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Psychological Struggles Faced by Women in Tuberculosis Affected Family - A Study from Coimbatore District

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Abstract

Tuberculosis (TB) and mental illnesses seriously exceed globally and frequently exist. While poor psychic illness is known to moderate resistant function, whether psychological syndromes play a crucial role in Tuberculosis, the relative occurrence is unknown. Cohesion to Tuberculosis (TB) treatment is the vital cause of poor Tuberculosis outcomes, and initial support or treatment for Tuberculosis patients is vital to governments. On the other hand, there has been trivial study or exploration on the possessions of family, social and national policy supporting factors on Tuberculosis treatment observance. This scoping review aims to outline the most frequent mental issues encountered by Tuberculosis patients and women in Tuberculosis-affected families and assess the mental health effects of Tuberculosis treatment. Results Tuberculosis (TB) ranks as a deadly disease resulting in millions of deaths worldwide. However, the effect of Tuberculosis on the emotional status of patients and women in the family and involvement in improving treatment outcomes is ignored, especially in underdeveloped and developing countries.

Keywords: Tuberculosis, Treatment, Mental Illness, Women, Non-Adherence

Introduction

Tuberculosis (TB), a contagious chronic respiratory disease affected by the Mycobacterium Tuberculosis complex (MTUBERCULOSIS), has affected humans for thousands of years, and it is one of the significant causes of death worldwide. In 2018, there were an assessed 10 million new cases of Tuberculosis and 1.5 million deaths globally. Approximately 1.7 billion people worldwide had diseased with Mycobacterium Tuberculosis, all of whom are at risk of developing Tuberculosis. Mental health disorders affecting people with Tuberculosis include overall emotional distress (which may itself be overwhelming and disabling) and situations that can diagnose according to established classificatory structures ((ICD)International Classification of Disease), for example, depression and anxiety disorders. In common, mental health conditions that cause acute distress and functional and social loss are starred as mental illness (although professional, individual and cultural factors may affect the application of this label). “Addressing the Tuberculosis depression syndemic to end the Tuberculosis epidemic” by Sweetland AC et al. described as Mental health conditions can act as a risk factor for Tuberculosis.

Tuberculosis patients act as an obstacle to Tuberculosis management and abolition by negatively impacting health behaviours such as health care, diet seeking, medication adherence and treatment completion.

Tuberculosis can turn into a risk factor for mental health issues, including psychological distress, Depression and anxiety, as a result of morbidity and reduced quality of life duration. Side effects of treatment include

- The social stigma attached to the illness,
- Fear of transmitting Tuberculosis disease to others, and
- Other possible comorbidities (especially HIV) associated with Tuberculosis.

In this way, mental ill-health and Tuberculosis share a syndemic relationship; each increases risk and worsens disease in the other. Therefore it creates a vicious cycle for those with the co-morbid presentation of both, negatively impacting health and well-being. Psychological distress is a common phenomenon experienced by humans in various conditions but is vaguely understood. It had defined as a state of mind where emotional suffering is associated with Depression and anxiety (Drapeau et al., 2011; Peddireddy, 2016). Psychological distress due to many living conditions, such as work pressure, societal changes, financial needs and changing lifestyle, leads to diseased states, and mortality in these individuals is on the rise (Kessler et al., 2009). It projected that individuals who experience immense psychological distress have fewer survival rates than the general population (NASMHPD, 2006).

On the other hand, people affected by any disease also undergo psychological distress, and the medical outcome in these individuals is dependent on psychological interventions (Trangle et al., 2016). Furthermore, Tuberculosis can infect the central nervous system (CNS), affecting neurological symptoms and assured anti-tuberculosis treatments have psychiatric side effects. The tremendous burden of Tuberculosis was going through in individuals with risk factors, homelessness, drug and alcohol misuse and migration. Mental illness is the most prevalent in all of these groups. The relationships between Tuberculosis and mental health are vastly complex. Tuberculosis–depression comorbidity is

a ‘syndemic’ due to the bidirectional interactions involved. Previous research has surveyed the impact of Tuberculosis and its treatment on mental health, the relationship between mental disorders and Tuberculosis treatment outcomes and adherence.

