Chapter – II
Conceptual Framework
2.1 HIV/ AIDS:

HIV/AIDS is one of the main health and social challenge in the contemporary world. India is experiencing rapid and extensive spread of HIV infection. Indian stands among the countries which have highest number of persons living with HIV/AIDS today.

HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. CDC estimates that about 56,000 people in the United States contracted HIV in 2006.

HIV is an acronym for the term “Human Immunodeficiency Virus” and can be explained as a virus, which enters into the cells of the body and weakens the body’s ability to fight other disease and infection (Muarry, 1999). It is further described by the centre of disease Control and Prevention as the Virus which causes, or results in the onset of AIDS (CDC, 2001).

Muarry (1999) describes AIDS as the disease a person with HIV gets. AIDS is an acronym for “Acquired Immune Deficiency Syndrome” (Mbuya, 2000). Acquired means that it is not genetically inherited but it is a result of an environmental factor. Immune Deficiency describes the resulting weakening of the infected person’s immune system, and Syndrome refers to the characteristic of this disease in that it does not present with one specific disease but rather a collection of symptoms.
There are two types of HIV, HIV-1 and HIV-2. In the United States, unless otherwise noted, the term “HIV” primarily refers to HIV-1. Both types of HIV damage a person’s body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases.

Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years. However, even if they feel healthy, HIV is still affecting their bodies. All people with HIV should be seen on a regular basis by a health care provider experienced with treating HIV infection. Many people with HIV, including those who feel healthy, can benefit greatly from current medications used to treat HIV infection. These medications can limit or slow down the destruction of the immune system, improve the health of
people living with HIV, and may reduce their ability to transmit HIV. Untreated early HIV infection is also associated with many diseases including cardiovascular disease, kidney disease, liver disease, and cancer. Support services are also available to many people with HIV. These services can help people cope with their diagnosis, reduce risk behavior, and find needed services.

AIDS is the late stage of HIV infection, when a person’s immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS. This is because of “highly active” combinations of medications that were introduced in the mid 1990s.

No one should become complacent about HIV and AIDS. While current medications can dramatically improve the health of people living with HIV and slow progression from HIV infection to AIDS, existing treatments need to be taken daily for the rest of a person’s life, need to be carefully monitored, and come with costs and potential side effects. At this time, there is no cure for HIV infection. Despite major advances in diagnosing and treating HIV infection, in 2007, 35,962 cases of AIDS were diagnosed and 14,110 deaths among people living with HIV were reported in the United States.
2.1.1 Brief History of HIV/AIDS:

In 1986, the first known case of HIV was diagnosed by Dr. Suniti Solmon amongst female sex workers in Chennai. Later the year, sex workers began showing signs of this deadly disease. At that time, foreigners in India were traveling in and out of the country. It is thought that these foreigners were the ones responsible for the first infections. By 1887, about 135 more cases came to light. Among these 14 had already progressed to AIDS. Prevalence in high risk groups reached above 5% by 1990. As per UNDP’s 2010 report, India had 2.39 million (23.95 lakh) people living with HIV at the end of 2009, up from 2.27 million (22.7 lakh) in 2008. Adult prevalence also rose from 0.29% in 2008 to 0.31% in 2009.

In 1986, HIV started its epidemic in India, attacking sex workers in Chennai, Tamil Nadu. Setting up HIV screening centers was the first step taken by the government to screen its citizens and the blood bank.

To control the spread of the virus, the Indian government set up the National AIDS Control Programme in 1987 to co-ordinate national responses such as blood screening and health education.

In 1992, the government set up the National AIDS Control Organization (NACO) to oversee policies and prevention and control programmes relating to HIV and AIDS and the National AIDS Control Programme (NACP) for HIV prevention. The State AIDS Control Societies (SACS) was set up in 25 societies and 7 union territories to improving blood safety.
In 1999, the second phase of the National AIDS Control Programme (NACP II) was introduced to decrease the reach of HIV by promoting behaviour change. The prevention of mother-to-child transmission programme (PMTCT) and the provision of antiretroviral treatment were materialized.

In 2007, the third phase of the National AIDS Control Programme (NACP III) targeted the high-risk groups, conducted outreach programmes, amongst others. It also decentralized the effort to local levels and non-governmental organizations (NGOs) to provide welfare services to the affected.

2.1.2 Modes of Transmission:

The HIV is transmitted through infected blood and body fluids. Sexual transmission is the most common route of transmission.

1. Sexual transmission (Unsafe sexual practices)
   - Heterosexual
   - Homosexual

2. Blood contact (Contaminated Blood)
   - Blood transfusion
   - Intravenous drug use
   - Occupation exposure (needle stick)

3. Mother to child transmission (Infected mother to new born)
   - In-Uterus
   - During delivery
   - Breast feeding
2.1.3 The key risk groups are

- High Risk Groups (HRG)
  - Female Sex Workers (FSW)
  - Men who have Sex with Men (MSM)
  - Transgender (TG)
  - Injecting Drug Users (IDU)

- Bridge Populations
  - Truckers
  - Migrants

Routes of Transmission of HIV, India, 2011-12

Estimated Annual New HIV Infections:

New HIV infections have declined by more than 50% over the past decade from 2.7 lakh in 2000 to 1.2 lakh in 2009. Of these, six high prevalence states account for only 39%, while the states of Orissa, Bihar, West Bengal,
Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat together account for 41% of new infections.

**Stages of Disease:**

AIDS is a disease which is caused in slow and gradual process. Theoretically, four stages have been identified in the development of HIV/AIDS infection.

1. **Initial HIV Infection:** In this stage, with the entering of HIV virus in the body, some people come to experience temporary seroconversion disease within few weeks which resembles influenza with symptoms like fever, body ache and headache. The immune system in the body produces antibodies which does not destroy the HIV virus. After this, no characteristic develops for months and years together, but during this period a person can spread the HIV infection to others through sex, shared needles, blood transfusion, etc.

2. **Persistently Enlarged Glands:** In the next stage of HIV infection, a person develops enlarged but painless glands in the neck and armpits which are free of any symptoms. They continue to persist for months and years without producing any apparent ill-health. The early symptoms of AIDS are fatigue, weight-loss, chronic diarrhea, prolonged fever, cough, night sweats and lymph gland enlargement. These characteristics are considered as first symptoms of AIDS in the developed countries but in the developing countries, since the
symptoms cannot be differentiated from the ordinary infections, people do not think of going for early treatment.

3. **Complexity**: In this stage, the virus damages the immune system which produces symptoms like attacks of diarrhea, sweating, loss of weight and extreme weakness.

4. **Full-blown AIDS**: This stage is reached after an average of nine to ten years from the time of HIV infection. The immune system is totally destroyed and many infections and cancers are produced. The HIV positive become very weak and always feels tired. A man does not survive for more than three to four years after this stage.

**Implication of the Disease**

AIDS is not just a health problem; rather, it is a societal problem with important social, cultural and economic dimensions. It threatens the basic social institutions an individual, family and community levels. Its economic consequences are equally serious as it could claim up to half of national expenditure for health if the needs of AIDS patients were to fully meet. AIDS selectively yet definitively, attacks people in their economic and socially most productive years and those responsible for the support and case of others. Consequently, when the earners are dead, they leave behind families without any source of livelihood. Thus, not only the HIV infected people initially face emotional trauma and later on social isolation and in the last one or two years suffer from serious body problems but economically too they are shattered. The victims are sacked from their job, disowned by
their families and communities, rejected by their friends, refused treatment by doctors, turned down by schools, colleges and universities, and even imprisoned and humiliated, their families to suffer economically, psychologically and socially. After the bereavement of the young and married victims, their wives suffer from the problems of widowhood and their children from the problems of orphanhood.

**Window Period:**

The time that elapses between entry of HIV into the body and the detection of HIV specific antibodies called window period usually the window period is 3 months. During this period, the person is highly infectious but may not test positive on common HIV antibody tests. Upto 30% - 50% of people have a recognizable acute illness at the time of infection characterized by fever, night sweats, skin rash, headache and cough.

