

ORIGINAL ARTICLE

The Impact of Counseling to Reduce the level of Anxiety and Depression among Tuberculosis patients at Tertiary care Specialty Hospitals Bengaluru

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ABSTRACT

There are several health issues that are prevalent worldwide. Illness is one of the most frequent. According to Global Issues.org, around 36 million people worldwide die each year from non-communicable (not contagious) diseases like chronic lung disease, cancer, and cardiovascular disease. The most widespread viral and bacterial communicable illnesses, including AIDS/HIV, TB, and malaria, cause millions of fatalities each year. The communicable illness of respiratory infection is typically brought on by Mycobacterium tuberculosis (MTB) germs (TB). Infecting the lungs, tuberculosis can damage other body organs as well. Recent respiratory infection is the name for a sepsis that is unnoticed. Nearly half of those with active illness which results from about 10% of latent sepsis expire if not treated. To find the impact of counselling to reduce the level of anxiety and depression among tuberculosis patients at tertiary care specialty hospitals, Bengaluru. In a pre-experimental research study, the effects of counselling on the levels of anxiety and melancholy in 300 tuberculosis patients were assessed. The purposeful sampling technique is used to select the samples. Fear assessment of children's, The Generalised Anxiety Disorder Assessment (GAD-7) and clients tools measuring devices were used to get the data. Time series of counseling to tuberculosis patients' day 1 started assessing the anxiety and depression after assessments of patients provided counseling day2 provided counseling, day 3 provided counseling, same time day 4 provided counseling to patients and after 15 days provided counseling to patients and assessed anxiety and depression of patients comes to normal. So counseling is effective in reducing anxiety and depression of tuberculosis patients. Demographic information was obtained from the individuals. The data was analyzed using descriptive and inferential statistics, the hypothesis was tested, the goals were met, and the findings were reported. Explain sociodemographic factors and describe the intensity of anxiety and sadness. Using a paired T-test, the effectiveness of counselling will be evaluated. The non-parametric Chi-Square test will be used to see the association between particular demographic characteristics and anxiety and depression levels both before and after counselling. The majority of TB patients (71.67 percent) in the current study experienced severe anxiety during the pre-test assessment, while the remaining patients belonged to the other anxiety group. The majority of patients' anxiety levels dropped to a moderate level (57.67%) after receiving counseling, while the remaining patients' anxiety levels fell below the moderate range. The majority of TB patients (57.67 percent), according to the current study, experienced acute depression before the test. The remaining patients belonged to the other group of depressed individuals, and counseling helped them feel less miserable overall. The majority of these patients (53%) fell into the category of moderate depression, with the remainder patients falling into the category of less severe depression. The mean anxiety levels for TB patients were before the test. According to the study's findings, anxiety and depression are prevalent symptoms among tuberculosis patients, and their prevalence is decreased when counselling sessions are included in the treatment plan for the disease.

Keywords: Tuberculosis, Anxiety, Depression, counselling, Tertiary care centre.

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INTRODUCTION

The bacteria *Mycobacterium tuberculosis* is the cause of tuberculosis, a disease that is transmitted from human to human through droplet infection. One although respiratory infection usually affects the lungs, it can sometimes affect other areas of the body, such as the brain, kidneys, or spine; this disease is called extrapulmonary tuberculosis [1]. Even if there is an effective antibiotherapy for tuberculosis, many patients may still pass away if they do not receive prompt, appropriate treatment [2]. Despite the availability of effective and affordable therapy, tuberculosis continues to cause millions of deaths and active cases globally. The lowest people in less money peoples and developing nations are afflicted by tuberculosis. In every year around more than million people dyeing with respiratory infection. It has been at the top of the list of infectious diseases that cause death for the last five years [3]. 167,000 of the 1.3 million TB-related deaths in 2022 were caused by T.B. After COVID-19, tuberculosis is the world's second most common infectious disease, killing more people than HIV and AIDS combined. In 2022, an estimated 10.6 million people worldwide developed tuberculosis (TB), including 1.3 million children, 3.5 million women, and 5.8 million men. TB affects all nations and age groups, and it is both preventable and curable. By 2022, only roughly two out of every five persons with drug-resistant tuberculosis will be treated, making multidrug-resistant tuberculosis (MDR-TB) both a public health disaster and a security threat. Since 2000, worldwide efforts to eradicate tuberculosis have saved an estimated 75 million lives. The global goal stated at the 2018 UN high-level TB summit is US\$13 billion per year for TB prevention, diagnosis, treatment, and care. The UN's Sustainable Development Goals (SDGs) include eradicating the tuberculosis epidemic by 2030 [4]. The burden of TB is increased by the incidence of psychiatric issues, especially sadness and fear, respiratory infection clients. Proper management of for TB in Ghana involves a 6-month course of antibiotics, which includes hospitalizing TB patients for the initial few weeks of treatment, significantly worsens the psychiatric wellbeing issues of patients. Because gloomy disorders lead to no proper, drug resistance, and high rates of transmission, they raise the risk of infection for other community members. Depressive TB patients also avoid social obligations and have less social interaction, especially when cold; reduce self-limitation and misery. Depression also affects psychosocial wellbeing and lowers the excellence of life cycle for those affected, which finally results in poor management for TB clients [5]. Important components of the TB response include establishing standards and guidelines for TB treatment and prevention, keeping an eye on the state of the TB epidemic, improving the budgeting and application of the TB answer at the international, local area, state, and national stages, making sure that member countries receive specialized technical assistance, and developing and refining practical and legal rules and regulations for TB prevention and treatment.

