

Psycho-Social Problems of TB Patients: A Social Work Intervention

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Abstract: Tuberculosis (TB) remains a major global health problem, responsible for ill health among millions of people each year. TB ranks as the second leading cause of death from an infectious disease worldwide, after the human immunodeficiency virus (HIV). The latest estimates included in this report are that there were 9.0 million new TB cases in 2013 and 1.5 million TB deaths (1.1 million among HIV-negative people and 0.4 million among HIV-positive people).

Objectives: This paper will quest on psycho-social problems of Tb patients in the light of social work intervention.

Keywords: TB, psycho-social.

I. Introduction

Tuberculosis (TB) is caused by a bacterium called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal.

Tuberculosis: Global & Indian scenario:

An estimated 1.1 million (13%) of the 8.6 million people who developed TB in 2012 were HIV-positive. About 75% of these cases were in the African Region. Globally in 2012, an estimated 450 000 people developed MDR-TB and there were an estimated 170 000 deaths from MDR-TB. Most TB cases and deaths occur among men, but TB remains among the top three killers of women worldwide. There were an estimated 410 000 TB deaths among women in 2012, including 160 000 among HIV-positive women. Half of the HIV-positive people who died from TB in 2012 were women. Of the estimated 8.6 million new TB cases worldwide in 2012, 2.9 million were women. There were an estimated 530 000 TB cases among children (under 15 years of age) and 74 000 TB deaths (among HIV-negative children) in 2012 (6% and 8% of the global totals, respectively). The majority of cases worldwide in 2012 were in the South-East Asia (29%), African (27%) and Western Pacific (19%) regions. India and China alone accounted for 26% and 12% of total cases, respectively. The TB incidence rate at country level ranges substantially, with around 1000 or more cases per 100 000 people in South Africa and Swaziland, and fewer than 10 per 100 000 population in parts of the Americas, several countries in Western Europe, Japan, Australia and New Zealand. (WHO executive Summary Report 2013).

Psychosocial problems:

The term 'psychosocial' is also quite widely used in the literature in connection with health outcome. The roots of 'psychosocial health' lie in the World Health Organization's (WHO) definition of health as 'a state of complete physical mental and social well-being and not merely the absence of disease and infirmity'. This WHO definition of health has been criticized on several grounds, but for us its main danger is one of confusing cause and effect. From an explanatory point of view the concept of 'psychosocial health', in some cases, may combine traditional medical definitions of disease and infirmity with measures that reflect individual responses to disease and even in some cases indicators of the social context itself. Such measures have merit in recognizing individuals' experiences and quality of life, a dimension that is becoming increasingly recognized for example, in clinical trials. But researchers using health outcomes based on such definitions need to guard carefully against circular arguments. (pekka Marttainen ,et al.2002).

Psychosocial problems & TB:

Causation of communicable disease like Tuberculosis cannot be explained on a purely bacteriological basis, because such an explanation ignores the fact that the disease process in man depends on the characteristics of disease agents (germs), the characteristics of man and his environment. It is often state that tuberculosis is a disease caused by the activities of tiny rod-shaped germs, i.e. tubercle bacilli. But every seed requires proper soil for its growth and tuberculosis, germs represent one of the environmental, and social factors

together with personal factors in the individual patient from the soil for the seed, i.e. tubercle bacillus. Individuals with mycobacterium diseases can have a wide variety of symptoms, including fatigue, weight loss, decreased appetite, fever, bloody sputum and cough. In other cases, the illness is diagnosed without any symptoms being present. Each of these situations presents different challenges. For the patient with many symptoms there is often fear and confusion regarding new symptoms. What is wrong with me? Why can't I do the things I usually do? Am I going to be okay? For patients without symptoms, it can be a shock to be told of a serious disease that requires long-term treatment when you feel fine. It may be hard to believe the tests were accurate. Once the diagnosis of mycobacterial disease is made, typical feelings include fear, shock, denial, anger, shame, and guilt. These feelings may come in waves and will gradually subside over time.