**CD4 Cells:** The cluster of differentiation (CD) is a protocol used for the identification and investigation of cell surface molecules present on leukocytes. CD molecules can act in numerous ways, often acting as receptors (the molecule that activates a receptor) important to the cell. A signal cascade is usually initiated, altering the behavior of the cell. Some CD proteins do not play a role in cell signaling, but have other functions, such as cell adhesion. There are approximately 250 different proteins.
The CD nomenclature was proposed and established in the 1st International Workshop and Conference on Human Leukocyte Differentiation Antigens (HLDA). This system was intended for the classification of the many monoclonal antibodies (m. Abs) generated by different laboratories around the world against epitomes on the surface molecules of leukocytes (white blood cells). Since then, its use has expanded to many other cell types, and more than 320 CD unique clusters and subclusters have been identified. The proposed surface molecule is assigned a CD number once two specific monoclonal antibodies (m. Abs) are shown to bind to the molecule. If the molecule has not been well-characterized, or that only one m. Ab, it is usually given the provisional indicator “W” (as in “CD W 186”).

**CD4 Cells Functioning:** Knowing how many functioning CD4 cells are circulating in the blood gives the HIV doctor an idea of how strong the HIV positive person immune system really is. A simple blood test called the CD4 count measure the number of functioning CD4 cells in the body and therefore measures the health of the immune system. The CD4 blood test results can vary a great deal.

**Normal values:** In a healthy adult, a normal CD4 count can vary a great deal but is typically 600 to 1200 cells per cubic millimeter of blood.

**Between 600 to 350:** In HIV positive persons this range is considered “Very good”.
HIV Medications are typically not being indicated:

**Between 350 and 200:** The immune system is weakened and therefore the HIV positive person may be at increased risk for infection and illness.

**Less than 200 CD4 count:** The immune system is severely weakened and the HIV positive person is at a much greater risk of opportunistic infections.

HIV medications and prophylactic antibiotics will be prescribed to help prevent illness and infections.

**2.1.4 AIDS Works in the Body:**

Before highly active antiretroviral therapy (HAART) became available, most people who contracted HIV eventually progressed to AIDS and had some AIDS related complication, such as:

- A deterioration of immune system function and an increased risk of infections and cancers.
- Brain damage that may cause dementia or memory loss
- Heart problems that can cause heart failure and symptoms such as shortness of breath, fatigue, and welling of the abdomen and legs
- Severe kidney damage requiring dialysis
- Metabolic changes that may cause significant weight loss or diarrhea.
Due to these potential problems, a person with AIDS is at very high risk of becoming very ill, and if some action is not taken to protect the person from these infections or reverse the damage done by HIV, he or she is at risk of dying. The of progression to AIDS the damage caused by HIV occurs more quickly in some people than in others, but generally an untreated HIV infected person can expect that they will progress to AIDS within 10 years of their infection. During the time the person is infected HIV, a war rages between the person’s immune system and HIV, with slowly wearing immune system out.

2.1.5 Laboratory Diagnosis of HIV Infection:

The diagnosis of HIV infection is based on the detection of HIV antibodies in the blood of infected persons.

Types of HIV Antibody Assays:

A variety of HIV antibody assays using different methodologies are available. These assays can be broadly classified into three groups:

1. Enzyme-linked immunosorbent assay (ELISA)
2. Western blot assay; and
3. Rapid tests.

Most current HIV antibody tests are capable of detecting antibodies to both HIV-1 and HIV-2.
ELISA:

HIV antibodies in the test serum are detected using an antibody sandwich capture technique. Essentially, HIV antibodies, if present in the serum, are ‘sandwiched’ between HIV antigens. This is fixed to the test well, and to ‘enzyme-conjugated antibodies’ that are added to the test well following addition of the test serum. The test well is washed thoroughly to remove any unbound enzyme. A colour reagent is then added to the well. Any bound enzyme will catalyze a change in colour in this reagent. The presence of HIV antibodies is thus inferred from the change in colour.

WESTERN BLOT TEST:

HIV antibodies in the test serum are detected by their reacting to a variety of viral proteins. The viral proteins are initially separated into bands according to their molecular weight on an electrophoresis gel. These proteins are then transferred or ‘blotted’ on to a nitrocellulose paper. The paper is then incubated with the patient’s serum. HIV antibodies to specific HIV proteins bind to the nitrocellulose paper at precisely the point to which the target protein migrated. Bound antibodies are detected by colorimetric techniques.

RAPID TEST:

A variety of rapid tests are available which employ a variety of techniques including particle agglutination; lateral flow membrane; through flow membrane, and comb or dipstick-based assay systems.
Rapid tests are most appropriate for smaller health institutions where only a few samples are processed each day. Rapid tests are quicker and do not require specialized equipment. Most rapid tests are dot-blot immunoassays or agglutination assays requiring no instrumentation or specialized training and take 10-20 minutes to perform. Most have sensitivities and specificities of over 99% and 98%, respectively. Only ‘WHO-recommended’ tests should be used to ensure a high level of sensitivity and specificity.

The major advantage of the rapid HIV test is that it allows results to be given on the same day as testing thus reducing the number of visits made by the client. There is also an increased likelihood of clients receiving tests results as opposed to the numbers who may not return when same day testing regimes are not used.

**HIV Treatment:**

In the time between initial infection and AIDS, the infected person may feel relatively normal, despite the constant attack by HIV. People living with HIV have to understand, however, that despite feeling well on the outside, significant damage can be occurring on the inside. Fortunately, over the past five years, significant progress has been made regarding the treatment of HIV and prevention of some of the infections and cancers that may be caused by it. Antiretroviral medications can directly attack HIV and stop it from reproducing and causing further damage. For most people, the biggest factor in preventing progression to AIDS is adherence to HAART,
which can suppress HIV replication to very low levels and not allow it to continue to attack the body.

Prophylactic medications in addition to HAART, other steps can be taken to prevent illness in people living with HIV and AIDS. Certain antibiotics, called prophylactic medications, can effectively prevent opportunistic infections. A physician can help to assess the appropriateness of these medications in particular treatment program, and which ones to use, but it is important that they be taken as prescribed so that infections and certain cancers can be detected in their early stages before they have spread, and the antibiotics can work more effectively to ward off further serious complications. I recommend that every person living with HIV or AIDS see a physician for appropriate monitoring and treatment.

2.1.6 HIV and AIDS Statistics – Worldwide:

HIV/AIDS remains one of the world's most significant public health challenges, particularly in low- and middle-income countries. As a result of recent advances in access to antiretroviral therapy (ART), HIV-positive people now live longer and healthier lives. In addition, it has been confirmed that ART prevents onward transmission of HIV.

In 2011, there were 34 million people living with HIV. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral (anti-HIV) therapy, which has helped reduce AIDS-related deaths, especially in more recent years.
Worldwide, 2.5 million people became newly infected with HIV in 2011. There were 2.7 million [2.4 million–2.9 million] new HIV infections in 2010. 25 countries have seen a 50% or greater drop in new HIV infections since 2001. In 2011, new infections in children were 43% lower than in 2003, and 24% lower than 2009.

At the end of 2012, close to 10 million people were receiving ART in low- and middle-income countries. However, over 16 million other people who are eligible for ART under new 2013 guidelines do not have access to antiretroviral drugs. There were also 2.1 million adolescents living with HIV in 2012. But progress has been made. In 2011, 56% of pregnant women living with HIV received the most effective drug regimens (as recommended by WHO) to prevent mother-to-child transmission of the virus.

WHO has released a set of normative guidelines and provides support to countries in formulating and implementing policies and programmes to improve and scale up HIV prevention, treatment, care and support services for all people in need.

**Misconceptions about HIV Contraction:**

People are often concerned that HIV can be contracted through common contacts with an HIV infected person, such as shaking hands or sharing glasses or eating utensils. Sharing the dresses, using the same toilet. These are not risk factors for contracting HIV. There is no evidence that HIV can be spread through these means, and people should not be afraid to be
around people who have HIV or to use a glass, eating utensils, or plate that an HIV infected persons has used, or to have other common contacts.