MATERIAL AND METHODS

Area of study and time

Study was conducted at tertiary care specialty health facilities Bengaluru and we took more than one month for completing the research.

Research design

Pre-experimental research design was conducted to obtain objectives of study.

Population

Resources and research participants: Respiratory tract infection clients who are coming to selected hospitals and whom can take action the proper information without any difficulties.

Addition criteria:

- Respiratory infection clients are visiting at selected hospital.
- Tuberculosis patients are interested for research

Ruling out:

- Respiratory infection clients are not present during collection of data
- Tuberculosis patients severe health problem

Sampling technique and size of samples: purposive sampling technique selected 300 tuberculosis patients.

Variables

Dependent variable: Anxiety and depression of the tuberculosis patients

Independent variables:

Counseling is the independent variable.

Sociodemographic characteristics: Age, sex, Religion, Learning status, type of family, place of residence, history of BCG vaccination, presence of co morbidities and Types of morbidities

Operational definition

Counseling is defined as the process of giving individuals the unintended to rapid their opinions, be heard, and get additional visions into their situation and involvements.

Anxiety is the state of being concerned, anxious, or painful about something whose outcome is uncertain.

Depression: Means *the* s a mood illness that might interfere with everyday tasks and results in a continuous sense of melancholy and disinterest.

Tuberculosis patients: Most frequently, the lungs are affected by this infectious disease. One kind of bacteria is the cause of tuberculosis. When infected persons cough, sneeze, or spit, it spreads via the air.

Hospital: the place providing promotive, preventive and curative health services to tuberculosis patients.

Data quality control:

One week prior to the actual date of collection of data, the tool was before test on five percentage size of sample and areas other than research areas. Questionnaire will be modified to meet the objectives of research after pretest. The supervisors closely monitored the data collectors and the collection method during the data collection process, and they regularly reviewed the collected data. Any items that were vomited from tools the data collector's misinformation were checked right away by the managers and fixed for the following information about collection of data with supervision of research.

Analysis of result:

Data collection entered into the SPSS software before the main collection of information through SPSS version 23. Finding of the study was described using rate frequency, scope and cross table value. A statistically significant relationship between the dependent and independent variables was defined as having a p-value of less than 0.05.

Analysis

Table-1: Demographic variables of samples [N= 300]

Demographic profile	No of tuberculosis patients	% of tuberculosis patients
Age groups		
20-34 years	123	41.00
35-44 years	56	18.67
45-54 years	63	21.00
55-64 years	22	7.33
Above >65	36	12.00
Sex		
Male	209	69.67
Female	91	30.33
Religions		
Hindu	198	66.00
Muslim	72	24.00
Christian and others	30	10.00
Marital status		
Unmarried	23	7.67
Married	253	84.33
Widow	18	6.00
Divorced	6	2.00
Employment status		
Employed	152	50.67
Non employed	148	49.33
Income groups		
<=10000	112	37.33
10001-20000	89	29.67
20001-30000	32	10.67
30001-40000	44	14.67
40001-50000	12	4.00
>=50001	11	3.67
Educational status		
Illiterate	57	19.00
Primary education	102	34.00

