Chapter – III
Review of Literature
In empirical researchers review of related literature provides strong foundations and generates insights in the mind of research. Reviewed theories and conducted studies are essential for a researcher to set the objectives research questions and formulate the hypotheses as well design the entire research. Hence, the present study is an exhaustive effort made to review the studies related of variables involved in the present investigation. The attempt was made by referring to the sources such as Psychological Abstracts, Psychological Review, Journal of Psychology, Social Science Journals and articles were reviewed. The internet search through various search engines such as Scopus, apa, com/journals and etc. in addition to this the researchers from various parts of the world were also contacted to collect the related literature.

3.1 Social Support:

Hass (2002) attempted to explore how particular sources of social support (partners, friends, and family) affect the relationship maintenance of gay male couples in which one (HIV-discordant couples) or both partners have HIV or AIDS (HIV-concordant couples). Using a qualitative grounded theory approach (Glaser and Strauss, 1967), 40, one-hour, in-depth interviews were conducted with 20 gay male couples, 15 discordant and 5 concordant couples. Findings indicated that relational partners were the primary source of social support for both HIV-positive and HIV-negative
partners, followed by close friends, and then family members. The support provided by relational partners was particularly salient to couples in this study. Contrary to past research that has found family members hesitant to provide social support, couples here reported moderate to high levels of support from families. Findings also indicated that gay male couples' social network support from close friends and family functioned both as illness-related social support on an individual level and as a means of relationship maintenance support on the dyadic level. For couples dealing with chronic illness, these findings suggest that illness-related social support also likely serves relationship maintenance functions. Future research is needed to explore the degree to which the interdependence of social support and relationship maintenance can be strategically utilized by couples coping with chronic illness.

The study by Song Y.S. and Ingram K.M. (2002) examined the relationship between perceptions of the availability of social support and enacted unsupportive social interactions relative to anxious and depressive mood among African Americans with HIV (N = 116). Multiple linear regression analyses revealed that greater satisfaction with the availability of social support was associated with lower levels of mood disturbance. In addition, HIV-related unsupportive responses received from other people accounted for a significant portion of unique variance in mood disturbance, beyond that accounted for by the availability of positive social support. As predicted, the direction of the association was that greater levels of
unsupportive social interactions were related to more mood disturbance. Results also indicated that the level of HIV-related unsupportive social interactions was positively related to the use of the coping strategy of disengagement/denial, which, in turn, was associated with greater mood disturbance.

Cutrona and Russell (1990), Green and Pomeroy (2005) suggest that social support functions as a deterrent in the experience of depression among victims of crime. Additionally, the interplay between social support and coping appears to have a critical role in successful recovery. Although social support has been shown to be an important protective factor among victims of crime, little is known about its differential effect, if any, for male and female individuals who experience different types of crimes. On the basis of the literature review, this study examined gender differences in regard to coping strategies, social support, and well-being of victims of violent and nonviolent crimes.

Julie M. Turner-Cobb and et al. (2002) to examined psychosocial correlates of adjustment to HIV/AIDS in a sample of 137 HIV-positive persons (78 men and 59 women). Multiple regression analysis was used to examine relationships between perceived quality of general social support, three attachment styles, and three coping styles with total score on Positive States of Mind Scale (PSOMS), our measure of adjustment. The influence of demographic and medical status variables was also accounted for. PSOMS total score was significantly associated with greater satisfaction with
social support related to HIV/AIDS, more secure attachment style, and less use of behavioral disengagement in coping with HIV/AIDS. These results indicate that for people with HIV or AIDS, those individuals who are more satisfied with their relationships, securely engaged with others, and more directly engaged with their illness are more likely to experience positive adjustment. Implications for physical health outcome and opportunities for intervention are discussed.

Cheryl Gore-Felton et al. (2002) examined the relationships between social support, coping, mood and sexual risk behavior. Participants were 122 HIV-positive adults (60 women and 62 men). All participants were assessed on sexual risk behavior, perceived partner social support, coping with HIV/AIDS and mood. The results showed that sexual risk behavior was associated with male gender, education, perceived support of their partners and the use of emotion-focused coping style to deal with living with HIV and AIDS. Intervening with partners and developing effective coping strategies may decrease risk among HIV-positive men and women. Indeed, effective HIV prevention interventions must consider the social, psychological and cultural context in which sexual risk behavior occurs and develop strategies that intervene on these psychosocial factors.

John A. Fleishman et al. (2000) investigated the interrelationship among, conflictual social interactions, and social support, as well as their combined associations with positive and negative mood. Research has shown that each of these variables affects adjustment to stressful
circumstances. Few studies, however, examine this full set of variables simultaneously. One hundred forty HIV infected persons completed a questionnaire containing measures of coping, social support, conflict social interactions, and positive and negative mood. Factor analyses showed that perceived social support and conflict social interactions formed separate factors and were not strongly related. Compared to perceived social support, social conflict was more strongly related to coping behaviours, especially to social isolation, anger, and wishful thinking. Conflict social interactions were more strongly related to negative mood than was perceived social support. Coping by withdrawing socially was significantly related to less positive and greater negative mood. The findings points to the importance of simultaneously considering coping, supportive relationship, and conflict relationship in studies of adjustment to chronic illness. In particular, a dynamic may occur in which conflict social interactions and social isolation aggravates each other and result in escalating psychological distress.

Gill Green (1993) investigated the relationship between social support and health for people with HIV. Current studies linking social support and HIV are described and the major findings summarized in order to identify gaps in the literature. It is argued that, to date, research in this area has focused primarily upon gay white men in the USA at a symptomatic stage of the illness. There are few studies which have considered the impact of social position on the relationship between social support and health, and few which have included HIV-negative controls. Whilst there is evidence of a
link between social support and the psychological well-being of people with, research is still in its infancy. Much information is required about which particular aspects of social support and health are associated, how this association changes over time according to the stage of the disease, and with the socio-economic and cultural characteristics of those with HIV.

