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RESEARCH ARTICLE

CONSULTATION IN BREAST CANCER AND THE EFFECT OF THE PSYCHIATRY ON DEPRESSION, ANXIETY, HOPELESS AND LIFE QUALITY

Sevda Bag*

****Department of Psychiatry Clinic, University of Health Sciences, Istanbul Training and Research Hospital, Turkey***

Abstsract

Breast cancer is the most common cancer among women. We aim to evaluate to difference between depression anxiety, hopelessness levels and to show the importance of psychiatric treatment and psychological support and difference between quality of life of patients with breast cancer.

Method: Fifty patients who signed the consent form were included in the study group.A sociodemographic data form was given to the patient and control groups during the first interview. Beck Anxiety Scale, Beck Depression Scale, World Health Organization Quality Of Life-Short Form Turkish Version (WHOQOL-BREF-TR) and Beck Hopelessness Scale were applied to the patient and control groups at the end of the first interview. Psychosocial support was provided at the 2nd and 3rd interviews, and the scales were re-applied at the end of the 6th month and the difference was evaluated.

Results: In the case group, Whool Brief physical area, mental area and environmental area score are increased ($p<0.05$) and Whool Brief social area score did not differ significantly ($p>0.05$) and the rate of being anxious at the 6th month after treatment declined significantly ($p<0.05$) the rate of dissatisfaction with body, at the 6th month after the treatment, showed a substantial decrease ($p< 0.05$) compared to the pre-treatment.

Discussion and conclusion: Our study showed the close association psychiatric treatment and and severity of qualıty of life and hopeless. Only goal in cancer treatment is not to eliminate the disease, but to increase the quality of life by reducing post-treatment morbidity.

Keywods: Breast Cancer, Psychological Support, Psychiatric Treatment, Quality of life, Hopeless

Introduction

Cancer is a chronic disease that also causes psychiatric disorders. Breast cancer is the most common cancer among women and is the leading cause of death from cancer. It is responsible for 33% of all cancers seen in women and 20% of cancer-related deaths. It ranks second after lung cancer in cancer-related deaths [1]. According to the information received from the Ministry of Health; The incidence of breast cancer in Turkey is 46.8 per 100 thousand. Nearly 17,000 women are diagnosed with breast cancer in each year. Women who are often diagnosed with breast cancer in our country have an age range between the ages of 50 and 69 [2].

There is a high rate of psychiatric disorders in cancer patients. Anxiety and depression are common symptoms in patients with cancer. Approximately one of three cancer patients complains of a psychiatric disorder [3]. The most common psychopathology is major depression (MD). MD is an important psychiatric disorder that needs attention in cancer patients, and it negatively affects patients' quality of life, compliance with treatment, disease severity, and response to treatment [4,5]. Patients with breast cancer and comorbid depression have been shown to have more severe pain, fatigue, severely impaired

quality of life, and even a reduced overall survival rate [6]. A recent meta-analysis found a 25% higher mortality rate in cancer patients with depressive symptoms and 39% in those with major depression compared to prognostic factors [7]. Diagnosis and treatment of breast cancer can cause psychological problems in patients such as anxiety, depression, anger, uncertainty about the future, hopelessness, despair, fear of recurrence of cancer, decreased self-esteem, deterioration of body image, fear of losing female characteristics, and fear of death.

The term hopelessness refers to sometimes negative emotions, negative consequences and desperate expectations. Beck; in his cognitive model, he defined despair as negative expectations about the future [8]. The intense fear of anxiety and death of cancer patients can be associated with a high level of hopelessness; It has been reported that the feeling of hopelessness may be caused by a negative perception of cancer and its treatment as a fatal disease [9]. Hope is an important factor in increasing the motivation of individuals which prevents the feeling of helplessness in the presence of a disease and helps patients to feel better and continue their cancer treatment. A strong sense of hopelessness is known to have the potential for new cancer to emerge and die due to illness [10] Hope, when used as a method of struggle, helps reduce the stress caused by cancer. Patients with breast cancer experience a deep feeling of hopelessness in the process of adaptation. Hopelessness is caused by perceiving cancer as a negative and fatal disease [11].

The frequency of anxiety in cancer patients is gradually increasing. The anxiety incidence in cancer patients is over 50%, in studies; Anxiety treatment positively affects compliance with treatment and quality of life in cancer patients [12]. Quality of life is an important outcome measure in evaluating health status and the effects of treatments. Health-related quality of life is accepted as a concept that measures the satisfaction of the individual with his / her health status and includes individual responses to the physical, mental and social effects of the disease on daily life activities [13]. Quality of life has been a notion that has been determined as an important evaluation criterion in patient monitoring after survival. The purpose of quality-of-life measurements in health is to examine a disease and its effects on the physical, social and emotional dimensions of life. In addition to being the most common cancer in women, breast cancer has been the most researched type of cancer in terms of psychological and psychosocial aspects among cancers since it poses a threat to the organ that symbolizes femininity and sexuality. Some studies reported that psychotherapeutic and social support was associated with improved survival for breast cancer patients [14]. In addition to the survival benefits of psychosocial support, other studies have recently revealed a major role in improving the quality of life [15] and significantly reducing the level of depression and other common mental disorders and increasing the level of hope.