High school education	97	32.33
Pre- university education and above	44	14.67
Family type		
Nuclear family	196	65.33
Joint family	104	34.67
Place of residence		
Rural residence	189	63.00
Urban residence	111	37.00
History of BCG vaccination		
Yes	263	87.67
No	37	12.33
Family History of TB		
Yes	67	22.33
No	233	77.67
Presence of co morbidities.		
Yes	130	43.33
No	170	56.67
Types of morbidities		
HIV	139	46.33
DM	89	29.67
HPT	76	25.33
others	86	28.67
Total	300	100.00

As shown in the **Table (1)**. The majority of patients (41%) were between the ages of 20 and 34, 21% were between the ages of 45 and 54, 18.67% were between the ages of 35 and 44, 12.0% were above 65, and 7.33% of TB patients were between the ages of 55 and 64. In gender distribution of tuberculosis patient. 69.67% of clients were Females and residual 30.33% were Males. Most of tuberculosis patient 66% were belonging to Hindus religion 24% of them were Muslim and (10%) were belongs to Christians and others. In most (84.33%) of tuberculosis patient married, 7.67% were unmarried, 6% were widow and 2% were divorced. In employment status 49.33% of tuberculosis patient were employed and 50.67% were unemployed. 37.33% of tuberculosis patient monthly income <10000, 29.66% were had 10001 - 20000, 10.66% had 20001- 30000, 14.66% had 30001-40000, and remaining 4 & 3.66 % were from family monthly income of 40001 – 50000 and more than 50000. Most 34 % of patients were primary education, 32.33% were high school, 19% were illiterate and 14.67% were primary education and above. Most (65.33 %) of patients were nuclear family, 34.67% were joint family. In 63.00 % of patients were residing in rural, 37.00% were residing in urban area. Most (87.67.00 %) of patients were taken BCG Vaccination, 12.33.00% were not taken BCG Vaccination. In most (77.67 %) of patients were having family history of tuberculosis, 22.33% were no tuberculosis history. most (56.67 %) of clients having no co-morbidities and 43.33% were having co-morbidities. 46.33 % samples reported presence of HIV. 29.67% reported a DM, 25.33% reported a presence of hypertension. 28.67% reported presence of other type of co-morbidities.

Table 2: Assessment between pre-test and post-test levels of anxiety of tuberculosis clients
N= 300

Fear level	Pretest levels		Posttest levels	
	n	%	n	%
No fear	0	0.00	13	4.33
Less fear	18	6.00	114	38.00
Moderate Anxiety	67	22.33	173	57.67
Severe Anxiety	215	71.67	0	0.00
Total	300	100.00	300	100.00

Above table revealed that assessment between pre-test and post-test level of fear of tuberculosis clients pre-test level no fear 0 percent, less fear 6 percent, moderate fear 22.33 Percent and severe anxiety 71.67% and post-test level of fear after giving counselling at post-test level no fear 4.33 percent, mild anxiety 38 percent, moderate anxiety 57.67 Percent and severe anxiety 0.00%.

Table 3: Assessment between pre-test and post-test levels of depression of tuberculosis clients

Level of sadness	Pre-test level		Post-test level	
	Number	Percentage	Number	Percentage
Minimal depression	0	0.00	18	6.00
Mild depression	16	5.33	89	29.67
Moderate depression	19	6.33	159	53.00
Moderately severe depression	92	30.67	34	11.33
Severe depression	173	57.67	0	0.00
Total	300	100.00	300	100.00

The table 3: Before therapy, the depression scores of TB patients were minimal (less than 5%), mild (5.33%), moderate (6.33%), severe (57.67%), and very severe (more than 30.67%), according to an assessment of their depression scores before and after counselling. 6.0% is considered minimal depression, 29.67% is considered light depression, 53.00% is considered moderate depression, and 0.00% is considered severe depression.

Table 4: Assessment of pre-test and post-test fear scores of TB patients t test

N= 300

Times	Mean	SD	%	%	t-valu	df	p-value
Pretest	15.96	3.19	76	15.19	37.27	299	0.0001,S
Posttest	9.67	2.89	46.04	13.76			
Reduction	6.29	2.92	29.95	13.90			

Table 4. the average anxiety score among TB patients before the test was 15.96 with a standard deviation of 3.19 and the average anxiety level after the test was 9.67 with a standard deviation of 2.89. It was determined that the paired "t" value of $t = 37.2762$ was statistically significant at the $P=0.0001$ level, This clearly showed that TB patients' anxiety levels reduced after receiving counseling, proving that, counseling is effective in reducing anxiety levels in tuberculosis patients. Hence the null hypothesis H_0 is rejected, H_1 is accepted. Hence counselling is effective for reducing anxiety of the patients.

