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# Psychosocial Characteristics of the Disease in Patients with Tuberculosis

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**Abstract:** A comparative analysis of reactions to the disease in children with a turn of tuberculin samples and various forms of active pulmonary tuberculosis showed that in the early period of tuberculosis infection in children aged 10-14 years, 50% have predominantly adaptive types of attitude to this condition, in the structure of which the anosognosic type of attitude to the disease was 15.6%, and in patients with tuberculosis In the lungs, the incidence of adaptive types of disease attitude (TOD), including anosognosic, decreased by 3-5 times. The high significance of the diagnosis as a traumatic and stigmatizing factor has been established. With positive dynamics in the treatment process, anosognosia again came out on top, the defense mechanisms were denial of the disease, detachment from the past and hypersocial behavior.

**Keywords:** tuberculosis, diagnosis, tuberculosis, psychosocial characteristics.

**Introduction.** The concept of the "internal picture of the disease" (VKB) was first introduced by A.R. Luria, who continued the development of A. Goldscheider's ideas about the "autoplastic picture of the disease". Compared with a number of similar terms of medical psychology ("experience of illness", "consciousness of illness", "attitude to illness", etc.), "the internal picture of the disease" is the most general and integrative [3]. Luria proposed to understand by the "inner picture of the disease" "everything that the patient experiences and experiences, the whole mass of his feelings, his general well–being, self-compassion, his idea of his illness, its causes ... - the whole vast world of the patient, which consists of rather complex components of perception and sensations, emotions, affects conflicts, mental experiences and traumas" [5, 14]. The real internal picture of the disease does not always coincide with the complaints of patients and, of course, often does not correspond to the data of an objective examination. Today, the internal picture of the disease is understood as a system of mental adaptation, which is based on mechanisms of psychological protection and coping behavior, which are formed for protective purposes to reduce emotional tension and overcome difficulties caused by the disease [14]. The initial idea of the WCB structure, which includes two levels (sensitive and intellectual), was further differentiated by highlighting four levels: 1) sensual – a complex of painful sensations; 2) emotional – the experience of the disease and its consequences; 3) intellectual – knowledge about the disease and its real assessment; 4) motivational – developing a certain attitude to the disease, changing lifestyle and updating activities aimed at recovery [3]. There are various circumstances that are undoubtedly- However, the following take part in the formation of the HCB: objective living conditions of the patient (social conditions, objective severity of the disease, objective prognosis, degree of vital threat), subjective factors (patient's orientation, level of general activity, features of self-awareness, the whole complex of morbid personality traits), situational factors, especially those related to treatment (severity and the duration of medical procedures, the degree of dependence of the patient on medical equipment and personnel, etc.) [15]. A subjective assessment of one's condition and the nature of painful symptoms is rarely adequate, since a number of serious somatic diseases are asymptomatic for a long time, and with strong affective reactions, a greater number of complaints without objective pathology is possible [1]. Numerous clinical observations show that in the initial stages of the disease, when the symptoms are still insignificant, the reaction to the disease may be manifested by its denial or by downplaying the significance of the consequences and possible complications, which is confirmed by psychodiagnostic studies. The opposite pattern is observed in diseases with a clearly defined clinical picture, chronic tension, the presence of pain or other bodily or mental suffering, in which maladaptive types of attitude to the disease manifest themselves with the greatest frequency [16]. A comparative analysis of reactions to the disease in

children with a turn of tuberculin samples and various forms of active pulmonary tuberculosis showed that in the early period of tuberculosis infection in children aged 10-14 years, 50% have predominantly adaptive types of attitude to this condition, in the structure of which the anosognosic type of attitude to the disease was 15.6%, and in patients with tuberculosis In the lungs, the incidence of adaptive types of disease attitude (TOD), including anosognosic, decreased by 3-5 times. The level of self-esteem of tuberculosis patients is closely related to the peculiarities of their perception of other people's attitudes [19]. Stigmatization of tuberculosis patients by their social environment plays a very important role [21]. All this directly affects adherence to treatment [22-24] – after all, the issue of patients' non-compliance with doctor's prescriptions, "disruptions" of treatment contributes to the formation of stable forms of the disease and relapses. The aim of the work is to determine the types of attitudes to the disease that prevail in patients with pulmonary tuberculosis and psychosocial variables that determine the attitude of these patients to the disease. The studied variables include the duration of the disease, gender, employment, education, family, awareness of the disease, relationships with others, and the presence of bad habits.