2.1.7 Tuberculosis (TB):

TB is an infectious disease caused by *Mycobacterium tuberculosis* (M. tuberculosis) bacilli. TB bacilli mainly affect the lungs, causing lung tuberculosis (pulmonary TB). However, in some cases, other parts of the body may also be affected, leading to extra-pulmonary tuberculosis. Extra pulmonary TB is more common in HIV infected TB patients compared to in HIV negative TB patients.

TB germs usually spread through the air. When a patient with untreated pulmonary TB coughs, sneezes or talks, they involuntarily throw TB germs into the air in the form of tiny droplets. These tiny droplets, when inhaled by another person, may cause TB. Untreated TB cases spread the infection to others in the community; each infectious patient can infect 10-15 individuals in a year unless they are effectively treated.

2.1.8 TB Infection versus TB Disease:

- **TB infection**: Organism is present but dormant, cannot infect others, person is not sick.

- **TB disease**: Person is sick and can transmit disease to others if in lungs.

- 10% of individuals with TB infection will develop TB disease

- Each individual with active but untreated TB can infect 10-15 people /year.
When does TB Infection Become a Disease?

- Most likely to occur in first two years after infection
- If person become immune compromised
- HIV
- Cancer
- Chemotherapy
- Poorly controlled diabetes
- Malnutrition.

Symptoms of TB

Pulmonary TB

HIV –infected patients with TB can have:

- Cough with expectoration of more than two week’s duration,
- Fever
- Night sweats
- Weight loss
- Loss of appetite
- Chest pain
- Haemoptysis
- Anemia

Extra-Pulmonary TB:

A person with extra pulmonary TB may have the following general symptoms:
• Weight loss
• Loss of appetite
• Fever
• Night sweats.

Sites and Symptoms of Active Extra Pulmonary TB Disease:

Other symptoms depend on the organ involved:

• **Lymph node TB:** Swelling in the neck or armpit or without discharge

• **TB meningitis:** Headache, fever, drowsiness, confusion, neck rigidity

• **Spinal TB:** Back pain, fever and in some cases, swelling of the backbone

• **Pericardial TB:** Chest pain, Shortness of breath.

How Tuberculosis Spreads:

TB can spread when a patient sneezes or coughs. People in close contact with the patient can become infected when they breathe in these germs (tubercle bacilli). Stress the importance of taking all family members exposed to the disease (contacts) and who have symptoms of TB to the closest health facility for screening of TB. Prevention of TB from spreading (for example, by covering the mouth when coughing and sneezing and avoiding spitting in public).
2.1.9 TB and HIV:

- HIV infection fuels the TB epidemic in several ways. HIV infection promotes progression to active TB in people with recently acquired as well as latent TB. HIV infection is the most powerful known risk factor for reactivation of latent TB infection to active disease manifestation.

- The annual risk of developing TB in person living with HIV/AIDS (PLHA) who is co-infected with Mycobacterium tuberculosis ranges from 5% to 15%. Up to 60% of PLHA develop active TB during their lifetime compared to about 10% of HIV negative individuals.

- HIV infection increases the rate of recurrent TB, which may be due to either endogenous reactivation (true relapse) or exogenous re-infection.

2.1.10 Impact of HIV on TB:

HIV is the most powerful risk factor for progression from TB infection to TB disease.

An HIV positive person infected with M. tuberculosis has a 50% - 60% lifetime risk of developing TB whereas an HIV negative person infected with M. tuberculosis has only a 10% risk of developing TB. This especially important in India where it is estimated that almost half of the adult population harbors M. tuberculosis. In some countries, the HIV epidemic has tripled the number of TB cases.
- HIV infected persons who becomes newly infected by *M. tuberculosis* rapidly progress to active TB disease.

- HIV has the potential to worsen the TB epidemic. HIV breaks down the immune system and makes patients highly susceptible to TB; these patients can then spread TB other people.

- TB is the most common serious opportunistic infection occurring among HIV positive persons and is the first manifestation of AIDS more than 50% of cases in developing countries.

### 2.1.11 Impact of TB on HIV:

The impact of TB on HIV can be summarized as follows:

- TB shortens the survival of patients with HIV infections.

- TB may accelerate the progression of HIV, as observed by a 6-7 fold increase in HIV viral load in TB patients.

- Worldwide, TB is the cause of death for one of every three persons with AIDS.

Clinical outcomes, however, did differ significantly for HIV-infected TB cases. From 2000 to 2005, 18% of all HIV-infected TB cases died during the course of treatment, compared to 3% of all HIV-negative TB cases. Dr. Munsiff noted, “If they have not died before their TB treatment is over, most remain in care and finish treatment. Overall default rates are very low. And whether the cause of death is from TB is very hard to tease out.”
However, of all culture-positive HIV-infected TB cases who died before completing treatment, approximately 50% were still culture positive within thirty days of death. TB likely contributed to death in most of these cases.

**ART for HIV – Infected TB Patients:**

The National Guidelines for ART for HIV TB co-infection followed the 2006 World Health Organization Guidelines for ART. As per these guidelines, all HIV infected persons with pulmonary TB, extra pulmonary or disseminated TB with a CD4-lymphocyte count $\leq 350/\text{mm}^3$ were considered eligible for ART. The most common ART regimen initiated was Zidovudine or Stavudine plus, Lamivudine plus, and Efavirenz.

**2.2 SOCIAL SUPPORT:**

**2.2.1 Meaning and Definitions:**

Social support is concept that is generally understood in an intuitive sense, as the help from other people in a difficult life situation. One of the first definitions was put forward by (Cobb, 1976). He defined social support as ‘the individual belief that one is cared for and loved, esteemed, valued, and belongings to a network of communication and mutual obligations’. In the Mindful Project social support is defined as ‘the perceived availability of people whom the individual trusts and who make one feel cared for and valued as a person’ (Mindful, 2008).

Social support is the actual or perceived availability of resources in one’s social environment that can be used for comfort or aid, particularly in
times of distress. Social support is provided by one’s social network, which is all of the people with whom one has some form of regular social contact. Most social networks include family, friends, and co-workers. Not all social networks are supportive tend to bolster the health and well-being of the recipients of the support. Social support appears to enhance individuals’ physical and psychological health directly by reducing the negative effects of stressors on health.

There are several definitions on social support states social support as the comfort assistance and information one receives through formal or informal contacts with individuals or groups (Wallstan et al., 1983).

Another definition social support simply means as “resources provided by other people” (Cobb and Syme, 1985). Social support has been generally characterized as the degree of support provided to individuals, particularly in terms of need by persons involved with spouse, family members, neighbors, co-workers and members of large community (Johnson and Sarason, 1979b; Lin et al., 1979). Gottileb (1988) referred to the substance of social support as “the help that helpers extend”. Thoits (1982) argues that support is the degree to which an individuals’ need for affection, approval, belonging and securities are met by significant others. Studies conducted in the field of social support indicate supportive relationship appears to reduce uncertainly thereby increasing workers health and job satisfaction or decrease sing job stress and burnout.
Social support has been found to be a major predictor of quality of life among HIV positive individuals (Eller, 2000; Nunes et al., 1995; Bastardo and Kimberlin, 2000). Cohen et al. (2007) reported that psychological distress was an outcome of more illness stressors and lower perceived social support. Women with higher social support had better T (CD4+) lymphocyte count and T (DC4+)/T(CD8+) ratio, and lower viral load than did men. Additionally, sample who were suffering from HIV for a shorter duration, better adherence to drugs, and had greater social support exhibited improved immune indicators, but those who were suffering from psychological distress, did not exhibit any improvement in immune indicators. Similarly, it was found that increase in AIDS self-efficacy over a 3-month period was significantly related to increase in CD4 and decrease in viral load and increase in cognitive behavioral sills; self-efficacy was significantly related to decreases in distress over time (Ironson et al., 2005). Life stress and depressive symptoms were found to be related to decrease in immune measures (Leserman et al., 1997) and explained HIV (human immunodeficiency virus) disease progression (Patterson et al., 1995). Higher cumulative average stressful life events and lower cumulative average social support predicted faster progression of disease, higher anger scores, increase in CD8 T cells (were associated with faster progression to AIDS) associated clinical condition (Leserman et al., 2002; Leserman et al., 2000).

