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Student Corner

# Social Stigma, Level of Self Acceptance and Quality of Life Among Individuals Suffering from Tuberculosis in Sialkot, Pakistan

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## Abstract

**Objective:** This study examines whether tuberculosis sufferers' social stigma, quality of life, and self-acceptance are related.

**Methods:** An appropriate sample of 30 individuals was chosen (418 females and 29 men). Three scales were used to assess societal stigma, quality of life, and self-acceptance. The WHOQO-BREF 26-item scale was used to measure QOL. The Unconditional Self-Acceptance Questionnaire, a 20-item measure, and the Tuberculosis-Related Stigma Scale were used to assess self-acceptance and social stigma. The data for social stigma came from the general population, whereas the data for self-acceptance and quality of life came from TB patients. For data analysis, descriptive statistics and Pearson Product Moment Correlation Coefficient were applied.

**Results:** Among TB patients, self-acceptance and quality of life were significantly correlated (Pearson correlation =.529**), as well as a significant association at the .003 level of significance. Furthermore, results show that social stigma exists in the general population (M = 18.6400, SD = 6.38800).

**Conclusion:** The quality of life of TB patients is improved as a result of their high self-acceptance. We may say that social stigma against TB still exists in society, but it hasn't had a significant influence on tuberculosis sufferers' quality of life because of the positive association between quality of life and self-acceptance among tuberculosis sufferers.

**Keywords:** Tuberculosis, Social stigma, Quality of life, Self-acceptance, Depression, Anxiety.

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## Introduction

Tuberculosis (TB) continues to be a serious public health and economic issue across the world.[1] It is a highly contagious viral infection caused by the bacteria. Tiny droplets of Mycobacterium tuberculosis are released into the air by sneezes and coughs. A serious respiratory infection that mainly affects the lungs. Despite breakthroughs in identification and treatment, approximately 10 million incident of TB infections were reported in 2017, with an estimated 1.6 million fatalities owing to TB.[2] In 2018, an estimated 10 million individuals worldwide were infected with tuberculosis, with poor nations accounting for approximately 95 percent of infections and deaths.[3] Latent TB is inactive TB infection and it is not endemic. A latent TB infection means you have TB bacteria in your body, but they are inactive and cause no symptoms. Active TB is the TB disease; this infection is contagious. It can occur weeks or years after infection with TB bacteria. This condition makes you sick with clear symptoms. Active TB is marked by prolonged coughing, fatigue, chest pain, night sweats, coughing up blood or mucus, chills, loss of weight etc.

In spite of the fact that little attention has been given to clinical outcomes of therapy and microbiological cure, patient reports of their health-related quality of life play a significant role in clinical outcomes, has been overlooked. Patients suffer not just as a result of the disease's symptoms, but also as a result of the general decrease in their quality of life (QOL).[4] In order to obtain better clinical outcomes, treatment decisions should be based on psychological, emotional, and social factors as well as physical factors. A patient who is untreated can act as a source of infection transmission, causing illness to spread, and irregularities in treatment may cause the patient to become drug-resistant. The influence of perceived health status on regular everyday functions

is referred to as health-related quality of life. An unhealthy lifestyle can lead to depression and noncompliance with medication, both of which can aggravate the medical condition.[5]

TB is typically linked with filth, and sufferers are frequently connected with a disease label and suffer from social stigma.[6] Social stigma refers to discrimination by others because of social inferiority, However, perceived stigma refers to the guilt and shame that people feel when they talk about their experiences.[7] The media portrayal of migrants in reporting on TB has been cited as a concern in manufacturing stigma via TB control measures. Several conceptual models and theories were lacking regarding how social and structural influences relate to stigma. There are two theories for prescription non-adherence: inadvertent non-adherence in which people desire to take medicine but fail to do so correctly and purposeful non-adherence in which people choose not to take medication.[8] A prospective observational examination of 440 tuberculosis patients found a significant probability of recurrence due to poor drug adherence, and psychological illnesses were associated. Individuals with tuberculosis (TB) have been found to be more prone to depression based on factors such as personal and socio-demographic characteristics, environmental factors, and clinical characteristics.[9]

Furthermore, the stigma associated with tuberculosis is known to lead to low self-esteem and lack of self-confidence, which are typical indicators of depression, threatening emotional, mental, and physical well-being and interfering with QOL in TB patients.[10] The most common source of TB stigma is the perceived risk of infection spreading from TB-infected individuals to vulnerable community members.

