Around 3 billion people are suffering for being diagnosed as HIV positive in this world. Since 1981, 2 billion people have died because of this disease. It is not necessary that it will affect any particular section of population, but there no treatment of this disease. One should know the outcome of the disease and attempt to prevent it.

HIV stands for Human Immunodeficiency Virus. As the name suggests it is a virus and is mainly sexually transmitted, like some other sexually transmitted disease, it can also be transmitted through blood and during pregnancy. Like herpes, it is a virus, like syphilis, it affects the whole body and can take few or many years before it causes serious damage, and can be fatal. In spite of the attention it is getting from medical researchers, still there are many unanswered questions. Much remains to be thought about and discussed before it can be acted upon effectively.

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 that 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 that 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.

AIDS is the most severe acceleration of infection with HIV. HIV is retroviruses that primarily infect vital organs of the human immune system such as CD4+T cell,
macrophages and dendrite cells. It directly and indirectly destroys CD4+T cells. Once HIV has killed so many CD4+T cells that there are fewer than 200 of these cells per micro liter (µl) of blood, cellular immunity is lost. Acute HIV infection progresses over time to clinical latent HIV infection and then to early symptomatic HIV infection and later to AIDS, which is identified either on the basis of the amount of CD4+T cells remaining in the blood and/or the presence of certain infection. In the absence of antiretroviral therapy, the median time of progression from HIV infection to AIDS is only 9-12 month. However, the rate of clinical disease progression varies widely between individual from two weeks up to 20 years.

In absence of antiretroviral therapy, the median time progression from HIV infection to AIDS is nine to ten years, and median survival time after developing AIDS is only 9.2 month (Morgan et al., 2002). However the rate of clinical disease progression varies widely between individuals, from two weeks up to 20 years. Many factors affect the rate of progression. These include factors that influence the body’s ability to defend against HIV such as the infected person’s general immune function. Older people have weaker immune system and therefore have a greater risk of rapid disease progression than younger people. Poor access to health care and the existence of coexisting infections such as tuberculosis may also predispose people to faster disease progression (Gendelman, 1986). The infected person’s genetic inheritance also plays a role and some people are resistant to certain strains of HIV (Tang & Caslow, 2003). An example of this is people with CCRS-32 mutations are resistant to infection with certain strains of HIV. HIV is genetically influenced which cause different rates of clinical disease progression. The use of highly active antiretroviral therapy prolongs both median time of progression to AIDS and the median survival time.

HIV/AIDS no longer occupies the public consciousness in the United States the way it did in the mid-1980s, but it continues to threaten public health in historical proportion. In the United States, 733,374 cases of AIDS have been reported to the Centers for Disease Control and prevention (CDC) by the end of 1999. The majority (82%) of the cases have been among men. Nearly one half (47%) of AIDS cases have been among men who have sex with men (MSM), 25% in infection drug users, 10% in persons infected heterosexual and 2% in persons infected through blood or blood by
products. In the United States, AIDS has been identified as leading cause of death among young adults (men women aged 25 to 44 years.) This age group accounts for about 70% of all deaths from HIV infections. During 1994 and 1995, HIV was the leading cause of death among persons who are 25 to 44 years old. During 1995, HIV caused almost 31,000 deaths, 19% of the total in these age groups. Subsequent improvements in the treatment of AIDS have extended life such that by 1998, AIDS has become the fifth leading cause of death among adults causing about 85,00 deaths, or 7% of the total.

**SYMPTOMS OF HIV/AIDS**

The symptoms of AIDS are primarily the result of conditions that do not normally develop in individuals with healthy immune systems. Most of these conditions are infection caused by bacteria, viruses, fungi and parasites that are normally controlled by the elements of the immune system that HIV damages. Opportunistic infections are common in people with AIDS (Holmes et al., 2003). HIV affects nearly every organ system. People with AIDS also have an increased risk of developing various cancers such as Kaposi’s sarcoma, cervical cancer and cancers of the immune system known as lymphomas. People with AIDS often have systemic symptoms of infection like fevers, sweats (particularly at night), swollen gland, chills, weakness and weight loss. (Guss, 1994) Additionally, HIV/AIDS is also found to be a cause of pulmonary infection (Feldman, 2005), gastrointestinal infections (Zaida and Cervia, 2002), neurological disease, (Luft & Chua, 2000; Sadler & Nelson, 1997), tumors and malignancies and other infections (Skoulidis et al., 2004) also. The specific opportunistic infections that AIDS patients develop depend in part on the prevalence of these infections in the geographic area in which the patient lives.

