and trait anxiety, and depression. Szaflarski et al.(2006) have reported that the level of religiosity can directly as well and indirectly effect the way a person living with HIV/AIDS perceives
his/her life. Researchers have reported that HIV infected subjects with optimistic attitude towards life have a better mental well-being as compared to the pessimistic subjects.

The findings of this research study are expected to help people living with HIV/AIDS develop a better life style to improve their mental well-being. The clear picture of the lethal repercussions of higher death anxiety may help health-care professionals understand how important is for them to help people living with HIV/AIDS manage death anxiety. And the better comprehension about the role of religiosity and optimism may also be useful in helping people living with HIV/AIDS live relatively a better life.

1.2 Statement of the Problem

The title of this study is "Death Anxiety, Religiosity and Optimism as related to Mental Well-Being among people living with HIV/AIDS". HIV is a deadly virus that smashes up ones immune system. And AIDS is a bunch of symptoms caused by the fatal HI Virus. For decades, HIV has been the major concern of scientists and researchers. People living with HIV positive have many strong emotional reactions linked to their illness. Predominantly, Death Anxiety, Religiosity, Optimism and Mental Well-Being are the vital issues that entice researchers to study the present condition of the people living with HIV/AIDS.

1.3 Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)

HIV stands for human immunodeficiency virus. It is the virus which leads to AIDS or acquired immunodeficiency syndrome, if left untreated. Even when HIV is treated, the patient’s body cannot be entirely free of HIV. Therefore, once a person gets HIV, he/she has to live with it everlastingly. HIV invades the body’s immune system, particularly the CD4 cells (T cells), that assist the immune system wrestle against infections. Untreated, human
immunodeficiency virus lessens the count of CD4 cells (T cells) of the body, making the person more vulnerable to be attacked by the infections or infection-related cancers. In lapse of time, human immunodeficiency virus can obliterate so many of CD4 cells that the body would not be in a position to wrestle with the infections and disease. These cancers or opportunistic infections take benefit of already victimized immune system and indicate that the person has AIDS, the final stage of HIV infection (HIVgov, n.d). Researchers and scientists right now are working harder for the possibility of cure for HIV/AIDS. In fact, like many cancers, right now we know a lot about HIV/AIDS as well. No much useful cure presently exists, but with the help of appropriate medical care, HIV can be taken control of. The drugs that are made use of to treat HIV are identified as antiretroviral therapy or ART. If taken in an appropriate manner, each day; the very medicine can considerably extend the lives of the HIV/AIDS patients, keep them vigorous, and significantly lesser their possibility of infecting others. In the mid-1990s when ART was yet to be introduced, people living with HIV would progress to human immunodeficiency virus only in few years. Nowadays, a person diagnosed with HIV but goes swiftly and appropriately under treatment can live almost a normal life (HIVgov, n.d).

HIV belongs to a category of viruses known as Retroviruses which work by attacking the genetic material of a cell within the body. Usually, the body’s immune system fights against such a virus, but HIV ends this process up by infecting CD4, or T-cells, that are the cells that fight against the infection. Without significantly damaging the immune system, the HIV can go on living inside the body for the period of so many years, though the process of replication will not ever cease.

The body invaded by HIV is known as HIV positive, which means they have been diagnosed HIV positive. There are also the people who get infected and still live their entire life quite normal. Sometimes such people are unaware of the fact that they are HIV positive
but some patients develop variety of infections that their immune system fail to fight against. And, slowly and gradually such patients at one point in time are being diagnosed with AIDS.

1.3.1 Origin and Meaning of HIV/AIDS

It was 1959 when the first case of HIV was traced. The man who lived in Democratic Republic of Congo in Africa was the first person who was tested positive for HIV. But it’s yet unknown where from he received the infection. When the blood sample was tested, it was assumed that HIV has possibly originated from a lone source in the late 1940s or beginning 1950s.

The United States appeared to be hit by HIV and AIDS from mid to late 1970s (History of AIDS, n.d). During 1979 and 1981 doctors from New York and Los Angeles found the rate of illness higher in homosexual male patients. The illness included multiple kinds of pneumonia and cancer. Until this period of time, such conditions were unusual among the people with strong immune systems. Even the men who would be stronger and healthier were found developing the cancers like Kaposi’s sarcoma. In 1982, physicians discovered the phrase “acquired immune deficiency syndrome” to point towards such cases. And the same year, the Centers for Disease Control and Prevention (CDC) began to track such cases.

In 1983, scientists had reached the point where they were capable of identifying the virus that caused the disease. And finally they termed it as the human immunodeficiency virus, or HIV-1. In 1986, HIV-2 was found responsible for causing AIDS among the people living in West Africa. Scientists also suspected HIV-2 was in the region for many decades. Mostly, in US, people living with HIV usually have HIV-1 and the people living with HIV-2 are very few in numbers. Though these two viruses are different from each other, but both can result in AIDS. The epidemic is spreading at horrifying speed.
AIDS, a disorder caused by HIV attacks body's immune system. Characteristics consist of insufficiency of several forms of leukocytes, particularly T cells; opportunistic infections which take benefit of the damaged immune response, like bacterial pneumonia, tuberculosis, human herpes virus, or toxoplasmosis; several types of cancer, mainly Kaposi sarcoma; in capability of maintaining body weight; and in complex cases, AIDS dementia complex. Treatment for AIDS disease is now much more advanced. Antiviral and other medications for boosting up the immunity include existing treatment protocols.