II. Literature Review

E. Manoharam et al. (2001) on their study in South India a study conducted on psychiatric Morbidity, Patients' Perspectives of Illness and factors associated with poor medication, and they find that (86.5%) had pulmonary tuberculosis. In all, (17.3%) subjects satisfied the International Classification of Diseases 10 Primary Care Criteria for psychiatric disorders. Depression was the commonest disorder. The majority of subjects knew the name of their disease (87.7%), believed its infectious nature (51.9%), feared incapacitation (21.2%) and death (59.6%), wanted symptomatic relief (40.4%) and were satisfied with their treatment (82.7%).

P. Vega et al. (2004) delved with Psychiatric issues in the management of patients with multidrug-resistant tuberculosis, it was observed, Baseline depression and baseline anxiety were 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.

Baral SC et al. (2007) a study conducted in Nepal to find out Cause of stigma and discrimination associated with TB, and the findings were suggest that Causes of self-discrimination identified included fear of transmitting TB, and avoiding gossip and potential discrimination. Causes of discrimination by members of the general public included: fear of a perceived risk of infection; perceived links between TB and other causes of discrimination, particularly poverty and low caste; perceived links between TB and disreputable behaviour; and perceptions that TB was a divine punishment. Furthermore, some patients felt they were discriminated against by health workers.

Fazlul Karim et al. (2007) on their study in Bangladesh Stigma, Gender, and their Impact in their life of rural Tb patients, outcome revealed that in case of stigma, Female patients emphasized psychosocial and marriage or family related indicators more than men. Women said that they thought less of themselves due to TB, and felt ashamed or embarrassed. Female sex was significantly associated with greater Prominence of the stigma indicators 'shamed or embarrassed.

Anita S. Mathew et al. (2007). Said that in India, patients with TB often experience rejection and social isolation, Because of the lack of knowledge about the disease and fear of being ostracized, persons with TB often hide their symptoms and fail to receive appropriate treatment—a stumbling block in the control of the disease. A common belief is that TB is incurable and that the drugs for treatment of TB can harm the patient. Many fear that TB can cause impotence and sterility. The public is misinformed about the modes of spread of the disease and believe that TB is hereditary or spread in ways similar to those by which AIDS is spread, such as unsafe sex practices. The belief that TB spreads through handshaking and sharing food with an infected person causes patient to keep their condition a secret for fear of being shunned, even by their own family members. Patients with TB are often economic and social outcasts, with poor emotional quality of life, low self-esteem, and clinical depression, which may even lead to suicide. Men affected by the disease, who usually provide the sole financial support for the family, are forced to quit their jobs and, thus, experience extreme debt and poverty. Other patients have a reduced capacity to work and have to take long leaves of absence from work, with the end result being financial burden. Single women often find it difficult to find life partners and are rejected. Married women are abused by their in-laws and deserted by their husbands. A woman abandoned by her husband is often isolated, and for her to have any social relations is considered to be taboo. The stigma has taken a greater toll on women than on men. Many of the patients who start receiving therapy, frequently in secrecy, stop as soon as they start to develop adverse effects, such as orange discoloration of the skin (seen with rifampicin, a first-line drug for TB therapy), which reveals to the community that the patient has TB. Discontinuation of therapy can lead to emergence of multidrug-resistant TB and extensively drug-resistant TB, which are difficult to treat and can be fatal. Owing to the large psychosocial impact of this debilitating disease, the focus should not just be on early detection and symptomatic and microbiological cure, but should also be on providing psychosocial support to patients and their families. Although the importance of research and clinical trials of TB is unquestionable, health education of the masses by community health programs to dispel the myths and stigma surrounding the disease and its treatment cannot be overemphasized in India's progress toward controlling TB— “the captain of all men of death.”

Husain MO et al. (2008) on their studies of relationship between Anxiety, Depression and Illness perception in Tuberculosis patients in Pakistan it was revealed that Out of 108 patients, 50 (46.3%) were depressed and 51 (47.2%) had anxiety. Raised depression and anxiety scores were associated with an increase in the number of symptoms reported, more serious perceived consequences and less control over their illness.

