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INTERNALIZED STIGMA AND ASSOCIATED FACTORS IN PATIENTS APPLYING TO PSYCHIATRY OUTPATIENT CLINICS, A DESCRIPTIVE STUDY

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Abstract: This study was conducted to investigate internalized stigma and related factors in patients applying to psychiatry outpatient clinics. The descriptive-cross-sectional study was conducted with 187 patients. In the survey included in the study, socio-demographic data, data on previous clinical/disease and Internalized Stigma of Mental Illness (ISMI) Scale were used. It was determined that 16.6% of the patients were hospitalized due to mental illness and 10.7% of them were dismissed due to mental disorders. The total mean score of the participants in ISMI was found to be 56.2±11.3. The scale total score of the patients whose education level was university or higher was found to be lower than the other groups (P= 0.012). The mean scores of the patients with children were significantly lower than those without children (P= 0.012) and the patients living in the village compared to the patients living in the city center (P= 0.002). The total ISMI score was found to be higher in patients who were previously hospitalized due to mental illness and patients who were dismissed due to mental disorders (P= 0.016, P= 0.006, respectively). It was determined that there was a positive and low-level significant relationship between disease duration and ISMI total score (r= 0.152; P= 0.038). Educational status, place of residence, hospitalization due to mental illness, dismissal status due to mental disorders and duration of illness were determined as variables affecting the level of internalized stigma in individuals with mental disorders.

Keywords: Internalized stigma, Stigmatization, Mental illness, Mental disorders

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1. Introduction

According to the World Health Organization (WHO) (WHO, 2016) report, ranking third in the world in terms of disability and overall burden of disease, mental illness is one of the most important public health problems. According to WHO, 4.9% of the global burden of disease is mental health problems (WHO, 2022). Although there is no new data on the burden of mental illness in our country, in the Türkiye Burden of Disease Study in the 2011-2023 national mental health action plan conducted by the Ministry of Health, when ranking according to the causes of the burden of disease, it is seen that mental disorders take the second place with 19% (T.C. Sağlık Bakanlığı, 2011). It is known that people with mental health problems cannot fulfill their personal care, have difficulties in communicating with their families and the environment, and cannot fully perform their activities in many areas (Ayar et al., 2021). Mental health problems affect more and more individuals every day and are seen in all age groups. In addition, its importance is gradually increasing because it has effects on the family and society, increases economic losses, causes long-term drug use and suicide (WHO, 2013; Çakmak and Konca, 2019; OECD, 2019). Although there are proven treatment and support methods, it is a serious problem for people with mental disorders to delay treatment, avoid treatment, stop treatment or not use drugs (Hongo et al., 2021).

One of the biggest obstacles to the diagnosis and treatment of mental disorders is stigmatization, prejudiced thinking/behavior, stereotypical behaviors and discrimination against people with mental disorders. Among all patients, patients diagnosed with a mental disorder can be described as the individuals most exposed to the negative consequences of stigma. Stigma is the negative evaluation of a person or group as defective or discredited based on characteristics such as mental illness, ethnic group or physical disability (Link and Phelan, 2001; Kök and Demir, 2018; Yildirim and Kavak Budak, 2020). Cancer, tuberculosis, leprosy, sexually transmitted diseases, epilepsy, alcohol-drug addictions and AIDS; are some of the diseases that have a stigma on them, and one of the groups most affected by stigma is psychiatric patients diagnosed with a mental disorder (Çam and Çuhadar, 2011). Among various stigmatization(s), internalized stigmatization is the most damaging to the individual (Ersoy and Varan, 2007).

Once individuals with psychiatric disorders are labeled as "mentally ill", they involuntarily begin to see themselves as a member of the group with disabilities and excluded (Çam and Çuhadar, 2011).

The definition of internalized stigma is that the individual accepts the negative stereotypes in the society for himself and as a result withdraws himself from the society with negative feelings such as worthlessness and shame (Hongo et al., 2021). Internalized stigmatization causes individuals with mental illness to isolate from society, avoid getting psychiatric support, fail to comply with treatment, and worsen their prognosis. The fact that individuals with internalized stigma anxiety avoid applying to health institutions for treatment and that they are excluded from the society even if they start treatment cause problems in their treatment processes and adherence to treatment, and this creates a serious obstacle in their adherence to treatment (Yildirim and Kavak Budak, 2020). There are many factors in the literature that are thought to affect internalized stigma, but they show changes.