Debra A. Murphy, A. Barbara et al. (2000) investigated the effects of life events, social support, and coping on anxiety and depression among human immunodeficiency virus (HIV)-infected adolescents. It was hypothesized that higher levels of stressful events would be associated with higher levels of anxiety and depression, but that this association would be moderated by satisfaction with social support and by adaptive coping.

**Methods:** HIV-infected adolescents from 16 locations in 13 U.S. cities (N = 230, median age 16.09 years, standard deviation 1.2, range 13–19; 77% females) were recruited into the Reaching for Excellence in Adolescent Care and Health (REACH) project. REACH is the first large-scale disease progression study of HIV+ adolescents infected through sexual behavior or injection drug use. The adolescent assessment was conducted by audio-computer assisted self-interview.

Least squares regressions were used to test hypotheses.

**Results:** Life events with high impact were associated with higher levels of depression and anxiety. Frequently reported events included: being prescribed medications (74%), family financial problems (61%), and parental
alcohol abuse (20%). Contrary to expectations, the buffering hypotheses of social support and adaptive coping were not supported. Satisfaction with social support and adaptive coping methods were both associated directly with lower levels of depression, but no association was detected between these two measures and anxiety.

**Conclusions:** Although life event distress was directly associated with psychological distress, neither social support nor adaptive coping seemed to moderate this association. However, both satisfaction with support and adaptive coping were associated directly with depression in HIV-infected adolescents.

Koji Ueno and Rebecca G. Adams (2001) studied the perceptions of social support availability are formed among gay men coping with HIV. Experiences of receiving support increased perceived availability for specific types of support from specific individuals, but receiving support also gave these men a general sense that someone would be available for assistance. Other aspects of social relationships, such as closeness and role expectations, contributed to gay men's perceptions of support availability. The results suggest that when people with common problems cope together, collective knowledge of support availability may emerge from observations of others' support exchanges as well as from discussions of support experiences. Individuals or groups of individuals may actively create and modify their perceptions of support availability when they cope with anticipated problems. Thus, the study provided an opportunity to integrate concepts of
coping and social support into the collective action and social constructionist frameworks.

The study by Robbins M.; Szapocznik J.; Tejeda M.; Samuels D.; Ironson G.; Antoni M. (2003) examined the role of family functioning and social support in protecting HIV-positive African American women from the adverse psychological consequences associated with deterioration in their CD4 cell count. Participants were 38 African American HIV-positive women who had recently given birth. Results demonstrated that changes in CD4 cell counts were inversely predictive of psychological distress and were moderated by family functioning and social support satisfaction. Women with good family functioning were less affected by changes in their CD4 cell counts, and women with poor family functioning were more emotionally responsive to changes in CD4 cell count. Unexpectedly, women from families where conflicts tended to be clearly laid out and discussed were also more responsive to both changes in CD4 cell counts. Interventions are recommended that increase a client’s social support satisfaction, foster an adaptive level of connectedness to family, and enhance the family’s range of conflict resolution styles.

Social support a key component in models of the stress process is a multifaceted concept encompassing both structural aspects and the supportive functions performed by others, support functions, in turn include provision of information and expression caring and emotional connectedness (House and Kahn, 1985). A multitude of studies have
demonstrated relationships between social support and outcomes such as physical and mental health by (Kessler and McLeod et al., 1985).

Reddy G. Lokanatha and Reddy V. Srikanth (2013) investigated the any significant difference between male and female HIV/AIDS affected people with regard to their source of stress. Gender is the independent variable and a source of stress is the dependent variable. 244 male and 236 female HIV/AIDS affected patients constituted the sample of the study. They were administered stress scale developed by Srikanth Reddy and Jayanthi (2006) which provides measures on six sources of stress. A two way randomized group design is employed in the study. The data obtained on the sample are subjected to ‘t’ test, significant differences are found between male and female HIV/AIDS affected people with regard to emotional problems and family problems. Male HIV/AIDS patients experienced more stress due to emotional problems and family problems compare to female HIV/AIDS patients.

Patterns of HIV-status disclosure and social support were examined among 331 HIV-positive men and women. Structured interviews assessed HIV-status disclosure to family and friends, perceived stress of disclosure, social support, and depression. Results showed patterns of selective disclosure, where most participants disclosed to some relationship members and not to others. Rates of disclosure were associated with social support. Friends were disclosed to most often and perceived as more supportive than family members, and mothers and sisters were disclosed to more often than
fathers and brothers and perceived as more supportive than other family members. Path analyses tested a model of HIV-status disclosure showing that perceived stress of disclosing HIV was associated with disclosure, and disclosures were related to social support. Disclosure and its association to social support and depression varied for different relationships and these differences have implications for mental health and coping interventions by (Seth C. Kalichman; Michael DiMarco; James Austin; Webster Luke, 2003).

Schrimshaw E.W. and Siegel K. (2003) examined the HIV-infected adults age 50 and older are more socially isolated than younger HIV-infected individuals. This study examines the perceived barriers to obtaining emotional and practical social support from friends and family among 63 older adults (age 50+) living with HIV/AIDS. Many reported they did not receive enough emotional support (42%) or practical assistance (27%). Barriers to obtaining support included: (1) nondisclosure of HIV status; (2) others’ fear of HIV/AIDS; (3) desire to be self-reliant and independent; (4) not wanting to be a burden; (5) unavailability of family; (6) death of friends to AIDS; and (7) ageism. These barriers may explain the greater social isolation of HIV-infected older adults and inform interventions targeted at reducing these barriers.