HIV/AIDS is a chunk of deadly stressors. It can be controlled by the administration of treatment schedules which is quite complicated. HIV/AIDS harms the society as a foundation of unfairness, economic destruction, and illness (Joint United Nations Programme on HIV and AIDS, n.d).

HIV is a deadly disease that is caused by a virus called Human Immunodeficiency Viruses. It breaks down one’s immune system and the patient becomes inclined to develop fatal infections, neurological disorder and strange malignancies.

1.3.2 Global HIV AIDS Statistics

HIV persists to be one among the most important health issues of the world. It was seen that in 2016 around 36.7 million people were infected with HIV, which almost included 1.8 million children as well. The global HIV prevalence of 0.8% was found among adults. And at the same time 30% of these people are unaware about their being HIV positive. Since the beginning of this epidemic, around 78 million people have fallen prey to HIV. So far, around 35 million people have died because of the illness caused by AIDS. Alone In 2016, 1 million people died because of AIDS or the illness caused by AIDS. Mostly the people who have become victim of HIV live in low and middle income countries. Among estimated 25.5 million people living with HI/AIDS who live in sub-Saharan Africa, around
19.4 million live in East and Southern Africa that witnessed 44% increase in HIV infections globally in 2016 (AIDS Virus Education Research Trust, n.d).

![Number of people living with HIV in 2016](image)

Figure 1: Number of people living with HIV in 2016 (AIDS Virus Education Research Trust, n.d).

### 1.3.4 HIV and AIDS in India

India shelters the third highest number of HIV/AIDS patients. In 2016, in India, the prevalence of the estimated 0.3% is quite smaller when compared to other countries with middle-income. But this 0.3% in other words means 2.1 million people living with HIV/AIDS, because India is the country with a huge number of population. In 2016 in India an estimated 62,000 people died because of the illnesses begotten by AIDS. On the whole, the deadly wave in India is now slowing down. There was found the decline of a 32% in new HIV infections (80,000 in 2016), and between 2007 and 2015 there was found the decline of a 54% in AIDS-related deaths as well (AIDS Virus Education Research Trust, n.d).
In India heterosexual sex is the prominent cause for the epidemic and accounted for 87% of latest infections in 2015. On the other hand, the epidemic is intense mostly in key affected populations like sex workers. The three states which have the highest HIV prevalence (Manipur, Mizoram, and Nagaland) fall in the east of the country. Some of the states in northeast and north have increase in HIV prevalence.

**India (2016)**
- 2.1 million people living with HIV
- 0.3% adult HIV prevalence
- 80,000 new HIV infections
- 62,000 AIDS-related deaths
- 50% adults on antiretroviral treatment
- 33% children on antiretroviral treatment

Figure 2: HIV and AIDS in India (AIDS Virus Education Research Trust, n.d).

### 1.3.5 HIV prevention in India

NACO is an organization that makes and employs the policies and strategies to prevent and control the spread of HIV epidemic in India. Its latest programme, NACP-IV (2012-2017), intended to diminish yearly new HIV infections by 50% by employing the policy of inclusive HIV treatment, awareness, attention and support for the general population and help out the people who are more vulnerable to get the infection (AIDS Virus Education Research Trust, n.d).
1.3.6 SYMPTOMS AND STAGES OF HIV INFECTION

Stage 1: Acute primary infection

After approximately one to four weeks after getting the infection, patient may experience symptoms which can feel similar to flu. During this stage, per micro liter contains at least 500 CD4+ cell (WebMD, n.d). Sometimes, in this stage, the patient doesn’t feel any symptoms at all, and if he did then the symptoms may last for a week or more than that. Feeling such symptoms alone is not the reliable means to diagnose HIV. The patient necessarily has to consult the doctor and get himself/herself tested.

Symptoms may include:

- Fever
- Rashes on the skin
- Inflated glands
Headache

Distressed stomach

Muscle pain

Joint pain

The symptoms will emerge when the body is reacting to HIV. Infected cell will circulate throughout patient’s body. The immune system of the body in return will attempt to fight against the virus by giving birth to HIV antibodies. This process is known as seroconversion. At this phase of HIV it may be too early to get tested; rather the virus may take some weeks or some months to show up. But even at this stage very sever virus is still present in blood.

**Stage 2: The asymptomatic stage**

After the completion of seroconversion stage, people usually start feeling better. This is also the fact that HIV may not show any symptom for the period of 10 to 15 years. Even after not showing the symptom the virus will still continue making the copies. And in lapse of time the virus will cause an utter damage to the immune system. The duration of this phase depends on how faster the virus makes copies of itself. Some patients with HIV/AIDS can go on for ten or more than ten years without showing any symptom. While on the other hand others may experience getting their immune system too weaker only after few years of getting the infection (AIDSinfo, n.d).