Depression disorder had increased two to three times higher among chronic medical illnesses. On the contrary, chronic medical illness cover up up the probability of treating and diagnosing a depression disorder. Stigma experienced due to tuberculosis is the most common risk factor for common mental disorders. In the study, stigmatization due to tuberculosis by family, friends, or community has also been associated with PD. It might be due to being diagnosed with tuberculosis, which results in psychological problems. In addition, poor general health perception due to tuberculosis is the risk factor for common mental disorders. This review holistically observes all existing indications of the bond between mental health and Tuberculosis(TB) incidence. Comprehensive systematic review methods are used, following guidelines given by PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses). There was a substantial variation in the study design, which limits the comparability of results across the included studies and the occurrence of mental disorders between tuberculosis and multidrug-resistant tuberculosis (MDR-TB) patients. The 2015–2035 World Health Organization (WHO) Ends tuberculosis strategy strongly advocates integrating mental health and treatment. However, low and middle-income countries (LMICs) often lack the trained mental health personnel to deliver such services. Sweetland et al. discuss how a task-shifting module established tuberculosis care within many LMICs is well-placed for detecting and treating mental health conditions, like Depression, in tuberculosis patients. They emphasize that the bulk of tuberculosis care in LMICs, including Community health workers, conduct tuberculosis screening and follow-up of patients. They are training the crew of health workers on how to catch and accomplish mental health conditions among tuberculosis patients would be an efficient way of integrating mental health services into the current tuberculosis infrastructure.

Economic demonstrating also proposes that investing in the prevention, services and managing Depression or anxiety in tuberculosis patients yield high economic returns. Therefore, assessing the occurrence of psychological suffering among tuberculosis patients and its prompting issues is vital if the WHO goal of abolishing tuberculosis by 2035 is to achieve. Studies in several countries have observed factors inducing psychological discomfort in Tuberculosis victims. They determined that psychological suffering was more common in tuberculosis patients who were rural, female, unmarried, older, less educated, and of low economic status. Co-infected with relapse, multi-drug resistant Tuberculosis (MDR-TUBERCULOSIS), human immunodeficiency virus (HIV), alcohol use disorders, smoking, and experiencing Tuberculosis-allied stigma having at least one other chronic disease.

Aim

The present study understands the psychological struggles faced by women in the Tuberculosis-affected family-a study from the Coimbatore district.

Objectives

- To understand the situation of women in the affected families
- To understand the problems faced by women in Tuberculosis affected families
- To give better suggestions for the women to strengthen their families.

Methodology

The Quantitative research study through a survey had done in a Coimbatore district. To identify the respondents over Simple random sampling method was used, and 60 Tuberculosis-affected families had taken up for this survey with criteria for selecting respondents. Inclusion criteria were limited to women aged 25-50 years. Before commencing the study, oral consent had taken from the respondents. The survey includes and tries to understand their socio-economic status and Psychological problems like Depression chronicled by using the core diagnostic criteria-symptoms of depressed mood, disorders in sleep, decreased concentration and responsiveness.

Feelings of helplessness, socio-demographic characteristics (age, sex, residence, marital status, occupation, and others), psychological distress, and substance use data had collected through face-to-face interviews. In contrast, other variables like spouse health status and tuberculosis disease types.

Results

Women Facing Psychological issues

The analysis with this below title; the respondents were classified as 'with psychological issues'. The survey had a set of questions to identify the respondents were to classify by Depression had diagnostic criteria-symptoms of depressed mood, disorders in sleep, and decreased concentration. Responsiveness and socio-demographic characteristics (age, sex, residence, marital status, occupation, others). Psychological distress and substance use data had collected through face-to-face interviews. In contrast, other variables like spouse health status and tuberculosis disease types.

Table 1 No. of Respondents facing Psychological Issues in Tuberculosis affected Families

Content	Frequency	Percent
With Issues	54	90.00
Without Issues	6	10.00
Total	60	100.00

Table 1 comprehensively explains the No. Of respondents facing psychological issues in Tuberculosis-affected families. Here 90 percent of respondents had been diagnosed with Psychological problems, and the remaining 10 percent carried diagnosed without psychological issues.

Women with Psychological Problems in Tuberculosis Affected Families

The respondents were classified with disorders based on their symptoms. Depression had diagnostic criteria-symptoms of depressed mood, disorders in sleep, decreased concentration and responsiveness and other variables like Spouse health status and tuberculosis disease types. This table explains in detail the problems faced by women in Tuberculosis affected families. Namely depressed mood, disorders in sleep, decreased concentration responsiveness

and other variables like Spouse Health status and Tuberculosis disease types; based on this classification, the respondents had identified from the below table.

