INTRODUCTION

HIV is the most devastating disease of the 21st century. HIV and AIDS appeared in the late 1970s when doctors began to see an increasing number of patients with an unusual strain of pneumonia and cancers. Some noticed the disease appeared most often in men who had sex with men and began calling it Gay-Related Immune Deficiency Syndrome or GRD. The Human Immunodeficiency Virus (HIV) was isolated in 1983 by Montagnier. The virus was called lymphadenopathy- association virus. Not long after, Robert Gallo of the U.S. National Cancer Institute discovered a related virus which was called HIV-3.

HIV is a virus that takes over certain immune system cells to make many copies of it. HIV causes slow but constant damage to the immune system. HIV infection was first recognized in 1981 in U.S.A. and since then it has reached epidemic proportion in a span of barely a decade. HIV stands for Human Immunodeficiency Virus. Acquired Immune Deficiency Syndrome is a collection of symptoms and infections resulting from the specific damage to the immune system caused by human condition and leaves individual prone to opportunistic infection and tumors.

Current treatment for HIV infections consists of highly active antiretroviral therapy or HAART (Department of Health and Human Service, 2006). This has been highly beneficial to many HIV–infected individuals since its introduction in 1996 when the protease inhibitor based HAART initially become available. Current optimal HAART options consist of combination or “Cocktails” consisting of at least three drugs belonging to at least two types, or “classes”, of antiretroviral agents.

The psychological problem faced by patients suffering from HIV/AIDS is posing a challenge to psychologist and social health worker. Although the treatment of HIV/AIDS is not in the preview of social scientists but they can actively work in helping such patients deal with their psychological problems specifically depression which is the focus of this research work. Long term research has revealed that depression and HIV/AIDS are associated or highly correlated with each other.
Vance et al. (2010) carried out a study to examine the challenges of depression and suicidal ideation associated with aging with HIV/AIDS. As the number of older adults with HIV/AIDS increases, new challenges are emerging that threaten their ability to age with this disease. Threats of particular concern are depression and suicidal ideation. In particular, certain cognitive abilities needed to cope with depression and suicidal ideation may be compromised by aging with HIV/AIDS. A model of these stressors is needed for this purpose, as well as to suggest implications for social work practice and research.

THE PRESENT RESEARCH

The present research addresses the gaps in previous research by investigation the collective role of social support, personality and coping strategies depression among in HIV/AIDS patients. Though these factors have been studied as being the cause of increased depression in HIV/AIDS patients, inconsistencies have been reported. So the present study has been designed to study their effect on HIV/AIDS patients.

OBJECTIVE

Main objective of the study are:

(I) To identify HIV/AIDS patients and to classify them into high and low depression groups.

(II) To identify coping strategies used by High and low depression HIV/AIDS patients.

(III) To identify personality characteristics of High and low depression HIV/AIDS patients.

(IV) To identify social support system of High and low depression HIV/AIDS patients.

HYPOTHESES

1. Coping strategies adopted by High and low depression HIV/AIDS patients will be different.
Summary

(a) HIV/AIDS patients with high depression will score high on emotion-focused (confrontive coping, self controlling, accepting responsibility and, escape- avoidance) ways of coping.

(b) HIV/AIDS patients with low depression will score high on problem focused (distancing, seeking social support, planful problem solving and positive reappraisal) ways of coping.

2. Personality characteristic of High and low Depression HIV/AIDS patients will be different.

(a) HIV/AIDS patients with high depression will score higher on neuroticism.

(b) HIV/AIDS patients with low depression will score higher on extraversion.

(c) HIV/AIDS patient’s agreeableness and conscientiousness makes no difference regarding depression in HIV/AIDS patients.