**Stage 3: AIDS/Symptomatic HIV infection**

The most dangerous phase of HIV infection is AIDS and this is also the final stage of HIV. In this stage the immune system is severely wrecked and the body is not in a position to
fight the opportunistic infections anymore. These are the infections or cancers caused by infection that usually attack the person with weaker immune system (AIDS Virus Education Research Trust, n.d.). If the person living with HIV has the CD4 count lesser than 200 cells/mm$^3$, he/she is diagnosed with AIDS. If the person diagnosed with AIDS doesn’t go for the treatment dies in around three years (AIDSinfo, n.d).

Symptoms that the patient may experience during this phase:

- Severe weight loss
- Sweating during night
- Unstoppable cough
- Intense fever
- Chronic diarrhea
- Skin problem
- Constant infections
- Sever illness

1.3.7 Psychological response to HIV/AIDS and coping strategies

A huge number of studies have been conducted that suggest a higher rate of psychological problems among HIV/AIDS patients. In HIV/ADS patients living in United States there was discovered a significant rate of anxiety, depression and other form of psychological problems. Patients with HIV/AIDS are as well found aggressive and their response to annoying situation is found to be bizarre. During the situation of frustrating nature, a person becomes angry and is prone to be focused on his rage, regret and
unfriendliness on the people who are taken as the suitable objects. Nearly every HIV/AIDS patient has to experience psychological problems at some point of time. HIV is a major source of psychological challenges and the victim certainly finds his/her psychological health challenged. This virus is such a deadly virus that it can damage patient’s nervous system and ruin his entire personality. Depression and anxiety have been identified as the frequent indicator of psychological well-being among the patients with HIV/AIDS (Sun, Wu, Qu, Lu, & Wang, 2014). Below mentioned are some of the emotional responses to HIV/AIDS.

- Anxiety
- Distress
- Terror
- Shock
- Remorse
- Aggression
- Depression
- Hopelessness
- Numbness

Religion and spirituality have been found essential and helpful for HIV/AIDS patients in coping with the obnoxious repercussions of AIDS. Researchers are quite busy in studying the relationship of religiosity and spirituality with HIV/AIDS and in a number of studies it has been found that HIV progresses slower among the individuals who are religious/spiritual. It has been also found that higher religiosity leads to liveliness, lesser pain and stress and a better mental well-being among HIV/AIDS patients. Some AIDS patients stay stronger and optimistic and optimism in return help them keep their immune system healthy and fit. Ironson et al. (2005) suggested, optimism and immune response of HIV/AIDS patients is
positively correlated. Patients who are optimistic are able to suppress their viral load. Moreover, Blomkvist et al. (1994) found that the men who are optimistic have lesser mortality. Apart from religiosity and optimism HIV/AIDS patients employ many other techniques to overcome or wrestle the hardships and challenges that they suffer from because of HIV/AIDS.

1.3.8 Antiretroviral Therapy

Antiretroviral therapy (ART) includes the combination of drugs that helps the patient to fight off the virus or infections caused by AIDS. Every person living with HIV/AIDS must be initiated on ART soon after he is declared HIV positive. ART must be given in an exclusive manner so that it includes every counseling, routine/periodic laboratory investigations and all other instructions that would help patient how to prevent himself from the infections and keep his immune system healthy and stronger. The beginning of this therapy for treating HIV/AIDS has been successful in decreasing mortality that is connected with AIDS (Collier et al., 1996; D’Aquila et al., 1996; Staszewski et al., 1996).

ART has multiple objectives, which includes the attainment of sustained virologic and epidemiologic control over HIV. ART must lead to repression of viral load and that is how ART must help the patient to live a better life.

Successful ART means the restoration of immune system with an increase in CD4+ cell count. Patient becomes less vulnerable to infections and there is a noticeable improvement in his clinical outcomes. ART reduces the chances of falling prey to infections and enhances the quality of patient’s life (Autran et al., 1997).

ART also hampers the transmission of HI virus from one person to another person. This therapy noticeably holds back viral duplication and lessens the HIV viral load and
assists the patient to keep his immune system comparatively healthy (Komanduri et al., 1998; Lederman et al., 1998). The extensive use of ART may help in reducing transmission of HI virus in nations and communities and that is one among the main objectives of ART. ART has to be introduced in all community health centers and initiated among all infected pregnant women, adults, adolescents and children. It must be given at all stages of HIV and it must be given independent of CD4+ cell count. This is also important that priority must be given to the people living with advanced level of HIV. As the priority, ART must be started among all children ≤2 years of age or the children of below 5 years with CD4+ cell count ≤750 cells/mm³ or whose CD4 percentage is <25%. The children of 5 years and older living with WHO HIV clinical phase 3 or 4 or the CD4+ cell count ≤350 cells/mm³ must be given priority as well.