Biswa Urmi Nanda (2011) studied the effect of positive thought induction through hypnotherapeutical strategies, e.g., package of relaxation, guided imagery, positive suggestions, etc., on the coping strategies, clinical and immune parameters of disease progression in people with HIV/AIDS.
Data were collected from 20 adults HIV positive patients having CD4 count above 250 and plasma viral load less than 5000, screened from a large group of HIV +ve patients who had volunteered for the study. A repeated measure design of research was used. Results of post and follow-up tests indicated that positive thought induction through hypnotherapy had yielded significant positive changes in several dimension of coping strategies (e.g., active coping, alcohol/drug abuse, denial, planning, reinterpretation and growth). Similarly, it led to significant increase in different Immunological parameters (e.g., % of CD4 count, absolute CD4 count, absolute CD8 count, proportion of CD4 to CD8 count, and absolute CD3 count). These results suggest the effective use of hypnotherapy as an adjunct therapy to arrest disease progression and improve quality of life of PLWHA. In addition, the result highlights the effect of positive thoughts in strengthening positive coping strategies and improving immune competence in PLWHA.

The study by Seidl, Eliane Maria Fleury; Tróccoli, Bartholomeu T. (2006) investigated the factorial structure and the psychometric properties of The Social Support Scale for People with HIV/Aids based on items from a Canadian scale for evaluation of the social support for people living with HIV/AIDS, on initiatives of Brazilian researchers and on the revision of the literature about the social support construct. The validation sample was composed of 241 HIV positive individuals (66.8% males), with ages between 20 and 64 years old (M =37.4 years). The exploratory factorial analysis using
the principal axis extraction method and oblique rotation revealed two first order factors: emotional social support (12 items, $a=0.92$) and instrumental social support (12 items, $a=0.84$). A second order factor was also identified with all 24 original items, with good psychometric indicators ($a=0.87$). The factorial structure found corresponded to what is expected from an instrument aimed at measuring the major social support dimensions of people who are HIV positive.

Karolynn Siegel and Victorua H. Raveis (1997) investigated the psychological impact of the perceived availability of illness-related support and negative illness-related network interactions in a sample of men from these populations. The sample was comprised of 144 HIV-infected non-Hispanic white, African American, and Puerto Rican men living in the New York City metropolitan area. Analyses found evidence of a conjoint (interactive) effect between perceived support and negative network interactions. There was no evidence of either perceived availability of illness-related network support buffering or negative illness-related network interactions amplifying the effect of HIV/AIDS related physical symptomatology on depressive symptomatology.

3.2 Death Anxiety:

Diala, Chamberlain C., Muntaner and Carles (2003) estimated the correlates of mood and anxiety disorders among rural, urban and metropolitan residents in the United States. They analyzed the National Co-morbidity Survey (NCS), which yields the distribution and correlates of
psychiatric disorders in a probability sample (8, 098 males and females aged 15-54 yrs., ethnicity noted) of U.S. population using DSM-II –R for diagnosis. Logistic regressions of mood and anxiety disorders were stratified by geographical area. They found gender differences in mood disorders among urban and metropolitan but not among rural residents. Rural and urban African Americans were less likely to report mood disorders compared to rural and urban whites. Similarly, they found gender differences in anxiety disorders among urban and metropolitan, but not among rural residents. Rural men reported more mood and anxiety disorders than urban men, thus erasing expected rural gender differences in these disorders. Rural male mood and anxiety disorders may be a function of diminishing resources (steady, high paying jobs) or increasing financial strain particularly among whites, who comprise a majority of rural residents.

Wolf, Thomas M., Scurria, Philip L., Webster, Michael G. (1998) examined the anxiety, depression, loneliness, social support, and perceived mistreatment at 4 time points over the course of 4 yrs of undergraduate medical education. Representative samples of medical students completed a battery of questionnaires at freshman orientation, and at the end of each year up to and including the fourth year. Depression and anxiety were found to be highest at the end of the first year and lowest at the end of the fourth year. Perceived mistreatment, particularly of a psychological nature, was pervasive over the course of the 4 years. Perceived mistreatment was significantly positively correlated with depression and anxiety at the
Mehta, Kala and others (2003) studied the prevalence and correlates of anxiety symptoms in the absence of depression in the elderly. 3,041 participants (aged 70-79 yrs) of the Health Aging and Body Composition study were asked about the 3 major anxiety symptoms of feeling fearful, feeling tense and keyed-up, and feeling shaky and nervous. Results show that anxiety symptoms occurred in 15% of Ss without depression and 43% of those with depression. Of no depressed Ss, females were more likely to have anxiety symptoms than were males, especially white females. After multivariate adjustment, the chronic conditions of urinary incontinence, hearing impairment, hypertension, and poor sleep were associated with a higher prevalence of anxiety symptoms. Ss with poorer psychosocial functioning, low personal mastery, and the need for more emotional support also had higher rates of anxiety symptoms. It is concluded that anxiety symptoms are common in both depressed and non depressed older individual.

Shankman, Stewart A., Klein, and Daniel N. (2003) epidemiological studies have consistently reported that depressive and anxiety disorders co-occur frequently. This paper reviews the evidence for three models that have been proposed to explain the relation between these two conditions the tripartite, the approach-withdrawal, and valence-arousal models. Specially, we focus on predictions that the three models generate for cross-sectional
studies, prospective and family/twin studies of personality, and EEG studies. In sum, no model was strongly supported across all types of studies, though specific aspects of each model were. Because of the heterogeneity of depression and anxiety disorders, a model with 2-4 factors or dimensions may not be sufficient to explain, the relation between the two conditions.

Angst, Jules, Merikangas and Kathleen Ries (1998) examined the relevance of the diagnostic category of mixed anxiety depression (MAD) in a longitudinal community study of young adult in Zurich, Switzerland. The prevalence of MAD was similar to that of threshold level co morbid anxiety and depression; 2.5% of the sample met criteria for concomitant manifestation of sub threshold anxiety and depression over 5 interviews covering 15 yrs. Evaluation of the validity of MAD with respect to a series of clinical indicators including family history, level of work impairment, age at onset and duration of episodes provided some support for the validity of this diagnostics category. The high magnitude of treatment among the Ss with MAD in the current study suggests that MAD may be particularly relevant in treatment studies. However, to adequately address its relevance and validity further, particularly in community settings, development of specific diagnostic criteria is criteria to enhance the comparability of specific diagnostic criteria is criteria to enhance the comparability of studies with MAD both in clinical settings and in the community.