In our study, it was aimed to investigate internalized stigma and related factors in patients who applied to psychiatry outpatient clinics.

2.Materials and Methods

This descriptive and cross-sectional study was conducted by applying a questionnaire to the patients who applied to the psychiatry outpatient clinics of XX Mental Health and Diseases Hospital between 15 June and 15 September 2022. In order to determine the number of samples to be taken for the study, power analysis was performed using the G* power 3.1.9.7 program (Faul et al, 2007). The power of the study is expressed as 1-β (β = probability of type 2 error), and in general studies should have 80% power. According to Cohen's effect size coefficients; While the effect size was d=0.20, the sample size calculated by taking the type 1 error level=0.05, power=0.80 was calculated as a minimum of 199 individuals. The study included 187 patients who came to the polyclinic between the specified dates, were 18 years of age and older, had a diagnosed psychiatric disease for at least 1 month, had no communication barriers such as hearing and were able to communicate, and voluntarily agreed to participate in the study. In this study, 94.0% of the calculated sample size was reached. Data collection tools were applied by face-to-face interviews with randomly selected patients during their outpatient clinic examinations.

2.1. Data Collection Tools

In the first part of the questionnaire applied to the patients, there were a total of 17 questions regarding the socio-demographic data of the patients (age, gender, marital status, residence status, etc.) and their previous clinical/disease-related variables. In the second part, the Internalized Stigma of Mental Illnesses Scale (ISMI) was applied.

The Internalized Stigma of Mental Illness Scale (ISMI), developed by Ritsher et al (2003), is a self-report scale consisting of 29 items and evaluating internal stigma. The Turkish adaptation study was carried out by Ersoy and Varan (2007), and the Cronbach alpha value was found to be 0.93. The scale is a 4-point Likert-type measurement instrument. The total score ranges from 29 to 116 points. High scores on ISMI indicate high internalized stigma. Those who scored 0-25 on the scale were determined as low, between 26-39 points as moderate, and those with 40 and above points as high level of internalized stigma (Ersoy and Varan, 2007). In the sub-dimensions of the scale; There are “Alienation” (6 items), “Confirmation of the stereotypes” (7 items), “Perceived discrimination” (5 items), “Social withdrawal” (6 items), and “Resistance to stigmatization” (5 items). The “Resistance to stigmatization” sub-dimension is scored inversely.

2.2. Statistical Analysis

SPSS 22.0 package program was used for the statistical analysis of the data obtained in this study. Results were expressed using mean ± standard deviation (median (min-max)) and number (%) according to data. For those who fit the normal distribution in the analysis of the data; Student-t test and One-Way ANOVA test, for those who did not fit the normal distribution; Mann Whitney-U, Kruskal Wallis test was used. Spearman correlation analysis was used in the correlation analysis. Statistical significance level of $P < 0.05$ was accepted for all tests.

3. Results

The mean age of the 187 people who participated in the study was 36.45±12.05 (median= 35.0 ((18.0-70.0)) years. It was found that 73.3% (n=137) of the patients were female, 42.2% were high school graduates, and 56.1% were married (Table 1). The average monthly income of the participants was 7,300±3,780 TL (median= 6,000 (1,300-30,000)), the mean duration of follow-up for the disease was 7.99±8, It was 15 years (median=4.5 (0.08-38.18)).

It was determined that 72.7% of the patients had comorbidities and 16.6% of them were hospitalized due to mental illness before. In addition, 10.7% of the patients stated that they were dismissed due to mental problems (Table 2).

The total mean score of the participants in ISMI was found to be 56.2±11.3 (31.0-89.0). Scores from ISMI and its sub-dimensions are given in Table 3.

When the variables according to the Internalized Stigma of Mental Illness Scale and its sub-dimensions were examined (Table 4); age group; the total score of those aged 18-28 years was higher than those in the other groups ($P= 0.041$), but there was no statistically significant difference in pairwise comparison ($P > 0.05$). The mean scores of the alienation ($P < 0.001$) and social withdrawal ($P= 0.002$) sub-dimensions of the 18-28 years were found to be significantly higher. The total score of the scale ($P= 0.012$) and the mean score of all

sub-dimensions of the patients who graduated from university or higher were found to be lower than the other groups. In addition, the mean scores of the patients with children were significantly lower than those without children (P= 0.012) and the patients living in the village compared to the patients living in the city center (P= 0.002). The scale total score and the mean score of all sub-dimensions of the patients whose income is less than their expenditure according to family income perception were found to be higher than the other groups, but there was no statistically significant difference in pairwise comparison (Table 4). In patients who used alcohol and cigarettes, ISMI total score and mean scores of all sub-dimensions were found to be similar to patients who did not use (P > 0.05).