Earlier studies report that PLHWA with high emotional intelligence generally seek more of physical and instrumental support and consequently
receive more support from others (Wangehaum, 2003). Nunes et al. (1995) study on the relationship between social support and quality of life individuals with HIV collected from 50 HIV positive individuals indicated that social support, to HIV status (asymptomatic HIV, symptomatic HIV, AIDS), were positively correlated with quality of life. HIV infection in India carries with stigma, isolation, and discrimination. It is considered a dirty disease and PLWHA are considered as immoral and hence deserving of the suffering they experience (Ahuja et al., 1998). PLWHA often become clinically depression, anxiety, fear of impending death (Chandra et al., 1998), social stigma (Mawar et al., 2005), unforgiving attitude, guilt and rejection of the self (Temoshok and Chandra, 2000) reduce quality of life, inhibits positive interventions may be an important adjunct in increasing medication adherence of HIV positive women (Jones et al., 2007). This is perhaps due to the modification of cognitive coping and social support by psychosocial intervention that leads to changes in psychological well-being and quality of life during symptomatic HIV infection (Lutgendort et al., 2007).

### 2.2.2 Types of Social Support:

Types and sources of social support may vary. House (House, 1981) described four main categories of social support: emotional, appraisal, informational and instrumental:

- Emotional support generally comes from family and close friends and is the most commonly recognized form of social support. It includes empathy, concern, caring, love, and trust.
• Appraisal support involves transmission of information in the form of affirmation, feedback and social comparison. This information is often evaluative and can come from family, friends, co-workers, or community sources.

• Informational support includes advice, suggestions, or directives that assist the person to respond to personal or situational demands.

• Instrumental support or material support: Tangible assistances involve the provision of materials support, such as services, financial assistance, or goods.

2.2.3 Providing Support:

There are both costs and benefits to providing support to others. Providing long-term care or support for someone else is a chronic stressor that has been associated with anxiety, depression, alteration in the immune system, and increased mortality. However, providing support has also been associated with health benefits. In fact, providing instrumental support to friends, relatives, and neighbors, or emotional support to spouses has been linked to a significant decrease in the risk for mortality. Also, a recent neuroimaging study found that giving support to a significant other during distressful experience increased activation in reward areas of the brain.

2.2.4 Functions of Social Support:

Social support is reduce the Psychological and physical health problems and may be especially help to elderly, the recent widowed, or
victims of sudden, severe, uncontrollable life events. In addition to providing psychosocial benefits, social support appears to lower the likelihood of illness, to speed recovery from illness and to reduce the risk of mortality due to serious disease like HIV/AIDS, TB, cancer etc. Studies that control for initial health status indicate the people with a high quantity or quality of social support have lower mortality rates. Social isolation is a risk factor for death for both humans and animals. Social support also enhances the prospects of recovery among people who are already ill, a relationship that had been uncovered in broad array of specific diseases.

Donald and Ware Jr. (1984) assessed the measurement of social support as well as the conceptual and methodological issues related to it. Social support is the multidimensional concept that includes distinct but related categories of social contacts as well as social resources. Subjective evaluation of personal relationship is useful criteria for determining scale values of social contacts and resources. Social support seems to have a direct positive effect on the status individual’s performances or behavior.

The importance of social support continues well into adulthood for everyone. It would benefit a person’s general health and immune system, regardless of whether or not they have a lot of anxiety.

2.2.5 Models of Social Support:

Social support models have been proposed by different scholars. First models define social support in terms of number of persons for social
contacts. For example, one study of over six thousand residents of Alameda County, California, used a measure of social support that combined (i) marital status (ii) of close friend and relatives (iii) church membership and (iv) formal and informal group association (Beckman and Same, 1979). Women who had good marital relationship were more likely to experience stress. Because of their traditional responsibilities for taking care of others, women incur higher “costs of caring” than do man (Kessler et al., 1992).

Second model of social support focuses on a number of helpers available to a person in need. This respective defines social support in terms of the number of people from whom individual has received support in the recent past. Individual with the greater number of providers should have better health. Such findings illustrate the interacting nature of social support. It is not some inert substance we carry in our pocket to insure protection against adversity.

Third model, the intimacy model, predicts that having a close confining relationship with the significant other will be associated with better health. Similarly, among gay and bio sexual man infected with HIV, those with the history of close, confining relationship have lower level of suicidal tendency.

Fourth model of social support defines it in terms of its perceived availability (Sarason et al., 1983) Compared with those who doubt the adequacy of the social resources, individuals who believe that support is
available to them cope more effectively in many different situations in school (Curt Rona et al., 1994).

2.2.6 Theories of Social Support:

Theoretical conceptualization of social support have a relatively long history stemming from Durkheim’s (1951) notion of attachment and regulation by society, Cooley’s (1909) primary group, and Bowlby’s (1969) theories of attachment. In the 1970s, 2 publications, by Cassel (1976) and Cobb (1976), described the disease-protective effect of social support (or ‘host resistance”) and spawned an increased interest in social support and health. Cassel (1976) observed that patients who were more socially connected to have better prognosis in recovering from illness or in maintaining their health. Their conceptualization of social support emphasized feelings of belongingness. Alongside this perspective, an equally large literature arising out of epidemiological traditions also has grown and has focused more on the structure of the social network or more tangible types of support offered by the network (Pierce, 1997).

Although historically there has been little integration of differing theories of social support, there is increasing agreement among reviewers to structure social support within two broad domains: structural and functional support, or the structure of social ties and the support actually provided by the structure respectively (Sarasin, 1994; Uchino, 2004; O’ Reilly, 1988; Langford et al., 1997). Structural support refers to the size, type, density, and frequency of contact with the network of people
surrounding an individual. Measures of the density of social, frequency of interactions, the number of close contacts versus peripheral acquaintances, marital status, group or church membership, and geographic proximity describe varying structural patterns. Several limitations with this construct have been noted. Foremost among these criticisms is that merely describing the structure of relationship does not necessarily describe the nature of the relationships.

That is, network measures may be problematic to the extent that they group together supportive and non-supportive relationships or confuse quantity and quality. Functional support is the support provided by the social structure. Functional measures of support are delineated by type, including instrumental (e.g., help getting tangible tasks done), financial, informational (providing needed information), appraisal (help evaluating a situation), and emotional support (e.g., feelings of being loved). The label tangible is often used to describe types of support. Furthermore, theorists carefully distinguish functional support that is actually received (“received functional support”) from an individual’s subjective appraisal of their satisfaction with support or their perception that support would be available if needed (“perceived functional support”). Received functional support is limited by its overlap with distress, illness, or extent of need.

Indeed, measures of received support are rarely used in the literature covered by this review for this reason. Instead, measures of perceived functional support are more commonly used. Perceived functional support
has been conceptualized as the subjective appraisal of the degree of match between the amount and type of support needed and amount and type of support available, or the perception that support would be available if needed. As noted earlier, various domains of perceived and received functional support can be measured, including instrumental, financial, informational, appraisal, and emotional support. Throughout, perceived support is used as shorthand for perceived functional support. For e.g., “perceived emotional support” refers to the emotional domain of perceived functional support.