**HOW ARE HIV/AIDS TRANSMITTED**

HIV is transmitted when a person had contact with certain body fluids of another person who is HIV-positive.
Body fluids that can contain and transmit HIV include:

- Blood
- Wound discharge or pus
- Semen
- Vaginal
- Breast milk

Body fluids that can contain and transmit HIV which medical staff may contact include:

- Fluid surrounding the brain and spinal cord
- Fluid surrounding bone joints
- Fluid surrounding an unborn baby.

**HIV/AIDS are primarily transmitted in the following ways**

- Sexual transmission
- Blood transfusions
- Sharing needles or using syringes and razor blades
- Mother to child transmission

**False Transmitters**

HIV is not acquired through the following:

- Living in the same place with people who have HIV/AIDS
- Kissing (unless there are open sores on exposure to blood within the month)
- Touch (hugging, hand-shaking or sports contact)
- Bites from mosquitoes or other insects
- Shared food, utensils, cups or dishes
- Shared swimming pools or pools or bathing facilities
- Sneezes or coughs
• Hospital visits
• Sweat, saliva or tears
• Urine and faeces

**TREATMENT**

There is currently no vaccine or cure for HIV or AIDS. The only known methods of prevention are based on avoiding exposure to the virus or, failing that, an antiretroviral treatment directly after a highly significant exposure, called post-exposure prophylaxis (PEP) (Hamlyan et al., 2007). PEP has a very demanding four week schedule of dosage. It also has very unpleasant side effects including diarrhea, malaise, nausea and fatigue.

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. Typical regimens consist of two nucleoside analogue reverse transcriptase inhibitors (NARTIS or NRTIS) plus either a protease inhibitor or a non-nucleoside reverse transcriptase inhibitor (NNRTI). Because HIV disease progression in children is more rapid than in adults, and laboratory parameters are less predictive of risk for disease progression, particularly for young infants, Treatment recommendation are more aggressive for children than adults (Department of Health and Human services, 2006). In developed countries where HAART is available, doctors assess the viral load rapidity in CD4 decline and patient readiness while deciding when to recommend initiating treatment. Standard goals of HAART include improvement in the patient’s quality of life, reduction in complications, and reduction of HIV viremia below the limit of detection, but it does not cure the patients of HIV nor does it prevent the return, once treatment is stopped, of high blood levels of HIV, often HAART resistant (Dybal et al., 2002). Moreover, it would take more the life time of an individual to be cleared of HIV infection using HAART (Blankso et al., 2002). Despite this, many HIV-infected individuals have
experienced remarkable improvements in their general health and quality of life which has led to the plummeting of HIV-associated morbidity and mortality. In the absence of HAART, progression from HIV infection to AIDS occurs at a median of between nine to ten years and the median survival time after developing AIDS in only 9.2 months. HAART is thought to increase survival time by between 4 and 12 years.

Non-adherence with therapy is the major reasons why some people do not benefit from HAART, (Becker et al., 2002), the reasons for which are varied. Major issues include poor access to medical care, inadequate social support, psychiatric disease and drug abuse. HAART regimes can also be complex and thus hard to follow, with large number of pills taken frequently. Side effects can also deter people from persisting with HAART; these include lipodystrophy dyslipidaemia, diarrhea, insulin resistance, an increase in cardiovascular risks and birth defects (Saithoh et al., 2005). Antiretroviral drug are expensive, and the majority of the world’s infected individuals do not have access to medications and treatment for HIV and AIDS.