**Material and methods.** The diagnosis was made less than 2 months in 25 people (41.7%), from 2 to 6 months – 19 people (31.7%), from 6 months to 1 year – 13 people (21.6%), 3 people (5%) have been on treatment for more than a year. The results of the study of the professional composition of patients showed that the majority of patients are workers – 31 people (55.6%); employees – 5 (8.3%); employed in agriculture – 2 (2.7%); students – 2 (2.7%); pensioners – 3 (5.6%); unemployed – 15 (25.1%). The work used clinical interviews and psychodiagnostic techniques: 1) the questionnaire of E.M. Bogorodskaya et al. (2006) to determine patients' socio-demographic indicators, social risk factors, awareness of the disease, adherence to treatment, attitude to the disease and society; 2) a technique for the psychological diagnosis of types of attitude to the disease (TOBOL). Statistical processing of the obtained data was carried out using the computer program "Microsoft Excel".

**Results.** The results indicate that the majority of patients (78.3%) believe that they do not have severe clinical manifestations of the disease, especially this is typical for subjects with newly diagnosed pulmonary tuberculosis in the first month of illness and more than three months of hospitalization. Subjectively, this creates a perception of oneself as healthy. The majority of respondents attributed to the symptoms of the disease: weakness, drowsiness (66.7%), sweating (75%), back pain (28.3%), gastrointestinal problems (63.3%). The greatest number of symptoms are noted by patients during the initial period of taking medications. The emotional level of HCB was determined by the characteristics of the patients' response to the disease and its consequences. To the question "How did you react to the fact that you were diagnosed with tuberculosis?" 25% of respondents replied that they panicked, 22.2% closed down and withdrew into themselves, but the majority – 52.8% calmly reacted to the diagnosis. The general mood background in most patients is good and optimistic – 83.3%, 16.7% report mood swings. 94.4% believe in a positive outcome of treatment, 5.6% cannot give a single answer to this question, while 5.6% do not want to continue treatment. The presence of fears and anxiety was noted in 35% of the subjects. The worries are related to the uncertainty of their professional future, concern for the health of their relatives. It should be noted that during the study, a group of patients (12 people), mostly women, refused to participate in the questionnaire and diagnosis. Observations and conversations with medical staff indicate the presence of depressive, apathetic and angry emotional reactions in these patients, which was an indication for consulting a psychotherapist. When assessing the cognitive level of HCB, we took into account the patients' ideas about the duration of treatment, their own capabilities in the fight against the disease, and the peculiarities of the formation of the information environment. "How long do you need to recover?" – answering this question, 22.2% believe that six months, 19.4% – one year, 11.1% – indicate three to four months, which indicates their adequate assessment of their condition, the nature of the disease and treatment. The lack of awareness may be indicated by such an answer to this question as "I don't know" – 47.2% [8]. A study of the peculiarities of the formation of the information environment of tuberculosis patients showed that the majority of respondents seek to expand their knowledge about the disease – 83.4%, and 8.6% do not have this need. The main source of information for the bulk of patients is the attending physicians and

medical staff of the hospital – 35.8%, and for 30.6% – wall newspapers in the clinic. The Internet as a source of information is the second most popular for 23.2%. In addition to the above, popular science literature, periodicals, other patients and relatives were also noted. Moreover, as a result of communication with other tuberculosis patients, 72.2% had a desire and confidence in the outcome of treatment, 19.4% had no desire to be treated, and 5.6% claimed that as a result of exchanging information with other patients, the desire to be treated disappeared and they began to take not all drugs. Answering the question: "Who should help you get cured?" – 44.4% believe that doctors and medical staff, 50% are convinced that the outcome of treatment depends only on themselves; 5.6% rely on the help of relatives and friends. As a place of treatment, respondents indicate such options as "hospital" – 30.6%; "live at home, but come for pills every day" prefer 58.2%; "I want the pills to be brought home" – 5.6% think so, and for 5.6% – "it doesn't matter." The use of the TOBOL questionnaire data in the work will allow us to deepen the results of the study of HCB in patients with pulmonary tuberculosis. Based on the results obtained, the predominant TOBS were grouped into three blocks. The first block consists of 30 people (50%) and includes ergopathic (22 people – 36.7%), anosognosic (6 people - 10%) and harmonious (2 people – 3.3%) types of attitude to the disease, in which mental and social adaptation is not significantly impaired. The second block (4 people – 6.7%) includes anxiety (3 people – 5%) and hypochondriacal (1 person - 1.7%) TB, which are characterized by an intrapsychic orientation of personal response to the disease, which causes violations of social adaptation of patients with these types of response. Neurotic, melancholic, and apathetic types of attitude are absent in this sample. The third block (12 people – 20%) included sensitive (11 people – 18.3%), egocentric (1 person – 1.7%) TOBS, which are characterized by an interpsychic orientation of personal response to the disease, which also causes violations of social adaptation of patients. Dysphoric and paranoid types of attitude were not expressed in these subjects. Mixed types of attitude to the disease: ergopathic-anosognosic – 6 people (10%), ergopathic-sensitive - 5 people (8.3%), melancholic–sensitive - 1 person (1.7%), apathetic–paranoid - 1 person (1.7%), ergopathic–anxious - 1 person (1.6%). The predominance of the ergopathic type in patients is characterized by- with the desire to continue working, maintain professional status and the opportunity to continue active work in the same capacity. There are no unemployed patients in this group. The average age is under 35 years. The results of the assessment of changes in the financial situation of patients showed that 59.1% believe that their financial situation has worsened, 40.9% believe that it has not changed significantly. They note fluctuations in mood, fearing an unfavorable attitude from acquaintances, hide the diagnosis, are forced to rebuild their relationships with others, in their opinion, "healthy people are not able to understand patients, because they did not experience what patients experience" - 45.5%. 36.36% feel differences between themselves and others, because "you have to limit your communication with others." The results of the assessment of relations with relatives, on the contrary, showed that "the family has become more attentive to me, showing care and support" – 54.54%. The primary reaction to the disease is "shut down and withdrew into themselves." "I try not to show my poor health to others," the slightest troubles associated with the disease upset them greatly, they are "scared of the difficulties and dangers associated with the upcoming treatment," a negative emotional background affects relationships with others, they are "ashamed of their illness even in front of their loved ones," they try "to at work (at the place of study) they knew less and talked about my illness," but those around her did not notice it. Among the newly identified patients, there is a positive correlation with sensitive CB ($r = 0.412$ at $p < 0.05$). This TOB also correlates with the presence of family in patients ($r = 0.510$ at $p < 0.05$), a sense of difference between themselves and others ($r = 0.586$ at $p < 0.05$), mood variability ($r = 0.312$ at $p < 0.05$). In the subgroup of subjects with ergopathic-sensitive TOB (all men, working specialties), during interviews and surveys, signs of a so-called social phobia were revealed, they are embarrassed to talk about their disease, show fears for the health of their loved ones, feel guilty, believe that "relatives and friends began to avoid communicating with them", well-being it depends on how others treat them, "the mood deteriorates from the expectation of possible troubles, concern for loved ones, and uncertainty about the future." What is most depressing about the disease is that "people have become shunned." They worry that because of their illness, "difficulties and adversities await their loved ones," therefore they believe "that, despite the illness, they must continue their work