Table 2 Types of Problems Faced by Women Tuberculosis Affected Families

Content	Frequency	Percent
Depression	20	37.03
Sleep Disorders	13	24.07
Lack of Concentration	4	7.40
Spouse Health Status	17	31.48
Total	54	99.98

This table was about 60 respondents. We found 54 respondents with Psychological issues; these 54 were facing different disorders. Among 54 respondents, 20 (37.03 Percent) of the respondents are facing Depression. Next, 17 (31.48 Percent) are facing Spouse Health Status, the other 13 (24.07 Percent) respondents are facing Sleeping Disorder, and the remaining 4 (7.40 Percent) respondents are facing Lack of Concentration. At this point, Depression was the common disorder detected in women of Tuberculosis-affected Families.

Types of Tuberculosis-Affected

The above table expresses that Respondents were classified by the types of problems faced by women in Tuberculosis-affected families. Based on the table classification, the researcher identified the types of Tuberculosis-affected. The major types of tuberculosis affecting the spouse’s health are discussed below. However, this study revealed some causes similar to what the researcher discussed.

Table 3 Types of Tuberculosis Affected the Respondent’s Spouse

Content	Frequency	Total
Pulmonary Tuberculosis	35	58.33
Brain Tuberculosis	5	8.33
Joint Tuberculosis	10	16.7
Bladder and Kidney Tuberculosis	6	10.00
Miliary Tuberculosis	4	6.7
Total	60	100.00

Table 3 clearly shows the types of Tuberculosis that affected the Respondent’s spouse. In this table, 58.33 Percent of the Respondent’s spouses are suffering from Pulmonary Tuberculosis. The next 16.7 Percent of the Respondent’s spouses suffer from Joint Tuberculosis. The other 10.00 Percent of the Respondent’s spouse has been discovered with Bladder and Kidney Tuberculosis. The next 8.3 percent are covered with Brain Tuberculosis. Moreover, finally, 4 Percent of the Respondent’s spouses suffered from Miliary Tuberculosis.

Discussion

Our findings come at a time of rapid expansion of the Global Mental Health movement, whose aims are directly in line with the integration of mental health. Substance-related services into Tuberculosis treatment programs, eventually moving most mental health service delivery out of the psychiatric hospital setting into the community and primary care settings. In low-resource settings with few mental health specialists, it had achieved through ‘task shifting’, wherein non-specialists were trained to deliver essential mental health services with expert supervision. Given the high comorbidity of Tuberculosis and mental health and substance use disorders and the treatment of Tuberculosis at the primary care level in the highest-burden countries, mental health services could add to the existing Tuberculosis care delivery platform as a first step in providing enhanced care to patients in need.

Our findings also highlight significant challenges to integrating Tuberculosis and mental health care. At the same time, most NTP directors expressed high receptivity to integrating mental health care into their Tuberculosis programs. Among the top five barriers to Tuberculosis treatment completion, mental disorders other than substance abuse are not mentioned. It may be due, at least partly, to considerable variations in the global burden of psychiatric and substance use disorders and the limited knowledge of the respondents about mental health problems. NTP directors may also have difficulty prioritizing mental health care, given the numerous competing priorities and limited resources.

Limitations of the Study

Variables like psychological distress and stigma were assessed by the interviewer and managed. As a result, desirable responses and recall bias had mentioned. Since the study was cross-sectional, it does not review any cause-effect relationship. The outcome of this study may not be epitomized by the community or tuberculosis patients who lived in the community because of the institution-based study.

Conclusions

In this study, almost 2/3rd of the Tuberculosis patients had psychological distress. Chronic disease morbidity, HIV-Tuberculosis co-infection and experienced Tuberculosis-related stigma were associated with psychological distress. Attention should give to prolonged diseases, along with HIV/AIDS analysis and indicating long-lasting disease units to prohibit the impact on mental health. Consideration should be given to psychological distress and linking moderate to severe forms of the illness to psychotic clinics to hinder its effects. Tuberculosis patients should have raised, and effective interventions aimed at alleviating the psychological distress of tuberculosis patients should maintain development. At that time, more attention should be given to those patients with risk factors to produce better clinical outcomes and improve patients' quality of life. Interventions must include contextually appropriate identification and treatment methods, and efforts must address the social drivers of psychological distress and mental health conditions, including tuberculosis stigma.

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