Wang and Caikang (2002) explored the relationship between emotional intelligence and anxiety, depression and mood in college students.
438 college students from 3 universities in Guangzhou, China, were assessed with the emotional intelligence scale, the self-rating anxiety scale, the self-rating depression scale and the positive affect and negative affect scale (PANAS). The results show the college students EIS scores were negatively correlated with their anxiety level and depression level, the college students EIS scores were positively correlated with their positive affect scores of the PANAS, whereas negatively correlated with their negative affect scores of the PANAS. The study concludes that emotional intelligence plays an important role in college student’s mental health.

Jayashree H. and Chengti S. (2012) examined the Stress, anxiety and mental health of sample selected randomly from various colleges of Raichur (N=360). The students sample was administrated with Stress scale, mental health inventory and anxiety scale. Stress and anxiety are independent and mental health is dependent variable. The data collected were subjected to t-test. The results showed that stress and anxiety have produced significant differences in mental health. It is also observed that there is significant gender difference in mental health of the student sample.

Kirkcaldy, B. and Sifen, G. (1998) studied the depression, anxiety and self mage among children and adolescent’s subjects were administered questionnaires that measured self-image, depression, trait anxiety, and parental and educational attitudes. Trait anxiety was the most potent predictor or trait depression, together with emotionality, low self-confidence, inferior family relationships, mental ill health and impulsivity.
Adolescent scoring high on the depression scale differed in their attitudes toward parents, siblings and school. They were more likely to complain about their relationship to their parents (low family involvement and cohesiveness), and to display low achievement motivation and obedience. Although a main effect was found for anxiety (highly anxious Ss were likely to be more depressed) and externality (externals are more susceptible to depression than internals), a significant anxiety by externality interaction term was found: it was the combination of low self-confidence or externality and trait anxiety which seems to determine trait depression.

Downey (1984) investigated the association between religiosity and death anxiety indicated that experience of death or amount of contact the subjects had with death was not related to death anxiety. The study did not support the hypothesis that those subjects who were less religious would exhibit higher scores on death anxiety than would those subjects who were more religious.

Templer (1971) examined the correlation between depression, death anxiety and health of a population of elderly. The findings revealed a positive relationship between depression and death anxiety but health status and death anxiety were not found to be related.

Mahabeer and Bhan (1984) examined the influence of age, sex and religion on death anxiety and the relationship between death anxiety and religiously. Equal number of male and female subjects were included in each
age and religious group. Results showed that Muslim subjects were more
death anxious than Christian or Hindus subjects. The degree of commitment
to religious practices and beliefs did not intensify or reduce death anxiety.
Female subjects in all groups manifested higher death anxiety than male
subjects. The effect of age was not significant.

Hyams et al. (1982) investigated the relationship between locus of
control and death anxiety and results indicated a significant relationship
between external locus of control and concern about death. No sex
differences were found for death anxiety.

Schumaker (1988) examined the death anxiety in Malaysian and
Australian University students. Australian subjects had significantly higher
death anxiety scores than Malaysian subjects and in contradiction to the
findings of Hyams et al. (1982) females had significantly higher death
anxiety scores than males in both the samples. Findings were explained in
terms of factors in eastern cultures that more effectively control fear of
death. It was contended that women might be evaluating death emotionally,
whereas men might be doing so cognitively. Khalek and Omar (1988) too,
have reported that women had higher mean scores than men on death and
trait anxiety but they were similar in state anxiety. The mean death anxiety
score for Kuwaitians was very close to that of Egyptians. There was similarly
in death anxiety between Kuwaitian and United States men, but not women.
Significant differences appeared on trait anxiety, showing the order from
low to high mean scores: United States, Kuwaitian and Egyptian university
students. Correlations among the scales were significant. However, the
correlation between state and trait anxiety was higher than that between
death anxiety and both state and trait anxiety for men and women. 
Death anxiety was associated more closely with trait than with state anxiety. 
In another cross-cultural study reported by McMordie et al. (1984) it was 
revealed that women scored higher than men, subjects of different ages 
scored differently and eastern samples scored lower than western samples. 

Miller and Audrey K. (2012) examined the impact of illness-related 
symptoms on DA, and factors that may protect against DA. We conducted a 
systematic review of the empirical literature and meta-analysis to answer 
specific questions concerning correlates of DA in persons with HIV/AIDS 
and important factors that may help explain variability in effect size 
estimates. The meta-analysis included 18 studies (N = 1,757) examining 
DA in adults with HIV/AIDS. Meta-analytic findings indicated a small-to-
medium effect of HIV/AIDS diagnostic status on DA, which was moderated 
by duration since diagnosis and by relation to the advent of highly active by 
antiretroviral therapy. Results also indicated a small effect of illness-related 
symptoms on DA, which was moderated by participant age. Social support 
and intrinsic religiosity were modest protective factors, but results indicated 
that extrinsic religiosity may exacerbate or be exacerbated by DA. 
Finally, results indicated a medium-to-large relation between psychological 
symptoms and DA. The implications of these results and other study 
findings are discussed.
3.3 Psychological Well-being:

Scand J. Caring (2010) examined the association among reduced psychological well-being, anxiety, sleep disturbances and HP by comparing people with HP and general population. A national survey of 12,166 individuals (hypertensive n = 2047; rest of population n = 10,119) was conducted using two-step multiple logistic regression with an odds ratio and a 95% confidence interval. The study was in accordance with Swedish legislation pertaining to ethics. Reduced psychological well-being, anxiety and sleep disturbance were higher in the HP group and, in addition, reduced psychological well-being was, still higher in the presence of severe anxiety and serious sleep disturbances. These three factors are of major importance for HP, but it is difficult to know whether they are causes or consequences. In order to prevent HP, support for people who exhibit such risk factors should be a matter of high priority.