Table.5: Comparison between pretest and posttest depression scores of tuberculosis patients by t test

N= 300

Times	Mean	SD	Mean %	SD %	t-value	df	p-value
Pretest	19.60	4.47	72.59	16.55	41.01	299	0.0001,S
Posttest	10.35	3.32	38.33	12.29			
reduction	9.25	3.91	34.25	14.48			

$P < 0.001$. S-Significant

Above table revealed that, While the mean depression score among TB sufferers was 19.60 with a standard deviation of 4.47 at the pre-test, it was 10.35 with a standard deviation of 3.32 in the post-test. The statistical significance level for the resulting paired "t" value of $t = 41.0155$ was set at $P=0.0001$. This report demonstrated that the post-test levels of depression in TB patients were much lower after receiving counselling, demonstrating that counselling was effective in decreasing the severity of the depression. Thus, H_2 is accepted and the null hypothesis, H_{02} , is rejected. Counselling is therefore useful in lowering patients' levels of depression.

Table: 6 Relationship between demographic factors and anxiety pretest levels

N= 300

Variables	Pretest levels of anxiety							Chi-square	df	p-value
	No fear	%	Reason able	%	Worst fear	%	Total			
Age group										
20-34 years	17	13.82	35	28.46	71	57.72	123	34.5230 S	8	0.0001*
35-44 years	1	1.79	15	26.79	40	71.43	56			
45-54 years	0	0.00	9	14.29	54	85.71	63			
55-64 years	0	0.00	3	13.64	19	86.36	22			
>65	0	0.00	5	13.89	31	86.11	36			
Gender										
Female	0	0.00	19	20.88	72	79.12	91	8.9740 NS	2	0.0110*
Male	18	8.61	48	22.97	143	68.42	209			
Religions										
Hindu	0	0.00	45	22.73	153	77.27	198	57.7010 S	4	0.0001*
Muslim	9	12.50	22	30.56	41	56.94	72			
Christian and others	9	30.00	0	0.00	21	70.00	30			
Marital status										
Unmarried	0	0.00	4	17.39	19	82.61	23	46.4380 S	6	0.0001*
Married	12	4.74	55	21.74	186	73.52	253			
Widow	2	11.11	7	38.89	9	50.00	18			
Divorced	4	66.67	1	16.67	1	16.67	6			
Employment status										
Employed	0	0.00	20	13.16	132	86.84	152	40.0020 S	2	0.0001*
Non employed	18	12.16	47	31.76	83	56.08	148			
Income groups										
<=10000	3	2.68	13	11.61	96	85.71	112	30.6310 S	10	0.0011*
10001-20000	10	11.24	27	30.34	52	58.43	89			
20001-30000	0	0.00	7	21.88	25	78.13	32			
30001-40000	2	4.55	16	36.36	26	59.09	44			
40001-50000	2	16.67	3	25.00	7	58.33	12			
>=50001	1	9.09	1	9.09	9	81.82	11			
Educations										
Illiterate	0	0.00	11	19.30	46	80.70	57	127.6730 S	6	0.0001*
Primary education	0	0.00	13	12.75	89	87.25	102			
High school education	0	0.00	34	35.05	63	64.95	97			
Pre- university education and above	18	40.91	9	20.45	17	38.64	44			
Type of family										
Nuclear family	11	5.61	46	23.47	139	70.92	196	0.5130 NS	2	0.7740
Joint family	7	6.73	21	20.19	76	73.08	104			
Place of residence										
Rural residence	14	7.41	40	21.16	135	71.43	189	2.0030 NS	2	0.3670
Urban residence	4	3.60	27	24.32	80	72.07	111			
History of BCG vaccination										
Yes	18	6.84	65	24.71	180	68.44	263	11.0430 NS	2	0.0040*
No	0	0.00	2	5.41	35	94.59	37			
Family History of TB										
Yes	6	8.96	19	28.36	42	62.69	67	3.6280 NS	2	0.1630*
No	12	5.15	48	20.60	173	74.25	233			
Presence of co morbidities										
Yes	0	0.00	40	30.77	90	69.23	130	21.2650 S	2	0.0001*
No	18	10.59	27	15.88	125	73.53	170			
Total	18	6.00	67	22.33	215	71.67	300			