Morbidity and mortality among HIV-infected adults with adequate dietary nutritional intake is unaffected by multivitamin supplementation. A large Tanzanian trial in immunologically and nutritionally-compromised pregnant and lactating women showed a number of benefits to daily multivitamin supplementation for both mothers and children. (Islam et al., 2005) Dietary intake of micronutrients levels by HIV-infected adults is recommended by the World Health Organization (World Health Organization, 2003-05). There is some evidence that vitamin a supplementation in children reduces mortality and improves growth. Daily doses of selenium can suppress HIV viral burden with an associated improvement of the CD4 count. Selenium can be used as an adjunct therapy to standard antiviral treatment, but cannot itself reduce mortality and morbidity.

Various forms of alternatives medicine have been used to treat symptoms or alter the course of the disease. Current studies indicate that alternative medicine therapies have little effect on the mortality or morbidity of the disease, but may improve the quality of life of individuals with AIDS. The psychological benefits of these therapies are the most important ones. Acupuncture has been used to alleviate some
systems with no success and cannot cure the HIV infection. Several randomized clinical trial testing the effect of herbal medicine have shown that there is no evidence that these herbs have any effect on the progression of the disease, but may instead produce serious side effects.

**HIV/AIDS AND DEPRESSION**

HIV/AIDS carries a negative connotation not only in developing countries but also in developed countries. HIV/AIDS can affect men or women or even to new born child. Those who have been affected by HIV/AIDS underwent higher level of depression because of the physical as well as social cultural condition related to the disease. It has been found that majority of the HIV/AIDS patients are having major depression disorder (Jin et al., 2006). Recent studies (Baldcwich et al., 2002; Cruess et al., 2000; Cohen et al., 2002; Murphy et al., 2001; Pendo et al., 2003) reported that higher level of distress was experienced by patients infected by HIV. The psychological distress experienced by these patients leads to poorer quality of life among these patients. Several studies (Eller et al., 2001; Geurtsen et al., 2005). Jacobson et al., 2002; Most et al., 2004; Rotherman et al., 2001 and Weaver et al., 2004 pointed out that overall the patients of HIV/AIDS experience poor quality of life. The poor quality of life is because of many factor like stigma, deterioration of work function, adverse effects of treatment, poorer coping strategies etc.

Depressive symptoms are common in HIV-infection, but investigations on the causes of depression provide conflicting results. Social, psychological and biological factors have all been suggested as possible causes of depression in people living with HIV/AIDS. Symptoms of major depression include (1) depressed mood most of the day almost every day, (2) decreased interest and pleasure in nearly all activities, (3) changes in appetite or weight without dieting, (4) disruptions in sleep patterns nearly every day, (5) psychomotor retardation or agitation, (6) feelings of worthlessness or inappropriate guilt, (7) diminished ability to concentrate and (8) recurrent thoughts of death or suicide. Moreover, these symptoms in HIV/AIDS patients result in significant disturbances in social and occupational functioning leading to other problems.
Introduction

The psychological problem faced by patients suffering from HIV/AIDS is posing a challenge to psychologist and social health workers. 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.

Although a number of studies have shown a relationship between certain kinds of coping and outcomes such as depression, anxiety, and other psychological symptoms, the nature of the relationship is far from clear. McCrae and Costa (1986) provide interesting discussion of this question that includes the role of personality variables. They found that the relationship between coping and distress disappeared when they controlled for the personality variables of neuroticism, extraversion, and openness. Folkman et al. (1986) found, however, that coping continued to contribute significantly to distress after controlling for a different set of personality variables (mastery and interpersonal trust). Possibly, the personality variables used by McCrae and Costa accent for all of the variance in outcome measures because these variables were heavily confounded with the outcome variables. It is important that the choice of personality variables be considered carefully before investigating their role in depression the issue.

Another issue raised by McCrae (1986) concerns the causal relationship between coping and outcomes. A number of investigations have found that coping did not account for changes in measures of well-being over time (Felton & Revenson, 1984; Pearlin, Lieberman, & Mullan, 1981; Billings & Moos, 1984). Part of the problem may lie in the choice of outcomes. Are outcomes such as subjective well-being and psychosocial adjustment the most appropriate adaptation outcomes to consider?