1.4 Death Anxiety

Death anxiety is a melancholic, abnormal and unceasing terror of death. It’s the fear of one’s own mortality. Death anxiety is also defined as the feeling apprehension (anxiety). The person is deadly frightened when he thinks of the process of his own death or stopping to be or exist. This fear is also known as “Thanatophobia” (fear of death) which is never synonymous to necrophobia. Necrophobia is the fear of dead body or dying person while thanatophobia is the fear of dying or ceasing to live or exist (Wikipedia, n.d). So many physiological problems or the poorer ego integrity and a lot of psychological problems are the indications of death anxiety among elderly age people. Everyone human being is conscious of his death/mortality (Langner, 2002), and the people living with HIV/AIDS or any other life-threatening disease are compelled to experience mortality (Emanuel, Fairclough, Wolfe, & Emanuel, 2004).
Existentially speaking, death is non existence. In Kierkegaard's words death is the "fear of nothingness." Approximately, 60 years back, some conceptual work was published about death anxiety. And right now there is no one single definition of this concept that can be believed over. (Nyatanga & Vocht, 2006). Death by many American has been comprehended as a dead end, not the doorway. The Europeans who look at the world through more rationalistic and scientific spectacles believe death is the deadliest evil to befall us. They believe death is the most unloved and feared enemy. They also believe that death ends up everything, all of a sudden it leads to nothingness and eternal unconsciousness. This extreme selfish and hyper-rational attitude towards life has inspired science a lot and is now in a position to help health professionals save people from dying or delay their death with the help of advancement in medical sciences. Medical sciences are striving so harder to control or sugarcoat death at all cost. And it doesn’t matter even if it costs dying patient’s dignity. Hence our desire to live always stronger and longer continues. People in America glorify youth and fear old age and that is directly connected with death.

For so many westerners, death is a process that wipes out the meaning of life. Death for them makes all the entire human existence meaningless and absurd. They ask why must a person die? How this life could have any meaning when death perishes everything. The rejection of death, as anthropologist and philosopher Becker (1973) argues, is a sort of collective neurosis. If so, then what is the remedy?

1.4.1 Theoretical perspectives on death anxiety

Sigmund Freud is one among the first theorists who enlightened world about the concept of death anxiety. He argued that the fears related death projects the unresolved childhood conflicted rather than itself the terror of death. Freud was quite skeptical about our capability to believe mortality. Freud (1952) in his paper, “Thoughts for the Times on War
and Death,” stated “our unconscious does not believe in its own death; it behaves as if immortal” (p. 765). Freud believed that the unconscious is the primary source for thought and behavior, and therefore he noted that while we provide lip service to the brutal reality of death, “at bottom no one believes in his own death” (p. 761)

Contemporary theories of death anxiety are mostly based on Becker’s existential view of death (Becker, 1973). He argues death anxiety is very strong and real and it brings out so many other types of anxiety and phobia. He noted a person manages his anxiety by living and agreeing with his culture and society. A person escapes anxiety when he lives in accord with cultural worldview which literally or metaphorically offers him immortality. (Strachan et al., 2007, p.1138). Becker said that people waste a lot of energy in denying their mortality as a means to refrain themselves from feeling death anxiety.

Becker’s contribution gave birth to terror management theory (TMT) and that says that humans fight for self-preservation. It also proposes that every person knows that his death is quite inevitable (Pyszczynski, Greenberg, & Solomon, 1999). This theory states that when a person is reminded of his death, his need for meaning and structure maximizes and that eventually results in an increased attention towards culturally and personally admired goals. This theory also states that the person who has higher self esteem will have lower death anxiety and vice versa. (Solomon, Greenberg & Pyszczynski, 2004).

Posttraumatic growth theory (PTG) is one more contemporary death anxiety theory. This theory suggests that when a person comes across crisis in life, particularly when he dies or someone close to him dies, he changes or the person connected to him change in a positive direction. He learns to appreciate life and changes his priorities as well. And along with all positive changes in his life he improves his interpersonal relation (Tedeschi & Calhoun, 1996, 2004). Lykins, Sergerstrom, Averill, Evans, & Kemeny (2007) investigated and
compared TMT and PTG and argued that these two theories can be reconciled. Lykins et al. (2007) examined these two theories and identified some methodological differences between the approaches employed by the profounder of these two theories. TMT involves the manipulations of the clues on a particular occasion that reminds of death, like the short presentation of words that are related to death. While on the other hand PTG examines natural events or challenges, which includes any fatal illness or a natural disaster. Such events of threats are natural and cannot be controlled by a human being and may last for days, months or years. Lykins et al. (2007) stated that these two different approaches bring out two different categories of processing of the material related to death. TMT draws out more defensive processing like disruption and positively biased appraisals, while on the other hand PTG encourages and makes a person focus on his own death and then provides him the opportunity to take the perspective of others as well (p. 1089). Lykins et al. (2007) came up with a series of research studies to explain the issues and demonstrate that “when people encounter death over a longer period of time or in a manner consistent with their goal structure, they move to transcend their defensiveness, maintain or become more intrinsically oriented, and may end up healthier in the long-term” (p. 1097).