S= Significance NS= Significance

P values at 0.001% level

Table.6 showed that the calculated X2 values for age (X2= 34.52, P<0.001), religion (X2= 57.70, P<0.001), marital status (X2= 46.43, P<0.001), employment status (X2= 40, P<0.001), income group (X2= 30.61,

P<0.001), education qualification (X²= 127.67, P>0.001), and presence of co-morbidities (X²= 21.26, P<0.001) were less than the table values at the 0.001 level of significance. As a result, research hypothesis H3 is accepted and Null hypothesis H03 is rejected with regard to the aforementioned demographic variables. Therefore, in relation to these demographic factors, research hypothesis H3 is accepted and null hypothesis H03 is rejected. Therefore, the following factors were linked to patients' anxiety levels: age, gender, religion, work status, marital status, education level, history of BCG vaccination, family history of tuberculosis, and presence of co-morbidities. Counselling is a useful tool for lowering anxiety levels. P<0.0001 is considered significant.

**Table: 7: Association between pretest levels of depression and demographical variables
N= 300**

Demographical profile	Pretest levels of depression								Chi-square	df	p-value
	Mild	%	Moderate	%	Moderately severe	%	Severe	%			
Age group											
20-34 years	9	7.32	11	8.94	44	35.77	59	47.97	13.67NS	12	0.3220
35-44 years	4	7.14	4	7.14	16	28.57	32	57.14			
45-54 years	2	3.17	2	3.17	14	22.22	45	71.43			
55-64 years	0	0.00	1	4.55	7	31.82	14	63.64			
>65	1	2.78	1	2.78	11	30.56	23	63.89			
Gender									6.90NS	3	0.0750
Female	1	1.10	4	4.40	26	28.57	60	65.93			
Male	15	7.18	15	7.18	66	31.58	113	54.07			
Religions									16.92NS	6	0.0100*
Hindu	5	2.53	9	4.55	60	30.30	124	62.63			
Muslim	7	9.72	7	9.72	26	36.11	32	44.44			
Christian and others	4	13.33	3	10.00	6	20.00	17	56.67			
Marital status											
Unmarried	0	0.00	1	4.35	7	30.43	15	65.22	15.05NS	9	0.0900
Married	14	5.53	17	6.72	77	30.43	145	57.31			
Widow	0	0.00	0	0.00	7	38.89	11	61.11			
Divorced	2	33.33	1	16.67	1	16.67	2	33.33			
Employment status											
Employed	0	0.00	6	3.95	41	26.97	105	69.08	27.53S	3	0.0001*
Non employed	16	10.81	13	8.78	51	34.46	68	45.95			
Income groups											
<=10000	3	2.68	9	8.04	27	24.11	73	65.18	22.81NS	15	0.0880
10001-20000	8	8.99	8	8.99	33	37.08	40	44.94			
20001-30000	1	3.13	0	0.00	8	25.00	23	71.88			
30001-40000	2	4.55	1	2.27	17	38.64	24	54.55			
40001-50000	2	16.67	1	8.33	4	33.33	5	41.67			
>=50001	0	0.00	0	0.00	3	27.27	8	72.73			
Educations											
Illiterate	0	0.00	3	5.26	13	22.81	41	71.93	52.17S	9	0.0001*
Primary education	1	0.98	2	1.96	29	28.43	70	68.63			
High school education	6	6.19	6	6.19	38	39.18	47	48.45			
Pre- university education and above	9	20.45	8	18.18	12	27.27	15	34.09			
Types of family											
Nuclear family	14	7.14	14	7.14	57	29.08	111	56.63	4.62NS	3	0.2010
Joint family	2	1.92	5	4.81	35	33.65	62	59.62			
Place of residence											
Rural residence	14	7.41	13	6.88	58	30.69	104	55.03	4.97NS	3	0.1730.
Urban residence	2	1.80	6	5.41	34	30.63	69	62.16			
History of BCG vaccination											
Yes	16	6.08	18	6.84	86	32.70	143	54.37	10.01NS	3	0.0180*
No	0	0.00	1	2.70	6	16.22	30	81.08			
Family History of TB											