3. HIV/AIDS patients with low depression will score high on all the variables of social support.

METHODOLOGY

Sample

The sample of the study consisted of 150 HIV/AIDS patients disease. The HIV/AIDS Patients were taken from Network of Positive People (NPP+) from Haryana. NPP+ is an organization of HIV/AIDS Positive People who are working for their rights and welfare. All the selected subjects were the properly diagnosed HIV/AIDS patients at time of data collection. The age of subject was in the range of 18 to 45 years and was belonging to both urban and rural areas.

PSYCHOLOGICAL TESTS

After selecting the sample, to meet the objective of the study, the following tests were administered with the selected sample.

1. Beck Depression Inventory scale (Beck, 1994)
2. Multi Dimensional Support Scale (Winefield, Winefield and Tiggermann, 1988)

3. NEO Five Factor Inventory (Costa and McCrac, 2003)

4. Ways of Coping Questionnaire (Folkman and Lazarus, 1998)

RESULTS

In order to achieve the objective of the present study, the main analyses carried out on the data collected were, means, standard deviation, discriminant analysis and t-test. The discriminant analysis was applied to compare the group for different variables with scores on nominal scale. t-test was applied to compare the groups on the measures of depression, social support, personality and ways of coping. The Discriminant Analyses was done to identify the variables which are important predictors of the groups under study. of the table 4.15 indicated that the value of Wilk’s Lambda is .408 which is significant at .001 levels, thus indicating that the high and low group depression HIV/AIDS patients can be significantly discriminated on the basis of social support, ways of coping and personality. Group I consists of low group depression HIV/AIDS patients subjects whereas group II consists of high group depression HIV/AIDS patients.

These results are similar to the results of t-test where low depression group are scoring significantly higher on social support variable achieved family social support and perceived family social support, personality variable of extraversion, conscientiousness while high depression group scores higher on personality factor neuroticism. All other difference are insignificant on these basis we can conclude that social support, personality variables and coping strategies used by such patients are having significant role to play in depression among HIV/AIDS patients. Yi et al. (2006) explained the depression has been linked to immune function and mortality in patients with chronic illnesses. A majority of patients with HIV reported having significant depressive symptoms. Poorer health status and perceptions, less social support, and lower spiritual well-being were related to significant depressive symptoms, while personal religiosity and having a religious affiliation was not associated when controlling for other factors. Helping to address the spiritual needs of patients in the
medical or community setting may be one way to decrease depressive symptoms in patients with HIV/AIDS.

Gibbie et al. (2007) investigated the prevalence of depression in HIV-positive individuals and its association with adherence to highly active antiretroviral therapy (HAART). Fourteen percent of the HIV-seropositive group met the criteria for current mood disorder compared with 5% of controls. Similarly, 39% of the HIV-seropositive participants met the criteria for a past major depressive episode compared with 15% of controls. Non-adherence to HAART was reported by 30.5% of those prescribed HAART and was significantly associated with living alone and relationship status. The present study found compromised psychological health in people living with HIV infection. Kelly et al. (2010) investigated the relationships between positive religious coping (e.g., seeking spiritual support) and spiritual struggle (e.g., anger at God) versus viral load, CD4 count, quality of life, HIV symptoms, depression, self-esteem, social support, and spiritual well-being in 429 patients with HIV/AIDS. At baseline, positive religious coping was associated with positive outcomes while spiritual struggle was associated with negative outcomes. In addition, high levels of positive religious coping and low levels of spiritual struggle were associated with small but significant improvements over time. Judith et al. (2011) investigated the five-factor model of personality to examine personality traits in four samples of patients with chronic disorders. Patients with hyperlipidemia and those who had cardiothoracic transplants had similar patterns. Nurses and researchers need to consider personality traits that drive patterns of behavior in designing more effective ways to promote better health and manage disease. Another study conducted by Robert et al. (2007) had shown that HIV/AIDS stigmatization was related personality traits, chiefly low Openness to Experience, a variable associated with other forms of prejudice, and low Agreeableness, suggesting a lack of altruism and sympathy. HIV stigmatization is especially likely to be a problem with people, and in cultures, low in Openness to Experience.