(studies)," embarrassed by the disease, they try to distance themselves from people, and miss people alone. Women are worried about the health of their children, feeling guilty that they will have to take medications that can harm their health. Anxiety becomes a source of conflict with others, the subjects admit that "they can be impatient and irritable with doctors and medical staff and then regret it," it seems to them that those around them are shunned and cannot understand their suffering. From a conversation with the medical staff, it was found that this category of patients more often than others enters into conflicts, often behave irritably. The cognitive component occupies a special place in the structure of the HCB: the constant search for additional information about the disease, its further consequences and treatment options. They often communicate with other patients, and they themselves note that as a result of such conversations, "the desire to be treated has disappeared." Egocentric and hypochondriacal TOB were noted in only two of the subjects. An interesting fact is that these patients were diagnosed repeatedly, have an open form of this pathology (CD+) in their anamnesis, and there were interruptions in treatment. The sensitive and emotional levels are pronounced – they note a large number of complaints about their well-being, depression, and pessimism. At the same time, they do not show interest in additional information about treatment options, doubt the possibility of recovery, rely solely on doctors and ideally wanted medicines to be brought to their homes. An analysis of the results of a study of the features of HCB in patients with pulmonary tuberculosis indicates that the fact that an alarming type of attitude to the disease is present in only 5% of the subjects (and all of them are women with higher education), to a certain extent determines the response of patients to the diagnosis - "panicked". Anxiety becomes a source of conflict with others, the subjects admit that "they can be impatient and irritable with doctors and medical staff and then regret it," it seems to them that those around them are shunned and cannot understand their suffering. From a conversation with the medical staff, it was found that this category of patients more often than others enters into conflicts, often behave irritably. The cognitive component occupies a special place in the structure of the HCB: the constant search for additional information about the disease, its further consequences and treatment options. They often communicate with other patients, and they themselves note that as a result of such conversations, "the desire to be treated has disappeared." Egocentric and hypochondriacal TOB were noted in only two of the subjects. An interesting fact is that these patients were diagnosed repeatedly, have an open form of this pathology (CD+) in their anamnesis, and there were interruptions in treatment. The sensitive and emotional levels are pronounced – they note a large number of complaints about their well-being, depression, and pessimism. At the same time, they do not show interest in additional information about treatment options, doubt the possibility of recovery, rely solely on doctors and ideally wanted medicines to be brought to their homes. Conclusion An analysis of the results of the study of the features of HCB in patients with pulmonary tuberculosis indicates that there is no need for treatment, since most patients indicate the presence of forced social isolation, the negative attitude of others towards their diagnosis, which causes negative emotions. The alarming TOB is most typical for women with higher education. The dominant motives are the search for additional information about the disease and anxiety for loved ones. Scientists show that a doctor's more complete understanding of the psychosocial characteristics of the patient's attitude to his disease helps in the formation of psychotherapeutic targets in the system of complex therapy of somatic disease.

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