Gemeda Abebe. et al. (2010) find out on their study on Knowledge, Health Seeking Behavior and Perceived Stigma towards Tuberculosis among Tuberculosis Suspects in a Rural Community in Southwest Ethiopia, they find out that High stigma towards TB was reported by male (51.2%) & female (46.2%) who did not seek help for their illness.

Siddiqua Aamir et al. (2010) a study conducted in order to find out Co-Morbid Anxiety and Depression among Pulmonary Tuberculosis Patients in Pakistan & the findings revealed that forty seven out of 65 (72%) TB patients had severe/moderate level of anxiety and depression according to Hospital Anxiety and Depression Scale (HADS). Fourteen (22%) TB patients with co-morbid anxiety and depression showed multi drug-resistance (MDR-TB).

Basu G, et al. (2012) in their study on 'Prevalence of depression in tuberculosis patients: An experience from a DOTS clinic' & they found that 62% patients were depressed, two third of the depressed patients were suffering from mild to moderate depression whereas 5.5% patients were severely depressed. Elderly were most affected. The prevalence of depression is high in TB patients currently on DOTS.

Karl Peltzer et al. (2012) On study of Prevalence of psychological distress and associated factors in tuberculosis patients in public primary care clinics in South Africa and the findings highlighted that overall prevalence of psychological distress (32.9 % and 81 % according to the K-10 score ≥ 28 and K-10 score ≥ 16 , respectively) was found in this large sample of tuberculosis public primary care patients in South Africa.

B Venkatraju et al. (2013) conducted a study in Nalgona District Andhra Pradesh to find out psychosocial Trauma of TB patients & they find out that Six major themes emerged from the analysis of data which were considered to be of major importance in the lives of respondents: worry/depression (37.3%), disbelief/shock (23.6%), embarrassment/shame (16.4%), fear of dying (12.7%), fate/God's act (9%) and relieved that it was just TB (0.9%).

Argiro Pachi et al. (2013) on their studies shown that people infected with TB are more likely to develop mental and psychological problems than people not infected with the disease to be afflicted with pulmonary, tuberculosis is a unique and painful experience in the bio psychosocial history of an individual, and the emergent stress contributes to psychiatric morbidity. Depression, posttraumatic stress disorder (PTSD), and acute stress disorder are the most common stress-related conditions of TB patients. Reactions to the stressful situation brought about by the illness negatively affecting an individual's ability to work, in conjunction with social and respiratory isolation lowered self-esteem, fear of spreading the illness to others, helplessness brought out by incapacitation due to chronic illness, and social stigma attached to this illness, are all plausible causes that one can postulate for depression and anxiety. (Argiro Pachi et al. 2013).

Rameshchandra M Thakker et al. (2014) on their study in Gujarat they found that that significant proportion of patients were found to have adverse psychosocial reaction on informing that they are suffering from TB .Most commonly observed feelings by patients during interview were worry about cure and fear of death embarrassment due to disease misconception of the disease being a social stigma cursing the fate that this was happened to them.

III. Findings & Discussion

It has been seen that in prolong treatment of TB, patients generally developed psychological disorder. Significant proportions of patients were found to have adverse psychosocial reaction on informing that they are suffering from TB (Rameshchandra M Thakker et al. (2014). Six major themes emerged from the analysis of data which were considered to be of major importance in the lives of respondents: worry/depression (37.3%), disbelief/shock (23.6%), embarrassment/shame (16.4%), fear of dying (12.7%), fate/God's act (9%) and relieved that it was just TB (0.9%) (B Venkatraju et al. (2013). Depression is common among TB patients; Depression was the commonest disorder among TB patients (E. Manoharam et al. (2001). Similarly Basu also find out that 62% patients were depressed, two third of the depressed patients were suffering from mild to moderate depression whereas 5.5% patients were severely depressed (Basu G, et al. (2012).