The study by Vishwakarma Harshita and Chengti S. (2010) examined the influence of stress on psychological well-being of the hypertensive patients and normal. The study consists of 200 samples out of the 100 were normal and 100 were hypertensive patients. Attempt was made to examine the influence of stress on psychological well-being in normal and hypertensive patients. The sample of 100 was chronic hypertension with >140/90 Hg mm (clinically measured) and 100 normal sample, on psychological well-being scale and Stress inventory were administered.
It was hypothesized that there would be significant influence of stress on psychological well-being in normal and hypertensive patients.

Ruuskanen and Ruopilla (1995) investigated the relationships between physical activity and psychological well-being can be interpreted as reciprocal, physical activity may have positive effects on psychological well-being. Whatever the causal duration of the relationship, it is obvious that health and functional abilities affect daily living and activity levels of elderly people. These findings indicate that physical exercise may have a significant role and meaning for elderly individuals, when performed in the course of their everyday life situations.

Simonsen et al. (2000) conducted the study on gender role conflict and psychological well-being among gay men. Results revealed that the gay men with less gender role conflict has more positive view of seeking psychological help and reported fewer symptoms of anger, anxiety, and depression.

Chengti et al. (1997) in their study administered the modernity scale and psychological well-being scale on the student sample (N=100) to find out the relationship between two variables. Their findings clearly indicated the fact that as the level of modernity increases i.e., as the individuals develop high aspirations, internal locus of control, openness to change, Scientific temperament, work culture and also the favorable attitudes towards women equality, sense of nutrition and diet etc., the level of
psychological well-being i.e., feelings of worth about one’s own life also increases. They have found significant positive correlation between modernity and psychological well-being.

The study by Raff, Carol D. (1989) examined the psychological well-being have little theoretical grounding, despite an extensive literature on the contours of positive functioning. Aspects of well-being derived from this literature (i.e., self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth) were operationalized. Three hundred and twenty-one men and women, divided among young, middle-aged, and older adults, rated themselves on these measures along with six instruments prominent in earlier studies (i.e., affect balance, life satisfaction, self-esteem, morale, locus of control, depression). Results revealed that positive relations with others, autonomy, purpose in life, and personal growth were not strongly tied to prior assessment indexes, thereby supporting the claim that key aspects of positive functioning have not been represented in the empirical arena. Furthermore, age profiles revealed a more differentiated pattern of well-being than is evident in prior research.

Bryce et al. (2003) studied the psychological well-being of male and female office workers and examined how eight aspects of the work situation were associated with psychological well-being measured on several dimensions. The results of multiple regression analysis have indicated similarities and difference in the association of principal environmental
influences with well-being in males and females. In the male sample, control work was significantly associated with all dimensions of work-related mental health; but in the female sample, it was not associated with any dimension of mental health.

Jesus Ramirez-Valles et al. (2005) examined the community involvement may buffer or may compensate the adverse effects of stigma on psychological well-being. In this article, the authors explore this thesis in a stigmatized and seldom studied group of HIV positive Latino gay men. Specifically, they examine the effects of community involvement in AIDS and gay related organizations (e.g., volunteerism and activism) and experienced homosexual stigma on three psychological well-being indicators (i.e., self-esteem, depression, and activism) and experienced homosexual stigma on three psychological well-being indicators (i.e., self-esteem, depression, and loneliness). The cross-sectional sample includes 155 HIV positive men living in New York City and Washington, DC. Results suggest that experienced stigma attributed to homosexuality is associated with psychological well-being. Community involvement, however, seems to compensate the association between stigma and depression and loneliness, while buffering the association with self-esteem. Furthermore, community involvement appears to also heighten the perception of stigma.

Rammohan A. et al. (2002) examined the use of religious coping and it relation to psychological well-being in careers of relatives with schizophrenia. Finding indicates that coping strategies of denial and
problem solving, strength of religious belief and perceived burden were significant predictors of well-being. Strength of religious belief plays an important role in helping family members to cope with the stress of caring for a mentally ill relative. In addition to psycho-education and problem solving coping, the role of religious coping well-being of careers needs to be considered in family intervention programmes.

Braces et al. (1999) examined the relationship between religious commitment, spiritual well-being and psychological well-being. The purpose of the study was to identify the relationship between religious commitment spiritual well-being and psychological well-being in college students. A statistically, significant relationship was found between religious/spiritual well-being and psychological well-being. First, participants who experience existential well-being tend to be self-accepting and to a lesser extent have mastery of their environment and a purpose in life. Second, participants who experience existential well-being and a lesser degree, religious well-being tend to accept themselves, have a purpose in life, possess mastery of their environment, positively towards others, feel they are growing personally, and are autonyms. This study provided evidence of a relationship between religious/spiritual well-being and psychological well-being.

Shelly M. C. van der Veek et al. (2007) explored the relationship between cognitive coping, goal disturbance and psychological distress in HIV infected persons. A sample of 43 HIV positive persons completed
questionnaires that assess cognitive coping, goal frustration, depressive symptoms and quality of life. Goal frustration and, to a lesser extent, the cognitive coping strategy ‘positive reappraisal’ were related to psychological distress. Intervention programmes might usefully implement the topics of goal disturbance and positive reappraisal.

Maltby John, Lewis Christopher Alan; Day, Liza, (1999) examined the role of religious acts between measures of religious orientation and psychological well-being, and examines the theoretical view that religion can act as a coping mechanism. Though a number of significant correlations were found between measures of religiosity and psychological well-being, a multiple regression analysis using identifiable religious components suggests that frequency of personal prayer is the dominant factor in the relationship between religiosity and psychological well-being. The results suggest two points; (1) that the correlations between a number of measures of religiosity and psychological well-being may be mediated by the relationship between frequency of personal prayer and psychological well-being; (2) that personal prayer may be an important variable to consider within the theory of religious coping.