2.2.7 Importance of Social Support:

The Oxford dictionary defines support, in part, as to keep from falling or giving way, give courage, confidence, or power of endurance to apply with necessities. What presumably distinguishes social support from the border concept is that it necessarily involves the presence and products of stable human relationships. The concept of social support has been variously addressed in terms of social bonds (Henderson, 1977, 1980; Henderson et al., 1978), social networks (Muller, 1980), meaningful social contact, availability of confidants (Brown et al., 1975; Levinthal and Haven, 1968; Miller and Ingham, 1976) and human companionship (Lynch, 1877), as well as social support (Cobb, 1976; Dean and Lin, 1977; Murawski et al., 1978). Although these concepts are hardly identical, they share a focus upon the relevance and significance of human relationships.
This focus has been the subject of considerable attention and research effort among social scientists, psychiatrists, and epidemiologists. This intensified interest, however, hardly signals the discovery of a new idea. In Genesis the Lord Judges that “it is not good that man be alone” and philosophers have emphasized that the essence of human existence is expressed in our relations with other. Social bonds, social integration, and primary group relations in general are central concepts in sociological theory and have long been prime considerations are sociological analysis. As Hammer et al., have observed, social linkages “may be thought of as the basic building blocks of social structure; and their formation, maintenance, and severance are universal and fundamental social processes” (1978).

A number of researchers have described differing types or categories of social support. Dean and Lin (1977) differentiated instrumental and expressive support, whereas both Pinneau (1975) and Schaefer et al. (1981) distinguished tangible, informational, and emotional forms. The five distinct categories of cognitive guidance, social reinforcement, tangible assistance, socializing, and emotional support are specified by Hirsch (1980) and Funch and Mettlin (1982) and perceived potential support to the very concrete categories of professional support and financial support. Common to all the taxonomies is an acknowledgement of the relevance of emotional or perceived support on the one hand, and of actual aid or its availability on the other.
House (1981) has distilled four broad classes of social support from the array of conceptualization in the literature. These are (1) emotional support, involving empathy, love and trust; (2) instrumental support, involving behaviours that directly aid the person in need; (3) information support, composed of information useful in coping with personal and environmental problems and (4) appraisal support, involving information relevant to self evaluation or social comparisons, exclusive of any affect that might accompany such information.

House acknowledged that emotional support is the common element across most conceptualizations, that it’s what most people mean when they speak of being supportive, and that it seems to be the most important dimension. However, he saw the other three classes as worthy of attention, arguing that “all should be considered as potential forms of support and their impact on stress and health (and the relation between these) treated as an empirical question’ (1981).

2.3 DEATH ANXIETY:

2.3.1 Meaning and Definitions:

Anxiety is an emotion characterized by heightened autonomic system activity, specifically activation of the sympathetic nervous system (i.e., increased heart rate, blood pressure, respiration, and muscle tone), subjective feelings of tension and cognition that involve apprehension and worry. Although the subjective experience of anxiety is not necessarily accompanied by particular behaviours, behavioral indicators are often
present, such as speech disinfluences, avoidance of the focal object or event, immobilization or observable tremor.

Several subtypes of anxiety, such as test anxiety, sexual anxiety, speech anxiety and death anxiety, have been identified. These subtypes share certain features in common, and any one of them could be characterized with terms such as apprehension, dread, panic, tension and worry. The Diagnostic and statistical Manual of Mental Disorders (DSM- IV, 1994) lists no fewer than a dozen different diagnostic categories of anxiety disorders, including panic attacks, specific phobias, social phobias. Posttraumatic stress disorder and generalized anxiety disorder.

Two constructs to which anxiety is related are fear and phobia. Although the terms are frequently used interchangeably, fear is often defined as a response to a clearly identifiable threat or an anticipated danger. In addition whereas the fear response is proportionate to the objective danger, anxiety responses are often more intense than is warranted by the perceived threat. However, not all theorists agree with these distinctions between fear and anxiety.

As anyone who has experienced anxiety can attest, anxiety can have a detrimental effect on behavior and cognition. Students who anticipate performing poorly on a test may experience anxiety to such a degree that they have difficulty recalling relevant information. However, like most emotions, anxiety is inherently adaptive. The performance-enhancing effect
of moderate levels of arousal has long been known. In addition, anxiety acts as an interrupted mechanism drawing attention away from secondary concerns to the problem at hand, thereby leading the individual to stop behavior that may be dangerous or threatening. For example, a person who experiences social anxiety may stop behaviors that are potentially embarrassing and might lead to interpersonal rejection.

One way of distinguishing adaptive from maladaptive anxiety is by viewing the ‘reasonableness’ of the anxiety, for example, a person who is afraid of heights is, in fact, in little danger of failing. However, a person who is socially anxious may be rightfully concerned with being evaluated by others in undesired ways.

Death anxiety refers to the fear and apprehension of one’s own death. It is the neurotic fear of loss of the self which in intense state parallels feelings of helplessness and depression. Man’s awareness of his own death produces anxiety than can only be dealt with by recognizing one’s individuality. According to Fromm and the existential analysts, man’s awareness of death gives him the responsibility for finding meaning in life. Death is a biological, personal, socio-cultural and existential phenomenon. The biological death is useful to distinguish between the process of aging and the ending called death. Yet when the actual time comes, and the individual faces death alone, the psychological reactions appear to be remarkably similar. Kubler (1969) had found that in the majority of persons, almost regardless of age, the personal reactions to imminent death
pass through five phases – Denial, Anger, Bargaining, Depression and Acceptance (although not every individual achieves the final phase). Dying and death, like other major aspects of human life, are also every important cultural and social phenomena.

Even less than a century ago, death was a common and familiar event in everyday life. There was no widespread technology to control infection and medicine could not do much for most diseases. Among the poorer classes the young died at an appalling rate, and the old died in their time, and they all died at home. The average person had been in the immediate presence of dead bodies at least half a dozen times before reaching adulthood. Against this background, death was in former years much more a part of life than it is today. It was not a matter to be shunned or a taboo to be mentioned by means of euphemisms such as ‘passed on’ but was dealt with directly and was even elaborated at the wake. It was not unusual in small European towns of a few centuries ago, for someone who was dying to pass their death bed hours in the public square, greeting friends, saying goodbye, and glorying, for at least brief time in a position of respect. Under such circumstances, death was an occasion for sadness but not for shame. No one would have dreamed of hiding away the dying as we do, in the wards of hospitals or in old age homes.

The death can be fully understood only if it is viewed as one of the central meanings of human existence. An idea of the centrality of one’s own death can be gathered if individuals could be made to contemplate seriously
the possibility of their own death (McCarthy, 1980). As death is the final stage of life cycle, it can be approached naturally by dying individuals and their families. Death and dying can be seen as part of the life process, or they can be viewed as a dramatic, painful, tortured experience both for the patients and the families. Increasingly, more research reports are being presented on the nature of death and dying. Research on exactly when death occurs, how the dying should be treated, and how their families might better cope will continue for many years (Lefton, 1982).

In old age, people must confront the possibility of their own death as well as the death of loved ones. Death may also be considered in statistical terms, which supply us with significant figures and facts. Even though death most commonly occurs in later years, it may happen at any stage in life. Accidents and suicides are the major causes of death among younger persons, and continue to be so in later years, although their relative significance declines. Often death is associated with some special psychological stress; it may be acute mourning, or an anniversary, or some particular loss of status or self esteem. Death is sometimes defined as the absence of certain clinically detectable vital signs. A person is dead “if his heart stops beating and he quits breathing for an extended period of time, his blood pressure drops as low as to be unreadable, his pupils dilate, his body temperature begins to go down, and so forth. This clinical definition has been used over the centuries, both by physicians and laymen. More recently death has sometimes been defined as the lack of brain wave
activity. Still others say that death can only be defined as a bodily state which represents an irreversible loss of vital functions and from which the individual cannot possibly be revived. According to the concept of terminal drop, death can be predicted from certain dramatic changes in cognitive function in the period preceding demise. That is, significant changes both in personal adjustment and performance may serve as indicators of impending death (Reigal and Reigel, 1972).

Certain attitudes toward death are typical. Even when approaching death people ask, “why me?” and wish to find a meaning for their suffering. This question cannot be answered in generalized terms because the meaning of life and death vary from one individual to another (Kubler, 1975). The act of dying itself may involve a certain amount of “anticipatory self grief”, grief over the loss of one’s own life- that is, fearing what it may be to lose one’s self. In addition, fear of dying is often associated with unfounded beliefs that dying itself is quite painful, that one may be abandoned by everyone when dying, that death involves an ultimate aloneness, and “that there may be final medical procedures that will further dehumanize oneself by being turned into a sort of plumbing shop” (Holocomb, 1975). The fear of pain can be relieved by the knowledge of modern pain relieving processes. It can help to know that tough dying is rarely pleasant. It is neither as painful nor as unpleasant as is often feared. Fear of dying involves not only physiological but psychological factors, too. Pain is more easily dealt with than loneliness. It helps if the patient’s family visits frequently, communicate openly, and
gives constant assurance that the dying person will not be abandoned. About two-third of the dying are anxious about separation from their loved ones, they are concerned about how their loved ones will get along after they die. Many also feel that life no longer has any real meaning.