The evaluation of ISMI and its sub-dimensions according to the variables related to the clinical/disease of the participants is presented in Table 5. The mean total score (58.80±11.31) and social withdrawal mean score (12.74±3.61) of the patients previously hospitalized due to mental illness were significantly higher than the others (P= 0.016, P= 0.042, respectively). It was found that the mean score of ISMI total score and sub-dimensions was high in patients who stated that they had been dismissed due to mental diseases (P < 0.05).

It was found that the patient's psychiatric diagnosis duration (years) and ISMI total score, and the mean score of "confirmation of the stereotypes" were positively and low-significantly correlated (r= 0.152; P= 0.038, r=0.238; P= 0.001, respectively).

Table 1. Distribution of patients' socio-demographic characteristics (n=187)

Variables	n=187	%
Age		
18-24 age range	36	19.2
25-44 age range	106	56.7
≥45 age	45	24.1
Gender		
Female	50	26.7
Male	137	73.3
Education status		
≤Primary school graduate	43	23.0
High school graduate	79	42.2
≥Undergraduate	65	34.8
Marital status		
Married	105	56.2
Single	67	35.8
Widowed/Divorced	15	8.0
Child presence		
Yes	117	62.6
No	70	37.4
Residency		
Province	149	79.7
Country	29	15.5
Village	9	4.8
Working status		
Yes	78	41.7
No	109	58.3
Family income perception		
Low	71	38.0
Moderate	93	49.7
High	23	12.3
Smoking status		
Yes	70	37.4
No	117	62.6
Alcohol use status		
Yes	23	12.3
No	164	87.7

Table 2. Participants' clinical/disease-related variables

Variables	n=187	%
Additional disease status		
Yes	136	72.7
No	51	27.3
Prior hospitalization due to mental illness		
Yes	31	16.6
No	156	83.4
Number of applications made to psychiatry outpatient clinics for outpatient treatment in a year		
1-2 time	70	37.4
3-4 times	62	33.2
≥5 times	55	29.4
Presence of psychiatric illness in the family		
Yes	55	29.4
No	132	70.6
Dismissal status due to mental disorders		
Yes	20	10.7
No	167	89.3

Table 3. Distribution of scores obtained from the Internalized Stigma of Mental Illness Scale (ISMI) and its sub-dimensions

	Mean ±SD	Min-max
ISMI total	56.2±11.3	31.0-89.0
Alienation	11.9±3.6	6.0-22.0
Confirmation of the stereotypes	13.0±3.2	7.0-23.0
Perceived discrimination	8.8±2.6	5.0-16.0
Social withdrawal	11.5±3.6	6.0-22.0
Resistance to stigmatization	12.6±2.8	6.0-19.0

SD= Standart deviation, Min=Minumum, Max=maximum ISMI= The Internalized Stigma of Mental Illness Scale

Table 4. Evaluation of the participants' socio-demographic variables and ISMI score status