Srivastava Sweta and Arvind K. Sinha (2005) investigated the relationship of resilience, happiness, and self-esteem with well-being explored, using a sample of undergraduate students (N=30) from a premier technological institute located in north India. Results showed that resilience and happiness were positive related to well-being. Happiness had positive
association with resilience, but negative association with self-esteem. Self-esteem was negatively associated with resilience, and well-being. Experiential learning in a T-group type intervention seemed to cause an increase in the average magnitude of all core variables except self-esteem, which suffered a setback, as evidenced through data obtained at a second time-point. Results are discussed toward the importance of resilience, happiness, and experiential learning for increased well-being.

Lucas, Richard E.; Gohm, Carol (2000) investigated the effects of age and sex on subjective well-being (SWB) across cultures using 2 large international samples. The current chapter analyzes data from the World Values Survey II, which includes approximately 57,000 respondents from 41 nations and International College Students from 39 nations around the world. Results indicate that on several measures of well-being, women showed a slight tendency to experience greater unpleasant affect than men. This sex difference was found both in measures of frequency and intensity of unpleasant affect and it tended to increase among older. When individual emotions were examined, sex differences were largest in the internally focused emotions of fear and sadness. Women did report experiencing more anger than men, but the difference was not as large as it was for fear and sadness. Age had no effect on life satisfaction. Pleasant affect decreased steadily throughout the life-span and unpleasant affect showed a curvilinear relation with age, decreasing at first and then increasing among the elderly.
The literature on psychological well-being reveals a number of conceptual and methodological issues such as multiple definitions, non-theoretically based measures and neglect to study this concept in Muslim Arals cultures. Therefore, a study in this regard aims to provide base-line data on psychological health and well-being in a community sample of Bahraini adults and to examine moderating effects of positive between negative life events life events and depression. A survey method, using self administered questionnaires, was used in this descriptive co relational study and found these variables to be highly associated by (Mosalum, Lulwa D. Jassim, 1999).

Hao-Lingxin, Johnson, Richard W. (2000) examined the religious culture factors can enhance emotional well-being. Religious attention and participation are important for both immigrant and native’s sample, but religious participation appears to be more beneficial for immigrants. The effects of several determinants of emotional health differed across immigrant groups. It was found that marriage education and the presence of economically stable are particularly important for the sample of natives.

Catz et al. (2002) conducted a study on the psychological distress among minority and low-income women living with HIV. Greater anxiety and depression symptoms were associated with women who reported higher stress, using fewer active coping strategies and perceiving less social support.
Gil et al. (1998) studied the psychological adjustment and suicidal ideation in patients with AIDS. The study examined the relationship between adjustment and psychological and medical variables in 91 HIV infected patients. In patients with a diagnosis of AIDS, the number of psychological symptoms and the satisfaction with the social support received were clear predicates of poor medical adjustment.

Hackman et al. (2002) conducted a study on psychological symptoms among 50 years of age and older patients living with HIV disease. 25% of respondents reported moderate or severe levels of depression. A hierarchical multiple regression analysis revealed that HIV infected older adults who endorsed more psychological symptoms also reported more HIV related life stressor burden less support from friends and reduced access to health care and social services due to AIDS related stigma.

Wu Z., Zhang J., et al. (1997) assessed that the knowledge and risk perception of HIV and AIDS among young males aged 18 to 29 years in 82 to 29 years in 82 villages in Longchuan, Yunnan, China, in 1994. Information on demographic, behavioral, and drug-using factors, and knowledge of HIV transmission and prevention, and risk perception was collected using an interviewer-administered anonymous questionnaire. A total of 1,548 individuals were interviewed and 433 drug users, including 52 no sharing injectors and 140 sharing injectors, were identified. Over half the individuals scored 0 on HIV knowledge, but knowledge was greater among non sharing drug injectors. Most drug injectors had initiated drug injection after 1990.
The reported incidence continues to increase in all three major ethnic
groups. Sharing of equipment was common (73%) among injectors. Drug
users were four times more likely to have had premarital or extravamartial sex, but condoms were used only 2.5%. Thus, factors promoting spreading of HIV are common in this area. We recommend that a community-based intervention program, targeting both young men and women, be implemented and evaluated in Longchuan as soon as possible.

Hayasi and Fukunishi (1997) examined the kinds of social support are related to mood states in a sample of 50 HIV positive patients without AIDS. In the early stages of HIV infection, HIV +ve patients without AIDS may be prone to depressive symptoms. The depressive symptoms were not significantly related to lack of ordinary social support such as friends and family but were significantly associated with dissatisfaction with HIV/AIDS related medical support.

McCrough (1990) conducted a study on assessing social support of people with AIDS. Result indicates that social support has a direct effect on health, buffers the effect of physical and emotional stress and mediates immune dysfunction. Although nurses frequently incorporate social support needs during patient’s assessment, it may not be specific or systematic. Assessment of social support for the person with AIDS is important because of the devastating psychological consequences of the disease.
The literature reviewed so far indicates that the gender specific studies and studies highlighting the health problems of women HIV/AIDS patients are scarce; therefore the present study was conducted. The present study was conducted.

Pozzi et al. (1999) examined the psychological discomfort and mental illness in patients with AIDS. It was found that female patients showed an increased prevalence of anxiety and depressive disorders.