1.5 Religiosity

The concept of religiosity is quite difficult to define and there are at least two reasons behind its complex nature. The initial reason is the uncertain and vague nature of the English language. Colloquially, in Roget’s Thesaurus (Lewis, 1978), it was found that the term religiosity is synonymous with religiousness, belief, devotion, and holiness and etc. The second reason is, every discipline has a different understanding of the term religiosity and the very few agree with one another (Cardwell, 1980; Demerath & Hammond, 1969). For example, the theologian understands religiosity from his/her perspective (Groome & Corso, 1999), and the educator may focus on convention and belief (Groome, 1998). The
Psychologists will opt to address the elements of, saintliness, and faithfulness, while sociologists might consider religiosity to include the connection to church, acceptance of belief, and living life with belief (Cardwell, 1980). The making use of variety of terms to make out what possibly could be the dimensions of religiosity makes it complicated to explain it without having a clear definition given by the religious experts and it’s also important that this knowledge must be applicable to real life.

Gorsuch (1984) has identified that religion in itself is the general factor which could be further divided into many dimensions. He claims that religion is a perfect measure when employed to predict other variables and the sub dimensions are employed to forecast exceptions to this regulation. For instance, while investigating differences of age on religiosity, the researcher calculates the religiosity as a whole. And while predicting a more detailed variable, like empathy, it’s imperative for the researcher to employ all the dimensions of religiosity in order to under religiosity more comprehensively.

Tsang and McCullough (2003) has given a model about religiosity and spirituality and that model is hierarchical in its nature (phase one- dispositional, phase two - operational) and categorizes tools to measure the religiosity and spirituality on 2 levels. Therefore, the researchers have categorized the tools to measure religiosity into two levels: The instrument that will measure the dispositional part (religious faith, religious involvement, and spiritual well-being) and the instrument that will evaluate the operational side (prayer, religious coping, and religious orientation). The 2 levels have an interaction between them. For instance, the people that employ religious coping to overcome stress have generally a stronger religious bent. The researchers who have set out this model have suggested that the level 1 has to be taken into control before we conclude that the level 2 has a significant impact on the lives of people. If the proposed rule is not followed, the researcher will not be able to identify whether the effect is because of general religiosity or operational aspect.
Tsang and McCullough (2003) give details about the employment of this approach in the research conducted on religious coping held by Pargament (1997). In the studies conducted on religious coping (operational religiosity), Pargament along with his colleagues would often employ the general aspect of religiosity to gain control over individual differences at dispositional aspect. This approach has given a map to the researchers to come up with a tangible ending argument about the exact effect of religion. And simultaneously they were as well conscious not to contradict such results with the influence of dispositional and general differences in religiosity.

The Level 1 of religiosity shows the depth of religiousness in a person. The model’s authors state that it’s quite imperative to evaluate level one religiosity in order to measure association between psychological and physical health and religion. The Level 2 of religiosity (operational aspect of religiosity) indicates to inter individual multiplicity at the demonstration of religion, religious inspiration, and the employment of religion to overcome day to day challenges. Tsang and McCullough (2003) claims, the dispositional side of religion is self existing. The two separate people living with the identical religiosity dispositional level might live life of a different style, have dissimilar thinking pattern, and have divergent ways of using religion as a coping strategy.

1.6 Optimism

The term optimism refers to a set of belief that everything would turn out fighting fit. It’s a faith that everything that you will experience in your future will be utterly good. And it also refers to a mindset you will always be able to control your life the way you want to. In English language there are multiple number of words and phrases that give the detailed account of the term optimism, for instance, "To see the glass as half full and to make lemonade out of lemons." All the similar phrases explain the term optimism more
comprehensively and in a detailed manner. And they all clarify that optimism is a confidence that all pessimistic situations will transform into something positive and will help a person to fight off the hardships of life. Optimism leads to better and positive results and on the other side pessimism has a connection with painful results (Scheier & Carver, 1992; Scheier, Carver, & Bridges, 2001). Optimism leads to a greater level of life satisfaction. (Chang, Maydeu-Olivares, & D’Zurilla, 1997) while pessimism has a positive correlation with painful symptoms (Chang et al., 1997).

Even though the terms like optimism and pessimism frequently indicates to how an individual thinks about his future but these terms as well indicates to how an individual understands the cause of good and bad events that have already taken place. The optimistic people believe that even bad events happen for a good reason. While on the other hand, the pessimistic people believe otherwise. The findings of the studies have found astonishingly benefitting picture of optimistic attitude, whether the optimism is dispositional (Carver & Scheier, 2014) or otherwise.

The theories of optimism take in dispositional models, and the models of explanatory style. To evaluate or measure optimism, methods have been devised for both the theoretical systems. For instance, the multiple types of Life orientation tests were developed for the operational meaning or definition of the optimism. And to investigate optimism in the context of explanatory style, the Attributional Style Questionnaire was designed.

1.6.1 Dispositional optimism

Scheier and Carver (1992) held studies on a variable namely dispositional optimism which stands for an attitude that in future everything will happen good. Dispositional optimism is an innate inclination that everything will be alright. And it can also be defined as that everything will happen good and desirable in future life (Scheier & Carver, 1985). This
is the belief that can as well be a person’s personality trait, like there are people who are innately much more living with optimistic attitude than the pessimistic (Peterson, 2000). Scheier et al. (2001) argue that the optimistic people are not dismayed by their failure. They try even harder and are never defeated. They are confident and consistent while on the other hand pessimistic people have hesitation and problem to continue their struggle.