Variables	ISMI total	Alienation	CS	PD	SW	RS
Age						
18-24 age range	60.4±13.0	13.8±4.0	13.3±3.4	9.5±2.5	13.4±4.2	12.3±3.0
25-44 age range	55.5±10.4	11.9±3.3	12.9±3.2	8.6±2.5	11.1±3.3	12.7±2.8
≥45 age	54.5±11.4	10.6±3.4	12.9±3.2	8.8±2.8	10.9±3.3	12.9±2.6
P value	0.041++	<0.001**	0.757++	0.214**	0.002++	0.649++
	1-2 a =0.064	1-2 a =0.013			1-2 a =0.002	
	1-3 a =0.051	1-3 a <0.001			1-3 a =0.006	
	2-3 a =0.869	2-3 a =0.105			2-3 a =0.978	
Gender						
Female	56.2±11.7	11.3±3.6	13.2±3.3	8.9±2.6	12.0±3.5	12.5±3.3
Male	56.1±11.2	12.2±3.6	12.9±3.2	8.8±2.6	11.3±3.7	12.7±2.6
P value	0.965+	0.143*	0.550*	0.838*	0.211*	0.660+
Education status						
≤Primary school	57.6±11.7	11.6±4.0	13.5±3.7	8.8±2.8	12.1±3.8	13.3±2.6
High school	58.1±11.3	12.9±3.8	13.5±3.1	9.1±2.4	11.6±3.6	12.8±2.8
≥Undergraduate	52.8±10.4	11.1±2.9	12.0±2.9	8.4±2.7	10.9±3.4	12.0±2.7
P value	0.012++	0.010++	0.010**	0.311**	0.232++	0.061++
	1-2 a =0.973	1-2 a =0.135	1-2 a =0.986			
	1-3 a =0.074	1-3 a =0.774	1-3 a =0.040			
	2-3 a =0.014	2-3 a =0.009	2-3 a =0.016			
Marital status						
Married	55.2±10.8	11.4±3.5	13.0±3.4	8.6±2.7	10.9±3.3	12.9±2.9
Single	57.7±12.3	12.9±3.8	12.9±3.1	8.8±2.4	12.4±3.9	12.3±2.7
Widowed/Divorced	56.0±9.8	11.8±2.7	13.1±3.0	9.5±2.3	11.2±4.1	12.4±2.0
P value	0.388++	0.026++	0.987++	0.505++	0.028++	0.465**
		1-2 a =0.020			1-2 a =0.022	
		1-3 a =0.919			1-3 a =0.433	
		2-3 a =0.511			2-3 a =0.969	
Child presence						
Yes	55.2±10.4	11.4±3.4	12.9±3.2	8.7±2.6	11.0±3.2	12.8±2.8
No	57.8±12.6	12.8±3.8	13.2±3.4	8.9±2.5	12.3±4.0	12.4±2.7
P value	0.012+	0.017+	0.566*	0.749*	0.014+	0.443+
Residency						
Province	50.1±5.9	9.4±1.5	11.3±3.2	7.2±3.1	12.1±3.1	11.5±4.2
Country	56.2±12.2	11.9±3.8	12.9±3.3	8.7±2.7	11.4±3.9	12.8±2.8
Village	58.1±6.5	12.8±2.5	13.8±2.8	9.5±1.4	11.6±2.2	12.0±1.9
P value	0.018++	0.046++	0.114++	0.069*	0.845++	0.168*
	1-2 a =0.021	1-2 a =0.426				
	1-3 a =0.002	1-3 a =0.108				
	2-3 a =0.644	2-3 a =0.511				
Working status						
Yes	55.5±10.8	11.4±3.5	13.0±3.1	8.6±2.7	11.3±3.5	12.8±2.9
No	56.7±11.7	12.3±3.7	13.0±3.3	8.9±2.6	11.6±3.7	12.5±2.7
P value	0.465+	0.080*	0.988*	0.399*	0.632*	0.487*
Family income perception						
Low	58.3±11.6	12.5±3.7	13.5±3.5	9.2±2.7	12.4±3.9	12.5±2.7
Moderate	55.8±10.0	11.9±3.3	12.9±3.0	8.7±2.4	11.1±3.2	12.8±2.6
High	51.1±13.8	10.4±4.2	11.7±3.1	7.7±3.1	10.3±3.8	12.5±3.5
P value	0.027++	0.065**	0.078++	0.055**	0.019++	0.849++
	1-2a=0.330				1-2 a =0.065	
	1-3 a =0.022				1-3 a =0.040	
	2-3 a =0.176				2-3 a =0.581	

*Student-t test, **One Way ANOVA test, +Mann-Whitney-U test, ++Kruskall Wallis test, aMann Whitney U test with Bonferroni correction. ISMI= the internalized stigma of mental illness scale, CS= confirmation of the stereotypes, PD= perceived discrimination, SW= social withdrawal, RS= resistance to stigmatization

Table 5. Evaluation of the clinical/disease-related variables and ISMI score of the participants