Bischof (1976) summarized the attitudes of older adult’s feelings about death. They realized that they had already lasted longer than many of their earlier contemporaries. They have a strong belief that their life should not be prolonged artificially. They realized that thought of life, not as the number of years lived, but in terms of time that remained. Finally they desired to leave this world with respect and dignity. In general, the older the adult, the less important time becomes, so that death is less formidable to the very old that it is to the young. It is true that older people think about death most frequently, but they are less afraid of it. Many older persons come to accept, or even welcome, the idea of their own death. They may feel that they are ready; or they may wish to escape infirmity; or they may have religious convictions which convince them that their life will continue after death (Butler, 1975). Young people generally avoid thinking about death; and when it does intrigue on their consciousness; they view it negatively. Yet even at this stage, individual views vary. In a psychology today questionnaire, the typical respondent 20 to 24 years old, single, somewhat religious, protestant, somewhat politically liberal, college graduate from a small family had an ambivalent attitude toward death, both risking death and loving life, wanting happiness and behaving in self-destructive ways: regarding death as taboo.
and insisting on a new permissiveness to talk about it. Most of the respondents recognized death and dying as aspects of living. Almost half believed that most people participate consciously or unconsciously in their own death. Only 2% wanted formal funerals, and a third wanted one at all. Almost a third wished to donate their bodies to medical schools or to science. Almost none of them wanted to die in youth or in the prime of life. Two-thirds of them would have liked to live to old age, and more men than women wanted to live out their full life spans. Both sexes accurately placed the time of least fear of death in the years over seventy.

Death anxiety is the morbid, abnormal or persistent fear of one’s own death or the process of his/her dying. One definition of death anxiety is a “feeling of dread, apprehension or solicitude (anxiety) when one thinks of the process of dying, or ceasing to be”. It is also referred to as thanatophobia (fear of death), and is distinguished from necrophobia, which is a specific fear of dead or dying persons and/or things (i.e., others who are dead or dying, not one’s own death or dying). Lower ego integrity, more physical problems, and more psychological problems are predictive of higher levels of death anxiety in elderly people.

2.3.2 The Bases of Death Anxiety:

Death is the only certainty in life. All living organisms die; there is no exception. However, human beings alone are burdened with the cognitive capacity to be aware of their own inevitable mortality and to fear what may
come afterwards. Furthermore, their capacity to reflect on the meaning of life and death creates additional existential anxiety.

According to Goodman (1981), “The existential fear of death, the fear of not existing, is the hardest to conquer. Most defensive structures, such as the denial of reality, rationalization, insulation erected to ward of religiously conditioned separation- abandonment fears, do not lent themselves readily as protective barriers against the existential fear of death” (p. 5).

- **The Finality of Death** – There is no reversal, no remedy, no more tomorrow. Therefore, death signifies the cessation of all hope with respect to this world.

- **The uncertainty of what follow** – Socrates has made the case since we really don’t know what will happen, we should not fear. But uncertainty coupled with finality can create a potential for terror.

- **Annihilation anxiety or fear of non-existence** – The concept of non-being can be very threatening, because it seems to go against a strong and innate conviction that life should not be reduced to non-being.

- **The ultimate loss** – When death occurs, we are forced to lose everything we have ever valued. Those with the strongest attachments towards things of this world are likely to fear death most. Loss of control over affairs in the world and loss of the ability to care for dependents also contribute to death anxiety.
• **Fear of the pain and loneliness in dying** – Many are afraid that they will die alone or die in pain, without any family or friends around them.

• **Fear of failing to complete life work** – According to Goodman’s (1981) interviews with eminent artists and scientists, many people are more afraid of a meaningless existence than death itself; their fear of death stems from fear of not being able to complete their mission or calling in life.

2.3.3 Types of Death Anxiety:

Rober Langs distinguishes three types of death anxiety.

**Predatory Death Anxiety:**

Predatory death anxiety arises from the fear of being harmed. It is the most basic and oldest form of death anxiety, with its origins stemming from the first unicellular organisms’ set of adaptive resources, unicellular organisms have receptors that have evolved to react to external dangers and they also have self-protective, responsive mechanisms made to guarantee survival in the face of chemical and physical forms of attack or danger. In humans, this form of death anxiety is evoked by a variety of danger situations that put the recipient at risk or threatens his or her survival. These traumas may be psychological and physical. Predatory death anxieties mobilize an individual’s adaptive resources and lead to fight or flight, active efforts to combat the danger or attempts to escape the threatening situation.
**Predation or Predator Death Anxiety:**

Predation or predator death anxiety is a form of death anxiety that arises from an individual physically and/or mentally harming another. This form of death anxiety is often accompanied by unconscious guilt. This guilt, in turn, motivates and encourages a variety of self-made decisions and actions by the perpetrator of harm to others.

**Existential Death Anxiety:**

Existential death anxiety is the basic knowledge and awareness that natural life must end. It is said that existential death anxiety directly correlates to language; that is, language has created the basis for this type of death anxiety through communicative and behavioral changes. Existential death anxiety is known to be the most powerful form. There is an awareness of the distinction between self and others, a full sense of personal identity, and the ability to anticipate the future. Humans defend against this type of death anxiety through denial, which is effected through a wide range of mental mechanisms and physical actions many of which also go unrecognized. While limited use of denial tends to be adaptive, its use is usually excessive and proves to be costly emotionally.

Awareness of human mortality arose through some 150,000 years ago. In that extremely short span of evolutionary time, humans have fashioned but a single basic mechanism with which they deal with the existential death anxieties this awareness has evoked – denial in its many forms. Thus, denial is basic is basic to such diverse actions as breaking rules and violating
frames and boundaries, manic celebrations, violence directed against others, attempts to gain extraordinary wealth and/or power- and more. These pursuits often are activated by a death related trauma and while they may lead to constructive actions, more often than not, they lead to actions that are, in the short and long run, damaging to self and others.

2.3.4 Theories:

Thanatophobia:

Sigmund Freud hypothesized that people express a fear of death, called thanatophobia. He saw this as a disguise for a deeper source of concern. It was not actually death that people feared, because nobody believes in his or her own death. The unconscious does not deal with the passage of time or with negations, which does not calculate amount of time left in one's life. Furthermore, that which one does fear cannot be death itself, because one has never died. People who express death-related fears, actually are trying to deal with unresolved childhood conflicts that they cannot bring themselves to come to terms with and to display and show emotion relating to the conflict.

Wisdom: Ego Integrity vs. Despair:

Developmental Psychologist, Erik Erikson, formulated the psychosocial theory that explained that people progress through a series of crises as they grow older. The theory also envelops the concept that once an individual reaches the latest stages of life, they reach the level he titled as
"ego integrity". Ego Integrity is when one comes to terms with his or her life and accepts it. It was also suggested that when a person reaches the stage of late adulthood he or she becomes involved in a thorough overview of his or her life to date. When one can find meaning or purpose in his or her life, he or she has reached the integrity stage. In opposition, when an individual views his or her life as a series of failed and missed opportunities, then he or she do not reach the ego integrity stage. Elders that have attained this stage of ego integrity are believed to exhibit less of an influence from death anxiety.