The study by Thokozani Kanyerere and Asbjorn Aase (2005) examined the reasons why the TB suspects delay or are unwilling to go for hospital diagnosis and thus for effective treatment. A comparative study was undertaken in Zomba and Mangochi Districts in Southern Malawi using methodological pluralism during data collection and analysis. Results show that the main reasons for hospital delay were: TB stigma due to HIV/AIDS prevalence, lack of TB knowledge, geographical factors (climate, accessibility, occupations, and culture), and use of traditional healers to treat TB. Zomba people delayed more despite having higher educational levels than those in Mangochi. Gender and marital status had a significant impact in delaying TB suspects in Mangochi but not in Zomba. The study concludes that differences between places and socio-cultural groups need to be considered in studies of diseases such as the TB/HIV epidemic and taken into account for intervention to be effective. Furthermore, close collaboration between TB/HIV experts and traditional healers is recommended.
Surveys the literature on social support and cancer and reports results from an empirical investigation of the factors that led cancer patients to join social support groups. Questionnaire data from 21-89 year old cancer patients show that although most social support reviewed high level of social support following cancer, some experienced isolated instances of rejection or did not receive the type of support they wanted from family, friends, and medical caregivers. This appeared to be an impetus for joining cancer support groups, although social support reporting a lack of social support was not generally more likely to join support groups than were other social support. The profile of mood states suggested that attainders were somewhat less likely to be depressed than were non-attainders. In addition, cancer support group attainders were more likely to be white middle-class females, to report having more problems, and to use social support resources of all kinds than were non-attainders. Implications for outreach to cancer patients are discussed and it is concluded that while support groups may be beneficial for many cancer patients, current programmes tend to be used largely by the same segment of the population that uses traditional mental health by (Taylor and et al., 1986).

The incidence of Tuberculosis is currently increasing in HIV infected patients living Africa and Asia, where TB endemicity is high, reflecting the susceptibility of the group of patients to mycobacterium belonging to the TB group. In this population, extension of multiple resistance to anti-tuberculosis drugs is also a matter of anxiety. HIV induced immune
suppression modifies the clinical presentation of TB, resulting in typical signs and symptoms, and more frequent extra pulmonary dissemination. Finally, immune restoration induced by HAART in developed countries may be responsible for a paradoxical worsening of TB manifestations by (L. Aaron and et al., 2004).

Vega P. et al. (2004) investigated the Psychiatric issues present a challenge in the treatment of patients with multidrug-resistant tuberculosis (MDR-TB). Both baseline psychiatric disorders and development of psychiatric complications related to anti-tuberculosis drugs and psychosocial factors require aggressive management.

To review the literature for psychiatric complications associated with anti-tuberculosis medications, to describe the incidence and prevalence of depression, anxiety and psychosis among individuals receiving MDR-TB therapy, and to detail the management approach used in this cohort.

A retrospective case series was performed among the first 75 patients to receive individualized MDR-TB therapy in Lima, Peru, between 1996 and 1999.

Baseline depression and baseline anxiety were observed in respectively 52.2% and 8.7% of this cohort. Most individuals with baseline depression experienced improvement of depressive symptoms during the course of TB therapy. The incidence of depression, anxiety and psychosis during MDR-TB treatment was 13.3%, 12.0% and 12.0%, respectively. While the majority of individuals with depression, anxiety and psychosis
required psychiatric pharmacotherapy, cycloserine was successfully continued in all but one case. Psychiatric co morbidities are not a contraindication to MDR-TB therapy. Management of psychiatric complications is possible without compromising anti-tuberculosis treatment.

HIV/AIDS pandemic has caused a resurgence of TB, resulting in increased morbidity and mortality worldwide. HIV and *Mycobacterium tuberculosis* have a synergistic interaction; each accentuates progression of the others. Clinical presentation of TB in early HIV infection resembles that observed in persons. In late HIV infection, however, TB is often atypical in presentation, frequently causing extra pulmonary disease. These factors coupled with low sputum smear-positively, often result in a delayed diagnosis. HIV infected patients respond well to the standard 6 month anti tuberculosis treatment regimens, although mortality is high anti tuberculosis treatment is complicated by frequent drug-interactions with, high active antiretroviral therapy (HAART) and adverse drug reactions are more common among HIV infected patients. Guidelines for the management of patients co-infected with HIV and TB are still evolving. Timely institution of anti-tuberculosis treatment using the directly observed treatment, short-course (DOTS) strategy and HAART markedly improves the outcome of HIV – infected patients with TB (Sharma S.K., 2005).

Williams, G. (2008) examined the Human Immunodeficiency Virus (HIV) infection poses one of the greatest challenges to tuberculosis (TB) control. With tuberculosis killing more people with HIV infection than any
other condition. The standards in chapter cover provider-initiated HIV counseling and testing and the care of HIV infected patients with tuberculosis. All tuberculosis patients who have not previously been diagnosed with HIV infection should be encouraged to have an HIV test. Failing to do so is to deny people access to the care and treatment they might need, especially in the context of the wider availability of treatments that prevent infections associated with HIV. A clearly defined plan of care for those found to be co-infected with tuberculosis and HIV should be in place, with procedures to ensures that the patients has access to this care before offering routine testing for HIV in persons with tuberculosis. It is acknowledged that people caring for TB patients should ensure that those who are HIV positive are transferred for the appropriate ongoing care once their tuberculosis treatment has been completed. In some cases, referral for specialized HIV-related treatment and care may be necessary during treatment for tuberculosis. The aim of these standards is to enable patients to remain as healthy as possible whatever their HIV status.

Human Immune deficiency virus acquired immune deficiency syndrome HIV/AIDS and TB are overlapping epidemics that causes an immense burden of disease in Sub-Sharana Africa. This region is home to the majority of the world’s co-infected patients, who have higher Tuberculosis case fatality and recurrence rates than patients with TB alone. A world health organization interim policy has been developed to reduce the joint burden of TB-HIV Disease, an important component of which is provision of
HIV care to co-infected patients. This review focuses on HIV testing of TB patients and, for those who are HIV positive, the administration of adjunctive Cotrimoxazole Preventive Treatment (CPT) and antiretroviral treatment (ART). HIV testing has moved from a voluntary, client initiated intervention to one that is provider-initiated and a routine part of the diagnostic work up. The efficacy and safety of CPT in HIV infected patients is now well established, and this is an essential part of the package of HIV care. ART scale-up in Africa can substantially improve outcomes in co-infected patients. However, the clinical and programmatic challenges of combining ART with anti-tuberculosis is treatment need to be resolved to realize the full potential of this benefit. These include the optimal time to start ART, how best to combine rifampicin- containing regimens with first-line and second line ART regimens, management of immune reconstitution disease, the role of ionized preventive treatment with ART after TB treatment completion, and where and how to provide combined treatment to best suit patients. Clinical and operational studies in the next few years should help to resolve some of these issues (Harries, A.D. et al.).