Different researchers have operationalized the phrase “Dispositional Optimism” in their own way, and that depends a lot on their research. And to measure or evaluate optimism, researchers have developed many tools and techniques; Life Orientation Test (LOT) is one among them (Wikipedia, n.d).

Characteristically, dispositional optimism and pessimism are measured when people are asked whether for them future is coming up with positive or negative events. The LOT has separate items for optimism and pessimism. And has separate scores for optimism and pessimism for every single participant. If the score on optimism is high, that will indicate the superior results in relationships and the better position in society. Health enhancing behaviors are connected to optimism and the behaviors that damage the health are linked with pessimism (Wikipedia, n.d).

Some researchers are of the opinion that the optimism and pessimism are two sides of the same dimension. Confirmatory modeling, on the other hand, believes in two-dimensional model and the separate two dimensions indicate different results. Genetic modeling verifies what two-dimensional model believes in. it argues that the optimism and pessimism are innate independent traits and there is a correlation between the two which emerges because of environmental influence and the general well-being factor.
1.6.2 Explanatory style

The concept of explanatory style has come into being when learned helplessness model was reformulated (Abramson, Seligman, & Teasdale, 1978). Explanatory style is different than the dispositional theories about optimism. The Explanatory style argues that the dispositional optimism and pessimism are the mirror images of the ways people describe the events. For instance, the attribution causes the disposition. Attributional style differentiates in three different dimensions for the explanations of events: These explanations go like, internal versus external causes, stable versus unstable and globally versus situationally specific. Additionally, the measures differentiate attributions for the positive and negative happenings as well (Wikipedia, n.d). This theory is of the opinion that when there is no pessimism there will be optimism and this approach was devised to help people learn optimism. By using Beck’s and Ellis’s cognitive therapy models this theory helps people minimize helplessness and depression (Ellis & Harper, 1975).

The person who is optimistic attributes internal and stable and global explanations to the happenings that have a better outcome. While on the other hand the person who is pessimistic attributes stability, globality and internality to the happenings that are quite negative and harmful. Pessimistic and Optimistic attribution Models demonstrate that attributions are the cognitive styles in themselves. The people whose focal point is global explanations do the same for every kind of happening or event. Furthermore, the people differ in the ways how much optimistic their attributions are about the happening and events that are good and positive, and how pessimistic their attributions are for the happening that are negative and harmful in their nature, but the two abstractions of pessimism and optimism are not correlated. Lickerman (2013) suggests people who have a pessimistic self-explanatory style are prone to develop PTSD and depression when they are living a tough time.
CHAPTER ONE: INTRODUCTION

There is a lot of debate about the affiliation and connection between explanatory style and optimism. There are the researchers who claim that optimism is only a lay man’s term that researchers understand as the explanatory style. Generally, it has been identified that the explanatory style is different from dispositional optimism, and the two must not be used as synonymous to each other. The concepts demand further research to be explained and differentiated more comprehensively (Wikipedia, n.d).

1.7 Mental Well-Being

The World Health Organization suggests that the mental-well being refers to when an individual is able to comprehend his capabilities, can overcome the challenges of life, can work efficiently and in a more creative manner and is intelligent enough to make contribution to his/her society or community. This explanation declares that the mental well-being is different from the mere absence of mental disease (World Health Organization, n.d). The concept is relevant to a variety of disciplines. The terminology of mental health is now not in use so consistent. For FPH ‘mental health’ means mental illness, mental well-being and all other form of mental health states (The UK’s Faculty of Public Health, n.d). There is globally no sole definition of mental well-being and the possible reason is that presumably every individual or group has his/her own ways of understanding the meaning of the concept mental well-being. There are people in the world who suggest that mental well-being stands for contentment or ease. For some it is the absolute nonexistence of illness. And there are also the people living out there in the world who assert that mental well-being is financial prosperity. So basically, understanding the concept of mental well-being is the subjective matter of an individual and every individual comprehends it as per the goal he/she has set to achieve (World Health Organization, n,d).
Resilience – as in "to be able to fight off the hardships of life” – is the vital element of many definitions of mental well-being. To work efficiently and productively is also the significant from the viewpoint of economists (The UK’s Faculty of Public Health, n.d).

The person who has a good mental well-being is able to:

- Experience confidence in himself and has a higher self-esteem.
- Experience and articulate a variety of emotions.
- Make and preserve better relationships with other people.
- Experience himself busy with the people around.
- Live life of a better quality.
- Work productively and intelligently.
- Fight off successfully the challenges of life.
- Adapt and manage in times of change and uncertainty.

There are so many environmental factors that are identified to be linked to happiness, such things consist of: income of an individual, healthiness, family, morality and etc. (Carr, 2004; Deiener, Pishi & Lucas, 2003). Eventually, in the quest of comprehending happiness, there are major two theoretical viewpoints that stress on dealing with the problem that what leads to happiness and the experience of feeling good. The two perspectives include hedonic and eudaimonic viewpoints of happiness (Keyes, Shmotkin, & Ryff, 2002).