Variables	ISMI total	Alienation	CS	PD	SW	RS
Additional disease status						
Yes	55,6±11,8	12,0±3,7	12,7±3,4	8,7±2,6	11,4±3,7	12,4±3,0
No	57,7±9,9	11,8±3,5	13,7±2,7	9,1±2,5	11,6±3,3	13,2±2,0
P value	0,268+	0,705*	0,072+	0,279*	0,712*	0,117*
Prior hospitalization due to mental illness						
Yes	58,8±11,3	12,9±3,8	13,2±3,4	9,4±2,3	12,7±3,6	12,4±2,2
No	55,7±11,3	11,8±3,6	12,9±3,2	8,7±2,6	11,2±3,6	12,7±2,9
P value	0,016+	0,115+	0,619+	0,178+	0,042+	0,558+
Number of applications to outpatient treatment in a year						
1-2 time	55,8±11,3	11,8±3,7	12,8±3,2	8,8±2,6	11,2±3,4	12,8±2,7
3-4 times	55,2±11,1	11,5±3,6	13,0±3,3	8,5±2,7	11,5±3,8	12,2±3,1
≥5 times	57,7±11,6	12,6±3,5	13,2±3,3	9,1±2,5	11,8±3,8	12,9±2,4
P value	0,476++	0,232++	0,791++	0,531**	0,708++	0,361++
Presence of psychiatric illness in the family						
Yes	55,8±10,4	11,6±3,1	12,8±3,4	8,8±2,8	10,8±3,7	13,4±2,6
No	56,3±11,7	12,1±3,8	13,0±3,2	8,9±2,5	11,7±3,6	12,3±2,8
P value	0,767+	0,396+	0,734*	0,902+	0,117*	0,018+
Dismissal status due to mental disorders						
Yes	62,7±10,8	13,9±3,3	15,1±2,8	10,0±2,1	13,2±3,5	12,8±2,8
No	55,4±11,1	11,7±3,6	12,7±3,2	8,6±2,6	11,3±3,6	12,6±2,9
P value	0,006+	0,011*	0,002+	0,036*	0,025+	0,788+

*Student-t test, **One Way ANOVA test, +Mann-Whitney-U test, ++Kruskall Wallis test, aMann Whitney U test with Bonferroni correction. ISMI= the internalized stigma of mental illness scale, CS= confirmation of the stereotypes, PD= perceived discrimination, SW= social withdrawal, RS= resistance to stigmatization

4. Discussion

Mental illnesses are among the most common health problems in the society and show a rapid increase in different social levels, races and different cultures in the world (WHO, 2017). In addition, the cost of these diseases and the burden of the disease increase gradually due to the fact that mental diseases cannot be treated because they are not recognized (Andersen and Harthorn, 1989; Gonzales et al.,1994; WHO, 2019). In order to reduce the prevalence of mental illnesses, bio-psycho-socio-cultural aspects that affect the disease and treatment should be investigated and solutions should be produced. Therefore, in our study, we focused on the solution and investigated the level of internalized stigma and related factors in people with mental illness in our city.

In the literature, it is stated that those who score 40 and above on the internalized stigma scale have high levels of internalized stigma (Ersoy and Varan, 2007). In our study, the mean internalized stigma score of the patients was found to be 56 points, and the internalized stigma level of the patients was found to be high. In another study conducted in our country, the level of internalized stigma was higher and the mean score was found to be higher than ours (Ayar and Karasu, 2021). The higher scores than our results may be due to the different cultural structure and region of the city where the study was conducted. Kurt et al. (2021) found a high level of self-stigma in schizophrenia patients. According to this result; regardless of the diagnosis in mental illnesses, it is thought that the level of internalized stigma is high. The results we found in our study, similar to the literature, may be due to the fact that negative attitudes towards mental illnesses are still high in the society.

In the results we found, it is noteworthy that the group aged 18-28 years had higher scores than the others in the total score of ISMI. In the study of Ayar and Karasu (2021) found that in contrast to our study, the level of internalized stigma was higher in individuals over the age of 51 years. Similarly, in another study, it was stated that functional impairment increases internalized stigma due to the increase in the perception of loneliness with age and inadequate coping strategies (González-Domínguez et al, 2018). In our study, mean scores decreased with age. In the study conducted by Solano and Whitbourne (2001) in patients diagnosed with schizophrenia, one of the mental illnesses, they found that although the coping strategies used by older people

(50 years and older) to manage schizophrenia symptoms were similar to those of adults, they were more effective in the elderly. In our study, it is seen that high scores obtained from alienation and social withdrawal in the young group are effective in internalized stigma. It was thought that negative reasons such as environmental pressure and the effect of social status in young people were effective in high internalized stigma.