Padmapriyadarsini et al. (2011) examined the HIV associated tuberculosis (TB) remains a major global public health challenge, with an estimated 1.4 million patients worldwide, co-infection with HIV leads to challenges in both the diagnosis and treatment of tuberculosis. Further, there has been an increase in rates of drug resistant tuberculosis, including multi-drug (MDR-TB) and extensively drug resistant TB (XDR-TB), which are
difficult to treat and contribute to increased mortality. Because of the poor performance of sputum smear microscopy in HIV infected patients, never diagnostic tests are urgently required that are not only sensitive and specific but easy to use in remote and resource-contained settings. The treatment of co-infected patients requires anti tuberculosis and antiretroviral drugs to be administered concomitantly; challenges include pill burden and patient compliance, drug interactions, overlapping toxic effects, and immune reconstitutions inflammatory syndrome. Also important questions about the duration and schedule of anti-tuberculosis regimens and timing of ARV remain unanswered. From a programmatic point of view screening of all HIV infected persons for TB and vice-versa requires good co-ordination and communication between the TB and AIDS controlled programmes. Linkage of co-infected patients to antiretroviral treatment centers is critical if early mortality is to be prevented, we present here an overview of existing diagnostic strategies, new tests in pipeline and recommendation for treatment of patients with HIV-TB dual infection.

Ryan McBride (2007) examined the Tuberculosis is the leading cause of death in people infected with HIV, yet the existing vaccine for TB is not safe for those patients. A Rhode Island biotechnology firm aims to solve the problem with federal support. The National Institutes of Health has awarded Providence, R. I. based Epi Vax Inc. $590,912 grant to develop a TB vaccine that works in HIV-positive tuberculosis patients. The two-year grant renews the firm’s eight-year effort to make the vaccine, according to
company CEO Anne De Groot, who began to apply for federal dollars to support further study of her firm’s TB vaccine in 2003. “I think it has everything to do with the limitation on NIH funding for important diseases like this”, said De Groot.

Anja Schumann, Adeline Nyamathi and Judith A. Stein (2007) the study evaluated a six-month nurse case-managed intervention against a standard care control program among 295 sheltered homeless adults from Los Angeles, USA. The primary aim of the intervention was encouraging latent tuberculosis infection treatment completion. The secondary aim was reducing HIV risk, the focus of this report. A longitudinal path model revealed that the intervention impacted cognitive factors of AIDS Knowledge, Perceived AIDS Risk and Self-efficacy for Condom Use, but did not impact substance use and risky sexual behaviours. The dual intervention program for HIV and TB provided promising synergistic effects by targeting risk factors common to both infections.

Gesham Magombedze et al. (2010) investigated the Modeling the interaction of Tuberculosis (TB) and AIDS (HIV) drugs in the treatment of the TB/HIV co-infection shows that the treatment of Mtb (Mycobacterium tuberculosis) and AIDS improves. The administration of HIV drugs without TB drugs during co-infection favors the treatment of HIV, but the patient will eventually die of the Mtb opportunistic infection. Reducing the interaction of TB and HIV drugs and increasing the performance (efficiency of inhibition) of Reverse Transcripts Inhibitors (RTIs) in CD4+ T cell
improves the treatment of HIV and leads to the preferential replication of HIV particles in macrophages. The simultaneous administration of TB and HIV drugs is to be recommended for it prevents patients from dying of the Mtb opportunistic infection.

Thokozani Kanyerere; Asbjorn Asse (2005) examined the reasons why the TB suspects delay or are unwilling to go for hospital diagnosis and thus for effective treatment. A comparative study was undertaken in Zomba and Mangochi Districts in Southern Malawi using methodological pluralism during data collection and analysis. Results show that the main reasons for hospital delay were: TB stigma due to HIV/AIDS prevalence, lack of TB knowledge, geographical factors (climate, accessibility, occupations, and culture), and use of traditional healers to treat TB. Zomba people delayed more despite having higher education’s levels than those in Mangochi. Gender and marital status had a significant impact in delaying TB suspects in Mangochi but not in Zomba. The study concludes that differences between places and social-cultural groups need to be considered in studies of diseases such as the TB/HIV epidemic and taken into account for intervention to be effective. Furthermore, close collaboration between TB/HIV experts and traditional healers is recommended.

Richard J. Koehler (1994) studied the substantial percentage of New York city inmates surveyed has tested positive for HIV. Tuberculosis infection can be a death sentence for people who are immune-compromised by HIV. Jails are an ideal setting for the spread of both tuberculosis disease
and HIV. The author argues that new policy initiatives are necessary to reduce the danger of exposure to TB by HIV infected inmates. These initiatives should be pursued because they make sense both medically and fiscally. The author also argues that if such initiatives are not taken voluntarily, more costly policy changes will be forced by the courts.

Sandrine Simon et al. (2009) attempted to explore HIV/AIDS has led to a revival in community health workers to help alleviate the health human resource crisis in sub-Saharan Africa. Community health workers have been employed in Mozambique since the 1970s, performing disparate and fragmented activities, with mixed results. A participant-observer description of the evolution of community health worker support to the health services in Angonia district, Mozambique. Results an integrated community health team approach, established jointly by the Ministry of Health and Medicines Sans Frontiers in 2007, has improved accountability, relevance, and geographical access for basic health services. The community health team has several advantages over ‘disease-specific’ community health worker approaches in terms of accountability, acceptability, and expanded access to care.