Another part of the problem has to do with the stability of the outcome. Some outcomes, such as general health status are highly stable over month and even years, while others, such as morale or symptoms of illness, are more variable. To show a causal relationship, an outcome must be selected that is expected to change during the period of the study (Kasl, 1983).
As for as the relationship between ways of coping and depression is concerned Vitaliano et al. (1985) found that depression was positively associated with wishful thinking and negatively associated with problem-focused coping. Later on Vitaliano (1987) found that anxiety and depression were correlated negatively with problem focused coping and positively wishful thinking. Coyne et al. (1981) and Folkman & Lazarus (1986) also reported that those high in depression symptoms used more confrontive coping, self-control, and escape-avoidance and accepted more responsibility than did those subjects low in depressive symptoms.

On the other hand Folkman, Schaefer & Lazarus (1979) gave another explanation for coping and depression. According to them coping should fit the situation, such that problem-focused coping should be more appropriate in situations that are amenable to change than in situations that are not. Conversely, emotion-focused forms of coping, such a distancing and positive reappraisal, should be more appropriate in situations where nothing can be done than in situations that are changeable. Support for this principle comes from a study by Collins, Baum, and Singer (1983), who evaluated the relationship of coping and various outcomes among residents at Three Mile Island (TMI), both at the time of the accident and again two years later. Using for their assessments the Ways of Coping Checklist and psychological, behavioral, and biochemical aspects of stress, they found that the effects of coping were most evident on measures of symptom distress and task performance and had considerably less impact on catecholamine levels. The problems at TMI were chronic and not amenable to change. Residents of the TMI are who used greater amounts of problem-oriented strategies also reported more symptoms and greater emotional disturbance that did residents reporting lesser use of these option. Conversely, greater uses of emotion-focused coping among TMI residents were associated with less symptom reporting and emotional disturbance. Within the emotion-focused category, residents reporting greater use of reappraisal and emotion management showed less evidence of stress than those reporting evidence of stress than those reporting greater use of denial.
The sample of present study being HIV/AIDS patients, outcome of which is, as of now unchangeable, the evidence of the use of coping seems contradictory. But our focus is not on their treatment but on their depression, which is changeable, the hypothesis will be formulated accordingly.

Different ways of coping to be used by any person have traditionally been classified under various categories: Problem Focused and Emotion Focused being the most popular ones (Folkman & Lazarus, 1980). Problems -focused coping refers to efforts undertaken to manage or after the troubled person-environment relationship that is the source of stress, while emotion-focused coping refers to efforts undertaken to regulate stressful emotion. These functions of coping are also recognized, implicitly or explicitly, by George (1974), Kann et al. (1964), Lazarus (1966, 1968), Lazarus, Averill, and Opten (1979), Mechanic, (1962), Murphy (1974), Pearlin and Schooler (1978), and White (1974).

Although this classification is used extensively, it failed to reflect the richness and complexity of human coping processes. Certain strategies were found to serve both problem-focused and emotion-focused functions. For example, seeking advice serves a problem-focused if it provides concrete information to help solve a problem. However, it also serves an emotion-focused function if the process of seeking advice help the individual to feel emotionally supported. For these reasons we will not be classifying the ways of coping into these categories.

In addition to personality and ways of coping we can not ignore the role of social support in understanding depression among HIV/AIDS patients which has been highlighted by a number of studies (Nukes, 2003; Elliott et al., 2002; Ncama, 2010). Negative social support was significantly associated with higher depression while positive social support is found to be leading to low depression

The present study is designed to examine the role of coping strategies, social support and personality in depression among HIV/AIDS patients. The impetus to this study was given by link between depression and HIV/AIDS patients the present study was planned as there is dearth of research studies, especially in Indian context which is
having one of the highest HIV/AIDS patients, attempting to study the combined and interactive effect of ways of coping, personality and social support among high and low depression groups of HIV/AIDS patients. So the present study is an attempt in this direction. The problem for the present study may be stated as “Investigation Into the Role of Personal Characteristics and Social Support Systems in Depression Among HIV/AIDS Patients”.

OBJECTIVES

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.

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

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

(c) HIV/AIDS patients with high and low depression will not be different on agreeableness and conscientiousness.

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