1.7.1 Hedonic well-being

Hedonic aspect of well-being claims that the maximum pleasure and minimum pain ends up in happiness. This type of well-being is based on the concept of subjective well-
being. The phrase subjective well-being indicates to a better life or the life that is full of happiness and positive events. It includes the affective and cognitive factor. It’s believed that the individual is happier when positive affect and life satisfaction simultaneously are higher (Carruthers & Hood, 2007). The researchers who believed in hedonic viewpoint were inclined to give stress to broader notion of hedonism which takes in the preferences and contentment of mind and the body simultaneously (Kubovy, 1999). Certainly, the major viewpoint among the psychologists who believed in hedonistic view of well-being is that the well-being includes one's individual/subjective happiness and concerns the experience of happiness versus pain largely construed to embrace every judgment regarding good/bad constituents of life. Therefore, happiness is not the thing that can be reduced to bodily hedonism, for it could be obtained from attaining the target/goals or precious results in the diverse realms (Diener, Sapyta, & Suh, 1998).

In the volume which publicizes “the existence of a new field of psychology,” Kahneman, Diener, and Schwarz (1999) described the psychology of hedonism as the study of “what makes experiences and life pleasant and unpleasant” (p. ix). Its heading, Well-being: The foundations of hedonic psychology evidently propose that, inside this example, the term hedonism and well-being are fundamentally alike. By means of claiming well-being is all about pleasure and pain, psychology of hedonism created for itself a plain and clear-cut objective of investigation and intervention that is to maximize the happiness of human beings. Accordingly, the volume is full of proofs and confirmations that how an individual capitalize on the compactness of incentive, and optimize the inputs that are linked to happiness versus pain.

Even though we have a multiple number of ways to measure pleasure and pain continuum among human beings, research generally in the contemporary psychology of hedonism employ the assessment of subjective well-being (SWB) (Diener & Lucas, 1999).
SWB is made of three elements: satisfaction of life, the presence of optimistic mood, and the nonexistence of pessimistic mood, jointly, often known as happiness.

1.7.2 Eudaimonic Well-Being

Eudaimonic well-being, conversely, is vigorously based on Maslow’s notion of self actualization and that of Roger’s idea of the entirely functioning individual and his subjective well-being. Therefore, the eudaimonic concept of happiness is based on the principle that the person who has a purpose of life and comes across hardships and experience growth is happier. This notion agrees to Self-Determination theory for conceptualizing happiness (Ryan & Deci, 2001).

Waterman (1993) argues, while happiness is explained hedonically, the eudaimonic notion of well-being suggests people to live their life in agreement to their true self. He is of the opinion that eudaimonia takes place when an individual’s doings are matching with intensely rooted values and are entirely engaged. In such situation the person would experience himself extremely living and genuine, and existing as who he actually is.

The theory of Self-determination (SDT) (Ryan & Deci, 2001) is one more concept that has let in the perspective of eudaimonia, or realization of self, as the innermost definitional part of well-being and tried to identify both what self-actualization stands for and how this actualization of self could possibly be achieved. In particular, SDT believes in three fundamental psychological requirements that are, autonomy, and competence, and relatedness. And it believes that the attainment of these requirements is quite imperative for the growth in psychological perspective (for instance, inherent/intrinsic motivation), integrity (for instance, to internalize and assimilate practices of the culture), and well-being (for instance, satisfaction of life and the psychological health), and additionally, the experiences of liveliness (Ryan & Frederick, 1997) and self-congruence (Sheldon & Elliot, 1999). The
completion of need/requirement is therefore understood as the fundamental and natural ambition of a person’s life which describes numerous meanings and implication of basic human activities (Ryan & Deci 2001).

1.8 Significance of the Study

The previous psychological research studies conducted on people living with HIV/AIDS have contributed a lot to benefit the patients of such kind, but a great number of studies are still needed in this area. In this study, the researcher will examine how, death anxiety, religiosity and optimism are related to mental well-being among people living with HIV/AIDS.

The present study is indispensable for different reasons. The findings will be of great importance for counselors, community health workers, and health psychologists. And simultaneously the findings of the study will benefit the people living with HIV/AIDS as well.

People living with HIV/AIDS live a life so horrifying and unfortunate. The patients have a brutal inclination to fall prey to different health (mental as well as physical) related problems. The patients of such kind suffer a range of emotional problems that results into a deteriorated mental well-being. And in previous studies, researchers have also found, there are certain behaviors that help the patients to overcome emotional problems and live relatively a better life. So, in this study, the researcher will make an attempt to look into how, death anxiety, religiosity and optimism are related to mental well-being among HIV/AIDS patients.
1.9 Objectives of the study

The title of the present study is death anxiety, religiosity and optimism as related to mental well-being among people living with HIV/AIDS. To achieve the purpose of this study, the following objectives have been set:

1) To examine the relationship between death anxiety and mental well-being among people living with HIV/AIDS.

2) To examine the relationship between religiosity and mental well-being among people living with HIV/AIDS.