Depending on geographical location, TB is also stigmatized due to its links to HIV, poverty, low social status, malnourishment, or unethical activity. TB stigma has a greater impact on females and impoverished or less-educated community members, which is especially concerning considering that these groups are frequently at higher chance for health inequities. As a result, TB stigma may aggravate pre-existing gender and class-based health inequities.[11] A significant number of tuberculosis patients have acknowledged to fearing isolation or rejection as a result of the disease; for example, they are worried of losing their livelihoods, having less educational options, and being prohibited from sharing meals, utensils, or sleeping space with family members.[12] These concerns cause many tuberculosis patients to conceal their symptoms, postpone seeking medical help, hide their sickness, and refuse therapy.[13] According to research, social stigma affects patients' happiness and quality of life even after therapy, which has a detrimental impact on their quality of life. Social stigma has a one-way, negative impact on the quality of life of those who are stigmatized. Social stigma also has impact on the expectations of stigmatized people from society. They expect rejection from society when entered in social interactions because of their stigmatized social status. Expectation of facing rejection from society, although rejection may not actually occur this rejection expectation yields cognition obstruction that constitutes stigma-related stress and affect the quality of life of people being stigmatized. Patients who have been stigmatized by tuberculosis suffer greatly.[14]

TB has an impact on patients' mental health as well as their physical health. Various psychological disorders, such as depression, anxiety, feelings of loneliness, stigma, social isolation, and low quality of life (QOL), have previously been observed among these individuals.[15] Depressive symptoms have been shown to be present in roughly 16.8–70.0 percent of TB patients.[16] At the moment, researches are being conducted to investigate the variables that influence depression in TB patients in order to develop strategies to lower the risk of depression. However, as observed in India (39.5 percent), Ethiopia (43.4 percent), Pakistan (46.3 percent), and Cameroon, the incidence of depressed symptoms in TB patients remains high (61.1 percent). Previous research has shown strong support for the link between social support and depression. It's likely that individuals' race, sexuality, age, and locality increase their chances of becoming depressed. Furthermore, when patients with tuberculosis are depressed, they feel considerable psychological discomfort, which affects their QOL, which encompasses a person's physical, mental, and emotional well-being.[17]

Self-acceptance is precisely what its name implies: total acceptance of oneself. Inner self means accepting yourself as you are, without reservations, limitations, or exceptions.[18]

Morgado and colleagues' (2014) working definition: "[Self-acceptance is] an individual's acceptance of all of his/her abilities, positive or negative."

This definition highlights the significance of accepting one's entire self. To embody full self-acceptance, you must accept the less desired, negative, and ugly elements of yourself as well as the desirable, useful, or beneficial aspects of yourself.[19]

Although tuberculosis is treatable, therapy is unsuccessful without patient acceptance. When patients self-manage, they minimize treatment desertion, avoid hospitalizations, and gain confidence and a sense of control.

Self-management of tuberculosis include managing prescription regimens, monitoring laboratory markers, maintaining diet, coping with emotional and physiological demands, and regulating one's lifestyle. However,

little is known about the factors that promote or limit TB patients' self-acceptance.

Self-acceptance is the most essential facilitator of self-management since it is the patient's choice and deliberate desire to enhance their health and well-being. Nevertheless, the self may also be a hindrance, especially if there is no assistance from family, public support, or the whole medical team. And without it, one has a bad quality of life.[20]

## Methods

Two population samples were taken in data collection. One convenient sample of 50 participants of general population was taken from different areas of Sialkot. The sample consisted of 32 females and 18 males. Second convenient sample of 30 participants were taken from three hospitals (Bethaniya hospital, Allama Iqbal memorial hospital and Chest hospital) in Sialkot. All participants gave their informed consent. The age ranges of two populations was from 10-90 years. Their minimum level of education was no educational attainment and highest was at university level. Participants were belonged to lower middle, middle, upper middle and elite socioeconomic status. The participants belong to rural or urban areas and have marital status married or unmarried. A correlational study design was used in the current study to inspect the relationship between social stigma, quality of live and self-acceptance in TB patients. In general population the perspective of community towards TB patients were assessed. As well as, Quality of life and Self-acceptance in patients with Tuberculosis. All participants were given a detailed description of each statement on our measures. Before collecting data, all ethical concerns were followed.

For data analysis, person product moment correlation coefficient was used between variables.

## Results

The mean for social stigma about Tb among general population is calculated and the results for mean are 18.6400 from the total of 50 participants.

The Pearson product coefficient is used to determine the relationship between TB patients' quality of life and unconditional self-acceptance. The results obtained predicted that social stigma about TB exists among population but it does not much affect the quality of life of TB sufferers.