We found that the level of internalized stigma of the patients varied according to their educational status, economic status, and working status. Picco et al. (2016) stated in their study, similar to our results, that the mean ISMI score of those with low education level was higher. It is thought that it is important to plan psycho-educational training according to education level in preventing internalized stigma when intervening with individuals with mental illness. In addition, it is important for individuals to work at a job regularly in their lives in terms of increasing their functionality in society (Turan, 2019). It has been found that working in a job has a protective effect against internalized stigma in those with mental illness (Bozan, 2019). In our study, the internalized stigma total score of the patients who do not work in any job was found to be higher than those who work in any job. However, this difference was not statistically significant. According to the results of our study, working in a job is not associated with internalized stigma. In addition, in our study, it was shown that the internalized stigma level and alienation, confirmation of the stereotypes, perceived discrimination, and social withdrawal scores of those who quit their jobs due to mental problems were high. It was thought that the absence of employment in a job for individuals with mental diseases may have increased the scores obtained from alienation, perceived discrimination, and social withdrawal.

Our results show that there is a low level of positive correlation between the total score of internalized stigma and the duration of the disease in patients with mental disorders. In the literature, Beyazyüz et al.(2015) and Mercan (2017) could not find a relationship between disease duration and internalized stigma. Despite this, it has been determined that as the duration of the disease increases in patients with Obsessive Compulsive Disorder, the level of self-stigmatization increases (Kizilağaç, 2018). In addition, it is noteworthy that the internalized stigma scores of those previously hospitalized due to mental illness were found to be high in our results. The finding in the literature that patients with more than one hospitalization have higher internalized stigma scores is consistent with our results (Coşkun and Güven-Caymaz, 2012; Tel and Ertekin Pınar, 2012). Unrealistic thoughts that hospitalized psychiatric patients are more dangerous are common among the public. It can be thought that the level of internalized stigma will increase as the number of hospitalizations and the duration of the disease increase, and as the mental illness becomes chronic, individuals will be more exposed to stigma due to social effects and they may internalize the stigma. Frequency of hospitalizations probably prevents individuals from socializing, restricts opportunities to maintain family and work relations and living close to other people, and increases the stigma of patients as “psychiatric patients”.

5. Conclusion

In order for the treatment to be effective in diseases and for the disease process to progress positively, the patients must be compatible and committed to the treatment applied. Although there are many factors affecting adherence to treatment in mental disorders, one of the important causes of non-adherence to treatment is internalized stigma. As a result of our study, the variables affecting the level of internalized stigmatization were education status, place of residence, hospitalization in a psychiatry clinic, dismissal status due to mental problems, and duration of illness in individuals with mental disorders. Patient education programs are of great importance in reducing the level of internalized stigma in mental illnesses. It is thought that providing these trainings and psychiatric rehabilitation services will be beneficial in increasing the functionality levels, self-confidence and socialization opportunities of the patients, decreasing the hopelessness levels and hospitalizations, thus reducing the level of internalized stigma. It is thought that providing these trainings and psychiatric rehabilitation services will be beneficial in increasing the functionality levels, self-confidence and socialization opportunities of the patients, decreasing the hopelessness levels and hospitalizations, thus reducing the level of internalized stigma.

Author Contributions

Percentages of the author(s) contributions is present below. All authors reviewed and approved final version of the manuscript.

%	S.O.	N.A.
C	50	50
D	100	
S	50	50
DCP		100
DAI	100	
L	50	50
W	50	50
CR		100
SR	50	50
PM	50	50
FA	50	50

C= concept, D= design, S= supervision, DCP= data collection and/or processing, DAI= data analysis and/or interpretation, L= literature search, W= writing, CR= critical review, SR= submission and revision, PM= project management, FA= funding acquisition.

Conflict of Interest

The authors declared that there is no potential conflict of interest with respect to the research, authorship, and/or publication of this article.

Ethical Approval/Informed Consent

Samsun University Clinical Research Ethics Committee approval (SÜKAEK-2022/1/9) and institutional permissions were obtained for the study. All patients participating in the study signed the "Informed voluntary consent form". Attention was paid to the confidentiality of personal data of the patients.

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