3) To examine the relationship between optimism and mental well-being among people living with HIV/AIDS.

4) To examine whether death anxiety, religiosity and optimism predicts mental well-being among people living with HIV/AIDS.

5) To examine the mean difference between death anxiety scores for male and female HIV/AIDS patients.

6) To examine the mean difference between religiosity scores for male and female HIV/AIDS patients.

7) To examine the mean difference between optimism scores for male and female HIV/AIDS patients.

8) To examine the mean difference between mental well-being scores for male and female HIV/AIDS patients.

9) To examine the mean difference between death anxiety scores for rural and urban HIV/AIDS patients.
10) To examine the mean difference between religiosity scores for rural and urban HIV/AIDS patients.

11) To examine the mean difference between optimism scores for rural and urban HIV/AIDS patients.

12) To examine the mean difference between mental well-being scores for rural and urban HIV/AIDS patients.

13) To examine the mean difference among death anxiety scores for HIV/AIDS patients of different levels of income.

14) To examine the mean difference among religiosity scores for HIV/AIDS patients of different levels of income.

15) To examine the mean difference among optimism scores for HIV/AIDS patients of different levels of income.

16) To examine the mean difference among mental well-being scores for HIV/AIDS patients of different levels of income.

17) To examine the mean difference among death anxiety scores for HIV/AIDS patients of different age groups.

18) To examine the mean difference among religiosity scores for HIV/AIDS patients of different age groups.

19) To examine the mean difference among optimism scores for HIV/AIDS patients of different age groups.

20) To examine the mean difference among mental well-being scores for HIV/AIDS patients of different age groups.
1.10 Hypotheses

H$_{A1}$: There will be the negative relationship between death anxiety and mental well-being among people living with HIV/AIDS.

H$_{A2}$: There will be the positive relationship between religiosity and mental well-being among people living with HIV/AIDS.

H$_{A3}$: There will be the positive relationship between optimism and mental well-being among people living with HIV/AIDS.

H$_{A4}$: Death anxiety, religiosity and optimism will be the predictors of mental well-being among people living with HIV/AIDS.

H$_{A5}$: There will be the difference between mean scores of death anxiety for male and female HIV/AIDS patients.

H$_{A6}$: There will be the difference between mean scores of religiosity for male and female HIV/AIDS patients.

H$_{A7}$: There will be the difference between mean scores of optimism for male and female HIV/AIDS patients.

H$_{A8}$: There will be the difference between mean scores of mental well-being for male and female HIV/AIDS patients.

H$_{A9}$: There will be the difference between mean scores of death anxiety for rural and urban HIV/AIDS patients.

H$_{A10}$: There will be the difference between mean scores of religiosity for rural and urban HIV/AIDS patients.
**H₂₀:** There will be the difference between mean scores of optimism for rural and urban HIV/AIDS patients.

**H₂₁:** There will be the difference between mean scores of mental well-being for rural and urban HIV/AIDS patients.

**H₂₂:** There will be the difference among mean scores of death anxiety for HIV/AIDS patients of different levels of income.

**H₂₃:** There will be the difference among mean scores of religiosity for HIV/AIDS patients of different levels of income.

**H₂₄:** There will be the difference among mean scores of optimism for HIV/AIDS patients of different levels of income.

**H₂₅:** There will be the difference among mean scores of mental well-being for HIV/AIDS patients of different levels of income.

**H₂₆:** There will be the difference among mean scores of death anxiety for HIV/AIDS patients of different age groups.

**H₂₇:** There will be the difference among mean scores of religiosity for HIV/AIDS patients of different age groups.

**H₂₈:** There will be the difference among mean scores of optimism for HIV/AIDS patients of different age groups.

**H₂₉:** There will be the difference among mean scores of mental well-being for HIV/AIDS patients of different age groups.
1.11 Operational Definitions

**Death Anxiety:** Death anxiety is the anxiety triggered by the thoughts related to death. It is a feeling of uneasiness and the anxiety of nonexistence of one’s being (Templer, 1970).

**Religiosity:** Religiosity refers to a tremendous participation in religious activities. Religiosity, more frequently, mirrors a person’s individual beliefs and is more than love for religion. Religiosity includes multiple components which go like organisational, non-organisational and intrinsic religiosity (The Duke University Religion Index (DUREL), 1995).

**Optimism:** Optimism is an inclination and a psychological attitude where a person is hopeful and confident that the result or outcome of a particular event or an attempt will be positive and pleasant. Pessimism as well is a psychological attitude where a person believes that unwanted events and happenings will occur in his life and has a negative attitude towards life overall (Scheier, Carver, & Bridges, 1994).

**Mental Well-Being:** Mental well-being comprises of two viewpoints: (1) Subjective happiness and the satisfaction of life (hedonic perspective); and (2) the healthy relations with other people and the realization of self (the eudaimonic perspective). The later includes the capability for the development of self, better and healthier relations with other people, and the self competence (NHS Health Scotland, the University of Warwick and the University of Edinburgh, 2007).
1.12: Conceptual Framework

Figure 4: Conceptual Framework