**Terror Management Theory:**

Theory of Ernest Becker was based on existential view which turned death anxiety theories towards a new dimension. It said that death anxiety is not only real, but also it is people's most profound source of concern. He explained the anxiety as so intense that it can generate fears and phobias of everyday life—Fears of being alone or in a confined space. Based on the theory, many of people's daily behavior consist of attempts to deny death and to keep their anxiety under strict regulation. As an individual becomes more aware of the inevitability of death, they will instinctively try to suppress it out of fear. The method of suppression usually leads to mainstreaming towards cultural beliefs, leaning for external support rather than treading alone. This behavior may range from simply thinking about death to severe phobias and desperate actions.
Meaning Management Theory:

Paul T.P. Wong’s work on the meaning management theory indicate that human reactions to death are complex, multifaceted and dynamic. His “Death Attitude Profile” identifies three types of death acceptances as Neutral, Approach and Escape acceptances. Apart from acceptances, his work also represents different aspects of the meaning of Death Fear that are rooted in the bases of death anxiety. The ten meanings he proposes are finality, uncertainty, annihilation, ultimate loss, life flow disruption, leaving the loved ones, pain and loneliness, prematurity and violence of death, failure of life work completion, and judgment and retribution centered.

Other Theories:

Other theories on death anxiety were introduced in the late part of the twentieth century. The existential approach, with theorists such as Roll May and Victor Frankl, views an individual's personality as being governed by the continuous choices and decisions in relation to the realities of life and death. Another approach is the regret theory which was introduced by Adrian Tomer and Grafton Eliason. The main focus of the theory is to target the way people evaluate the quality and/or worth of their lives. The possibility of death usually makes people more anxious if they feel that they have not and cannot accomplish any positive task in the life that they are living. Research has tried to unveil the factors that might influence the amount of anxiety people experience in life.
Personal Meanings of Death:

Humans develop meanings and associate them with objects and events in their environment. These meanings that we associate to certain things are what provoke certain emotions within an individual. People tend to develop personal meanings of death and those meanings could accordingly be negative or positive for the certain individual. If they are positive, then the consequences of those meanings can be comforting to the individual. If negative they can cause emotional turmoil in the individual when faced with the death of someone or when faced with death itself. Depending on the certain meaning one has associated with death, the consequences will vary accordingly whether they are negative or positive meanings.

Relationship Between Adult Attachment and Death Anxiety:

There has been much literature that supports the existence of a correlation between one's state of coping skills, mental health, emotions and cognitive reactions to stressful events, and a one's ability to regulate affect concerning one's death anxiety. A series of tests determined that significantly high levels of death anxiety tend to occur in close relationships with an intimate partner (more so amongst females than males).

Sexes:

The connection between death anxiety and the sex one belongs to appears to be strong. Studies show that females tend to have more death
anxiety than males. Thorson and Powell (1984) did a study to investigate this connection, and they sampled men and women from 16 years of age to over 60. The Death Anxiety Scale showed higher mean scores for women than for men. Moreover, researchers believe that age and culture could be major influences in why women score higher on death anxiety scales than men. The prevalence of death anxiety is often higher in women due to increased responsibility and status that women hold in families. The maternal bond between children and mothers often never leaves. The truth is that mothers always want the best for their children and look out for their well being, even when they have left their care. This increased fear for women, that their children will be alone and defenseless when they die, is a major attribute to why death is such a fearful demise. Through the evolutionary period, a basic method was created to deal with death anxiety and also as a means of dealing with loss. Denial is used when memories or feelings are too painful to accept and are often rejected. By retaining that the event never happened rather than accepting it, allows an individual more time to work through the pain that is inevitable. When a loved one dies in a family, denial is often implemented as a means to come to grips with the reality that the person is gone. Closer families often deal with death better than when coping individually. As society and families drift apart so does the time spent with bereaving those who have died, which in return, leads to negative emotion and negativity towards death. Women, who are the child bearer and often the ones who look after children hold greater concerns
about death due to their caring role within the family. It is this in-built mechanism in women that leads to greater death anxiety and the ‘importance to live’ for her offspring. Although it is common knowledge that all living creatures die, many people do not accept their own mortality, preferring not to accept that death is inevitable, and that they will one day die.

**Age:**

It is during the years of young adulthood (20 to 40 years of age) that death anxiety most often begins to become prevalent. However, during the next phase of life, the middle age adult years (40–64 years of age), death anxiety peaks at its highest levels when in comparison to all other age ranges throughout the lifespan. Surprisingly, levels of death anxiety then slump off in the old age years of adulthood (65 years of age and older). This is in contrast with most people’s expectations, especially regarding all of the negative connotations younger adults have about the elderly and the aging process (Kurlychek and Trenner, 1982).

**Measuring Death Anxiety:**

There are many ways to measure death anxiety and fear. Katenbaum and Ainsberg (1972) devised three propositions for this measurement. From this start, the ideologies about death anxiety have been able to be recorded and their attributes listed. Methods such as imagery tasks to simple questionnaires and apperception tests such as the Strop test enable
psychologists to adequately determine if a person is under stress due to death anxiety or suffering from Post Traumatic Stress Disorder. The Lester attitude death scale was developed in 1966 but not published until 1991 until its validity was proven. By measuring the general attitude towards death and also the inconsistencies with death attitudes, participants are scaled to their favorable value towards death.

2.4 PSYCHOLOGICAL WELL-BEING (PWB)

2.4.1 Meaning and Definitions:

The literature on psychological well-being has progressed rapidly since the emergence of the field over five decades ago. As recent surveys show psychologists and other social scientists have taken huge steps in their understanding of the factors influencing psychological/subjective well-being.

Well-being, Well-being is a complex construct that concerns optimal psychological functioning and experience. In part, this reflects the increasing awareness that just as positive affect is not the opposite of negative affect (Cacioppo and Bernston, 1999), well-being too is not the absence of mental health illness.

For more than twenty years, the study of psychological well-being has been guided by two primary conceptions of positive functioning. One formulation, traceable to Bradburn’s (1969) seminal work, has distinguished between positive and negative affect and defined happiness as
the balance between the two. The second conception, which has gained prominence among sociologists, emphasizes life satisfaction as the key indicator of well-being.

Psychological well-being refers to how people evaluate their lives. According to Diener (1997), these evaluations may be in the form of cognitions or in the form of affect. The cognitive part is an information based appraisal of one’s life that is when a person gives conscious evaluative judgments about one’s satisfaction with life as a whole. The affective part is a hedonic evaluation guided by emotions and feelings such as frequency with which people experience pleasant/unpleasant moods in reaction to their lives. The assumption behind this is that most people evaluate their life as either good or bad, so they are normally able to offer judgments. Further, people invariably experience moods and emotions, which have a positive effect or a negative effect. Thus, people have a level of subjective well-being even if they do not often consciously think about it, and the psychological system offers virtually a constant evaluation of what is happening to the person.

In this paper we have defined psychological well-being in terms of internal experience of the respondent and their own perception of their lives. We focused both on momentary moods and long term states of their mental well-being.

Current social indicators can capture phenomena such as crime, divorce, environmental problems, infant mortality, gender equality, etc.
Thus, they can capture aspects of quality of life that add to the description drawn by economic indicators. However, these social indicators fail to capture the subjective well-being of people because they do not reflect the actual experiences such as the quality of relationships, the regulation of their emotions and whether feelings of isolation and depression pervade in their daily life. On the other hand, economic indicators fail to include side effects and the tradeoffs of market production and consumption. For example, the environmental costs of industries certainly are not observed from the national accounts. Another disadvantage of economic and social measures in terms of their links to psychological well-being is that they are based on models of rational choice, whereby people follow a set of logical rules when making development plans. However, works by Kahneman (1994) in psychology and economics reveal that people do not always make rational choices, and that these choices do not necessarily enhance psychological well-being.

Currently in Bhutan, economic and social indicators are available and frequently updated as most organizations do some research on it. Even the media and policies provide emphasis on such indicators, while no national measures of psychological well-being exist. The measurement of psychological well-being has advanced so much over the years that it is time to give a privileged place to people’s well-being in policy debates. A GNH society calls for the inclusion of well-being indicators at par with economic ones. Media should provide attention to how a society is progressing in
terms of psychological well-being and politicians should base their campaigns on their plans for reducing distress, increasing life satisfaction and happiness level.