Yes	10	14.93	6	8.96	26	38.81	25	37.31	23.87S	3	0.0001*
No	6	2.58	13	5.58	66	28.33	148	63.52			
Presence of co morbidities											
Yes	5	3.85	5	3.85	38	29.23	82	63.08	4.51NS	3	0.2110.
No	11	6.47	14	8.24	54	31.76	91	53.53			
Total	16	5.33	19	6.33	92	30.67	173	57.67			

S= Significance NS= Non-Significance

P values at 0.001% level

Table 7.1 showed that the calculated X2 values for employment (X2= 27.53, P<0.001), education level (X2= 52.17, P<0.001), and family history of tuberculosis (X2= 23.87, P<0.001) were greater than the table values at the 0.001 level of significance. As a result, the null hypothesis H02 is rejected and research hypothesis H2 is accepted with regard to the demographic variables mentioned above. However, the calculated X2 values for age (X2= 13.57, P>0.001), gender (X2= 6.90, P>0.001), religion (X2= 16.92, P>0.001), marital status (X2= 15.05, P>0.001), income group (X2= 22.81, P>0.001), family type (X2= 4.62, P>0.001), residence (X2= 4.97, P<0.001), history of BCG vaccination (X2= 10.01, P>0.001), and presence of co-morbidities (X2= 4.51, P>0.001) were less than the table values at the 0.001 level of significance. Hence Religion, Employment status, educational status, History of BCG vaccination, Family History of TB, was association with Depression level of patients, counselling is effective for reducing the Pretest levels of depression. P<0.0001 level of significant.

DISCUSSION

The finding in our study that Comparison between pre-test and post-test level of fear of tuberculosis client's pre-test level Minimal anxiety 0 percent, mild anxiety 6 percent, moderate anxiety 22.33 Percent and severe anxiety 71.67% and after test after giving proper information at post-test level less fear 4.33 percent, mild anxiety 38 percent, moderate anxiety 57.67 Percent and severe anxiety 0.00%.

Comparison of the depression scores of TB patients before and after receiving counselling reveals that the depression scores before counselling were minimal (less than 5%), mild (5.33%), moderate (6.33%), severe (57.67%), and very severe (more than 30.67%). Minimal depression is 6.0%; mild depression is 29.67%; moderate depression is 53.00%; and severe depression is 0.00%. These results are consistent with prior research showing that mental health therapies can ensure adherence to TB treatment. Psycho-emotional support therapies have been shown to improve TB treatment outcomes, according to a comprehensive study. Furthermore, in a pilot study conducted in Nepal, clients in the 2 treatment patients in the two intervention groups—information and counsel results with economical information had a greater percentage of successful management outcomes than those in the control group, which received no help. Furthermore, compared to those who simply received the directly observed therapy intervention, those who establish the mental information respiratory information observation instruction had noticeably higher medicine observance, according to a Ethiopia conducted a cluster randomized controlled study [6]. With each additional counseling session, we also saw a tendency of symptomatic persons becoming more compliant with their therapy; the biggest improve the completion was seen at assembly amount four. Furthermore, we discovered that those with symptoms who got the mental health intervention finished their respiratory infection management at a rate comparable to those without symptoms. Given that symptomatic persons are more likely to discontinue therapy, having a complete or incomplete mental health management could improve management for patients with reported anxiety and depression, according to the results of the trend analysis and same management between the two [7]. The findings of this study also strengthen the information supporting the efficacy of adopting the lay wellbeing model to provide mental health services. According to research, psychological therapy plans that are contextually relevant and administered by qualified lay health counselors typically have a positive impact on lowering total disability. When rescreened at the end-line, psychological wellbeing based on models of lay wellbeing workers typically warrant a large decrease in mental illness rate. According to a randomized control experiment conducted in a less income family neighborhood in Muslim country, eight counseling sessions led by lay medical professionals can considerably improve anxiety and depressive symptoms. These results corroborate our hypothesis that, in judgement to baseline, those who established the mental health involvement experienced significantly lower levels of anxiety and/or depression [8].

CONCLUSION

According to this study, adding psychiatric wellbeing transmission and psychotherapy facilities to respiratory tract infection patients enhances treatment completion rates and alleviates anxiety and depression symptoms. Our research strengthens the case for the adoption of these strategies to help close the management gap for psychiatric illness issues by adding to the increasing amount of data showing the value of employing lay health counselors to provide mental health services in current programs.

CONFLICTING INTERESTS

The writers say they have no conflicting interests.

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