Overall prevalence of psychological distress among Tb patients is 32.9% Karl Peltzer et al. (2012). Depression, posttraumatic stress disorder (PTSD), and acute stress disorder are the most common stress-related conditions of TB patients (Argiro Pachi et al. 2013). It was also observed, Baseline depression and baseline anxiety were respectively 52.2% and 8.7%. The incidence of depression, anxiety and psychosis during MDR-TB treatment was 13.3%, 12.0% and 12.0% respectively (P.Vega et al. (2004). There is also evidence that Depression and anxiety have relation in Tb cases found in Pakistan, raised depression and anxiety scores were associated with an increase in the number of symptoms reported, more serious perceived consequences and less control over their illness 50 (46.3%) were depressed and 51 (47.2%) had anxiety. (Husain MO et al. (2008)).

Forty seven out of 65 (72%) TB patients had severe/moderate level of anxiety and depression (Siddiqua Aamir et al. (2010). So we would say that Depression is higher among Tb cases compare to other psychological Symptoms. In another arena it was also observed that for TB patient's stigma and discrimination still persist in the society, Causes of self-discrimination identified included fear of transmitting TB, and avoiding gossip and potential discrimination. Causes of discrimination by members of the general public included: fear of a perceived risk of infection; perceived links between TB and other causes of discrimination, particularly poverty and low caste; perceived links between TB and disreputable behaviour; and perceptions that TB was a divine punishment. Also some patients felt they were discriminated against by health workers. (Baral SC et al. (2007). Female TB patients were more offenders than man in terms of stigma in Bangladesh. (Fazlul Karim et al. (2007). Interestingly these case were just reverse in Ethiopia, High stigma towards TB was reported by male (51.2%) & female (46.2%), Gemeda Abebe. et al. (2010). Furthermore TB patients in India, often experience rejection and social isolation, (Anita S. Mathew et al. (2007).

From the above Discussion we are able to understand that the researchers discussed various types of mental illness arises due to TB and which are actually provided enough fuel for ignition of psycho-social problems. Also, these reviews help us to acknowledge verities of psycho-social problems of TB patients which are still exist in the society.

But these reviews lacking few arenas which are to be addressed in future studies:

- Social support system (who provides emotional support in time of Crisis).
- Disruption of Family interaction (At What extent family interaction disturbed).
- Disruption of Routine Activities (At what extent TB affects patients and families routine activities).
- Financial Management of TB patients (How funds have been managed for treatment).
- Patients coping strategies (what types of strategy adopted by patients to cope with TB illness).
- Stereotypes behavior of TB patients (patient's stereo types thinking and attitude about TB).

In a nut shell to combat with TB issues is really a hardship for all of us so a proper comprehensive intervention plan has to chalk out from the government and Nongovernmental sector. Some **suggestion** as well as intervention plans are given below:

- Psychosocial support should be specifically included in national guidelines for the management of TB.
- Training on the provision of psychosocial support should be incorporated into the curriculum for all health care providers.
- Guidelines for home care services can be developed and should include the provision of basic psychosocial care by community volunteers and family caregivers.
- Training courses for community volunteers can be organised and provided by health care workers.
- Training in professional disciplines (counselling, psychology, psychiatry) can be made available at the Primary Health centre.
- Strategies for providing psychosocial support can be developed for specific groups (e.g. women, youth, old age people, children, etc.).

Social Work Intervention:

- ❖ Advocacy for psychosocial support and access to basic health services(Using wide publicity propaganda in social media about TB) functioning governance systems, into which psychosocial support needs to be mainstreamed, and the assurance of security in order to reestablish wellbeing and mitigate further psychosocial harm.
- ❖ A smaller percentage of the population, with particularly stressful reactions, will require more focused and specialized support interventions with attention to the individual, family or group (eg. psychosocial first aid by health workers, Medical Social workers).
- ❖ Good channels of communication should be established within the general hospital and with community services with regard to psychiatrics well as physical health.
- ❖ Social worker will work as a bridge between TB patients and Health professionals, She/he will help the doctors in psychological intervention.
- ❖

IV. Conclusion

TB is the deadliest disease in the world. So let's come together to support TB patients in fighting with TB bacillus.

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