Psychological well-being leads to desirable outcomes, even economic ones, and does not necessarily follow from them. In a very intensive research done by Diener and his colleagues, people who score high in psychological well-being later earn high income and perform better at work then people who score low in well-being. It is also found to be related to physical health. In addition, it is often noticed that what a society measures will in turn influence the things that it seeks. If a society takes great effort to measure productivity, people in the society are likely to focus more on it and sometimes even to the detriment of other values. If a society regularly assesses well-being, people will provide their attention on it and learn more about its causes. Psychological well-being is therefore valuable not only because it assesses well-being more directly but it has beneficial consequences.

Psychological well-being or well-being (these two are used interchangeably) consists of factors like self-esteem, positive effect, satisfaction, wellness, efficiency, Social support, somatic symptoms, personal control and the like. The well-being is a constituent of quality of life which a conceptualized as a composite of physical, psychological social well-being of individuals, as perceived by the person and the group. An important aspect is happiness, satisfaction and gratification subjectively experienced which is
often called subjective well-being or psychological well-being. Thus well-being is based on subjective experience instead of objective life condition, it has both positive and negative affects and it is global experience (Okum and Stock, 1987).

Quality of life is multidimensional concept, which includes specific core domains including physical, psychological, social and occupational well-being, physical pain, mobility, sleep appetite and nausea; sexual functions; personal social and sexual relationship; engagement in social and leisure activates; occupation ability and desire to carry out paid employment, ability to cope with house whole duties, etc., all constitutes the contributory factors.

Psychological well-being represents a proactive stance toward emotional health. Well-being refers to a person’s ability to cope with events in daily life function, responsibility in society and experience personal satisfaction. Mental health has several dimensions, each of which contributes to people overall health and well-being (Kisku Kiran K., 2001).

According to Hettler (1980) wellness encompasses of six dimensions namely social, occupational, spiritual, physical, intellectual and emotional. A health individual needs a good physical and psychological well-being. Psychological well-being is directly or indirectly affected by many psychological factors among which self-esteem and emotional maturity are vital importance of the several problems facing the entire life span, the
problems of the transition phase starting from late adolescent to early adulthood is a crucial one for the development of the individual. When coped up, it leads to successful achievement of the developmental tasks in the present and future.

Ryff (1989) explored the construct of well-being extensively in the light of various measures, i.e., autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance, family bonding etc. He also suggested a multidimensional model of PWB that distilled six psychological dimensions of challenged thriving. In combination, these dimensions encompass a breadth of wellness that includes positive evaluations of oneself and one’s past life (self-acceptance), a sense of continued growth and development as a person (personal growth), the belief that one’s life is purposeful and meaningful (purpose in life), the possession of quality relations with others (positive relations with others), the capacity to manage effectively one’s life and surrounding world (environmental mastery), and a sense of self-determination (autonomy).

Bhogale and Jayaprakash (1993) found satisfaction variables to be closely related to well-being while distress and meaningless represented a negative aspect or ill-being. Thus, PWS is a component both positive and negative. The factors like satisfaction, positive effect, social support and several others clearly reveal the multidimensionality of psychological well-being.
2.4.2 Characteristics of Psychological Well-being:

According to Diener (1984), Psychological well-being has several characteristics. First, the field covers the entire range of well-being from agony to ecstasy. It does not focus only on undesirable states such as depression or hopelessness. Instead, individual differences in levels of positive well-being are also considered to be important. Thus, the field of psychological well-being includes the undesirable states that are treated by clinical psychologist, but is not limited to the study of these undesirable states. In other words, the field is concerned not just with the causes of depression and anxiety but also with the factors that differentiate slightly happy people, moderately happy and extremely happy people.

Secondly, Psychological well-being is defined in terms of the internal experience of the respondent. An external frame of reference is not imposed when assessing psychological well-being. Although many criteria of mental health are dedicated from outside by researchers (e.g., maturity, autonomy and realism). Psychological well-being is measured from the individuals own perceptivity. In the field of psychological well-being, a person’s beliefs about his or her own well-being are of paramount importance.

A final characteristic of psychological well-being focuses on long term states, not just momentary moods. Although a person’s moods are likely to fluctuate with each new event, the researcher is most interested in the person’s moods over time. Often, what leads to happiness at the moment may not be the same as what produces long-term psychological well-being.
Thus, importance is in relatively enduring feelings of well-being, not in fleeting emotions.

2.4.3 Components of Psychological Well-being:

There are three primary components of psychological well-being viz., satisfaction, pleasant affect and low levels of unpleasant affect. Psychological well-being is structured such that these three components form a global factor of interrelated variables. Global satisfaction can be divided into satisfaction with the various domains of life such as recreation, love, marriage, friendship and so forth.

2.4.4 Theories on Psychological Well-being:

Telic theories of Psychological well-being maintain that happiness is gained when some state, such as goal is reached. One theoretical postulate offered by Welson (1960) is that the satisfaction of needs causes happiness and conversely, persistence of unfulfilled needs causes unhappiness.

Activity theories maintain that happiness is a byproduct of human activity. The most explicit formation about activity and psychological well-being is the theory of flow (Csikszentmihaly, 1990). Activities are seen as pleasurable when the challenge is matched to the personal skill level. If the activities are too easy, boredom will develop. If it is too difficult, anxiety will result.

Judgment theories maintain that happiness results from a comparison between some standard and actual conditions. In Social
Comparison Theory, one uses the other people as standard. If a person is better off than others, that person will be satisfied and happy.

2.4.5 Factors Influencing Psychological Well-being:

Researchers need to use both pleasant and unpleasant affects, because both are major components of psychological well-being. Bradhum and Caphovitz (1965) discovered that these two styles of emotion formally believed to be polar opposites, from two separable factors that often correlate with different variable. Although researchers can combine positive and negative affect into an affect balance or global happiness score, they may lose valuable information about the two types of affects.

In defining happiness, it is common sense to combine the frequency and intensity of pleasant emotions. That is people considered to be happy and those who are intensely happy most of the time. However, Diener and his colleagues observed that the frequency is a better predictor of happiness. Thus, feeling pleasant emotion most of the time and infrequently expressing unpleasant emotions even if the pleasant emotions are only mild is sufficient for high reports of happiness.

The next fundamental question that engages the emotion of researchers involved predictor of happiness. Since economic affluence is concerned by many as synonym for happiness, a great deal of research has been carried to such relationship Csikszentmihalys (1990). Such studies have included cross-cultural samples ranging from low income group to high
income groups. The overall pattern that averages from such studies indicated that economic affluence contributes to psychological well-being up to a level but it loses its impact after certain level (Diener, 1996).

The other element in the category of prediction includes close relationship and social support system. Human being always searches for close social and personal relationship. For seeking acceptance and belongingness, we spend a lot of money on clothes, cosmetics and diet and fitness aids, similarly being attached to friends and partners with whom we can share intimate relationship has effects.

In India, where low income threaten basic human needs more often being relatively well-off does predict well-being (Argale, 1999). The other element in the category of prediction includes close relationship and social support system.

A specific manifestation to close relationship is indicated by marital status a mountain of data reveals that most people are happier when attached than when detached. Repeated surveys have predicted consistent results compared with those who never marry and especially compared with those who have separated or divorced. Married people are report being happier and most satisfied with life. By marriage an intimated relationship is developed, commitment increased and as result loneliness is reduced which offers a dependable lover and a good companion (Hendrick and Hendrick, 1977).
Psychological well-being or subjective well-being is a new field of research that focuses on understanding the complete range of well-being from utter despair, to elation and total life satisfaction. Most people in surveys around the world report predominantly positive feelings (Diener and Diener, 1996) although this varies according to the wealth of the nation, because most people are not depressed most of the time, it makes sense to study positive forms of well-being, not just the absence of well-being. When we examine the entire range of well-being, we obtain hints about factors that can increase quality of life. As people come to meet their basic physical needs, they will increasingly turn to concerns about quality of life. If psychologists are to meaningfully contribute to public discussions about quality of life, they must understand psychological well-being through theory and research in this area.