The high self-acceptance among TB patients make their quality of life better. At the 0.03 level, the association is significant. The result shows high correlation (.529) between QOL and self-acceptance among tuberculosis suffers. The mean for social stigma about Tb among general population is calculated and the results for mean are 18.6400 from the total of 50 participants.

To assess QOL of TB sufferers, The WHOQO-BREF, a 26-item scale with four domains: physical well-being (7 items), mental well-being (6 items), social connections (3 items), and environmental health (8 items), as well as overall and QOL questions, was used. Each WWHOQOL-BREF question is graded on a 5-point ordinal scale ranging from 1 to 5.

For the assessment of self-acceptance among TB sufferers, The Unconditional Self- Acceptance Questionnaires, a 20-item scale with 11 reverse-keyed items was used. Moreover, social stigma related to TB among general population is evaluated by using Tuberculosis-Related Stigma scale. The dimension of the scale which is used to assess the behavior of people towards TB is known as Community perspective and consists of 11 items. The measure is a four-point Likert scale (1–4), with responses ranging from strongly disagree (1) through disagree (2), agree (3), and firmly agree (4).

**Table 1:** *Compare the means between gender*

| Total TRSSQ Scale | | | |
|---|---|---|---|
| **Gender** | **Mean** | **N** | **Std. Deviation** |
| **Male** | 18.5556 | 18 | 6.81022 |
| **Female** | 18.6875 | 32 | 6.24984 |
| **Total** | 18.6400 | 50 | 6.38800 |

**Table 2:** *Relationship between QOL and USAQ*

| | | Total QOL Scale | Total USAQ Scale |
|---|---|---|---|
| **Total QOL Scale** | Pearson Correlation | 1 | .529** |
| | Sig. (2-tailed) | | .003 |
| | N | 30 | 30 |
| **Total USAQ Scale** | Pearson Correlation | .529** | 1 |
| | Sig. (2-tailed) | .003 | |
| | N | 30 | 30 |

****. Correlation is significant at the 0.01 level (2-tailed).**

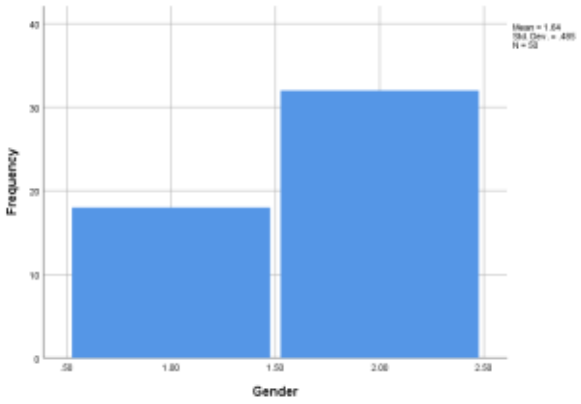


**Figure 1:** *Histogram related gender and social stigma*

## Discussion

The study's goal was to determine the amount of societal stigma associated with TB patients as well as their level of self-acceptance. Results of current research suggest that social stigma about TB does not much affect the QOL of TB suffers. A few medical studies have reviewed the patients understanding of TB. In our study it is indicated that the health of most TB patients is poor. However, patients described alarm at their symptoms and deteriorating health status.

TB is a disease that has the devastating social consequences. Recent studies indicate that patients feel isolation from their family and friends. In our research we indicate that the social isolation and stigmatization of TB are also the major problems. We use correlational method to indicate the relation between social stigma, QOL and level of self-acceptance among TB patients. There is no condition specific instrument to measure the QOL in TB patients.

Our results show that that the TB suffers sample shows that the level of the self-acceptance in TB patients in our community is also average. The major factor which contribute to the level of self-acceptance is the family support and friends gathering. There is the correlation between variables that shows moderate level of effect on TB suffers. Some people usually hesitates to reveal that they are the sufferers of TB.

To conclude, there is a social stigma in our community but it is not so much significant to affect the life of an individual. More researches should be conducted in this area because most of the people are unaware of this area. Through the generation of the awareness, level of social stigma should be abolished and self-acceptance could be increased.

Our study also has some limitations, that our research has more males than females. It makes it difficult to investigate the gender inequalities. Moreover, the females are less in number the findings are applied to both genders. In the future, the study may be conducted on a female population to explore for gender differences. Other elements such as religion, economy, and so on may be included in future studies. Future studies should consider equal data randomization to improve the generalizability of their findings.

**Conflict of Interest:** *None*

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