The purpose of this study was to evaluate the patients with breast cancer, who were diagnosed with breast cancer and who were sent to our psychiatry outpatient clinic for consultation at the 6th month after the evaluation and psychiatric interview, and to observe the difference between depression anxiety, hopelessness levels and to show the importance of psychiatric treatment and psychological support and difference between quality of life of patients with breast cancer [16].

Method

Patients who were followed up in our oncology and general surgery breast outpatient clinics and who were referred to our psychiatry outpatient clinic for consultation purposes and a healthy control group were included in this study. Terminal-stage patients with cognitive dysfunction at a level that prevented detailed psychiatric interviews or testing were excluded from the study. Patients were informed about the study; 50 patients who signed the consent form were included in the study group. The

control group was constituted with 50 people who without any psychiatric illness or chronic illness. Approval was obtained from the ethics committee of our hospital for the study. Ethical approved by ıstanbul training hospital ethical comitee. Ethical comitee number 2011-KAEK-50.Informed consent was taken from all patıents.The data of the study were collected by a psychiatrist using the data collection forms by face-to-face interview method. A sociodemographic data form was given to the patient and control groups during the first interview. Beck anxiety scale, Beck depression scale, World Health Organization Quality of Life-Short Form Turkish Version (WHOQOL-BREF-TR) and Beck Hopelessness Scale were applied to the patient and control groups at the end of the first interview.

Psychiatric evaluation was planned as a psychiatric interview and psychosocial support. Beck anxiety beck depression beck hopelessness and and quality of life scale was applied to evaluate the sociodemographic characteristics of the patients participating in the first interview study group. Psychosocial support was provided at the 2nd and 3rd interviews, and the scales were re-applied at the end of the 6th month and the difference was evaluated.

Sociodemographic and Clinical Data Form

There were questions questioning the sociodemographic characteristics, clinical conditions, and psychosocial attitudes of the patients participating in the study.

Beck Depression Inventory (BDI)

It is a self-assessment scale consisting of 21 items in total. It provides a quadruple Likert type measurement. Each item gets a gradually increasing score between 0-3 and the total score is obtained by adding them. The cut-off point is 17 in the Turkish validity and reliability study of the scale conducted by Hisli. In the scoring of the scale, 0-10 points were evaluated as no depression, 11-17 points as mild depression, 18-23 points as moderate depression, 24 and above points as severe depression [17].

Beck Anxiety Inventory (BAI)

It is a self-assessment scale developed by Beck to determine the frequency of anxiety symptoms experienced by individuals. It is a Likert type scale consisting of 21 items. Its validity and reliability in Turkey conducted by Ulusoy, Sahin and Erkmen (1998) [18,19]. In the scoring of the scale, 0-7 points were evaluated as minimal anxiety, 8-15 points as mild anxiety, 16-25 points as moderate anxiety, 26-63 points as severe anxiety.

Beck Hopelessness Scale

Beck Hopelessness Scale developed by was used to evaluate the hopelessness level of patients. Beck Hopelessness Scale, validity and reliability of which was made by in our country. The scale, which consists of 20 items, is scored as "yes" and "no". The highest score that can be obtained is "20"; The higher the total score, the higher the feeling of hopelessness in the individual [20].

World Health Organization Quality of Life Scale Short Form Turkish Version (WHOQOL-BREF-TR)

The health-related quality of life scale was developed by WHO and its validity and reliability were verified [21]. There are two versions of the scale: long (WHOQOL-100) and short (WHOQOL-27) form. The scale measures physical, mental, social and environmental well-being and consists of twenty-six questions. Since each field expresses the quality of life in its field independently from each other, domain scores are calculated between. The higher score is the higher the quality of life.

The Quality of Life Questionnaire Short Form was developed in 1998 by the World Health Organization Quality of Life Group (WHOQOL-BREF) (The WHOQOL Group, 1998).The questionnaire of the 26-item scale

consists of 4 areas: physical health, psychological health, social relations and environmental health. The questionnaire assesses the impact of disease as well as life satisfaction. In the questions, the subjectivity of the individual is at the forefront and provides a subjective assessment of the broad definition of quality of life. Each field scores are calculated between. The higher the score, the better the quality of life. The validity and reliability study in Turkey was performed.

Statistical Method

In the descriptive statistics of the data, standard deviation, median lowest, highest, frequency and ratio values were used. The distribution of variables was measured with the Kolmogorov Simirnov test. Mann-Whitney test was used to analyse quantitative independent data and Wilcoxon test was used in the analysis of dependent quantitative data. Mc Nemar test was used in the analysis of qualitative dependent data. SPSS 26.0 program was used in the analyses.

Results

The average age of 50 female patients included in our study was 54.7 ± 6.6 years and 53.2 ± 6.6 years for the control group. Stage I, II, and III patients were included in the study. However, stage IV patients were not included in the study. 23 of the participants in the study were primary school (46%), 18 of them were high school (36%) and 9 of them were university graduates (9%).24 of them were working (48%) 26 of them were housewives (52%). 34 of them were married (68%) and 16 of them were single (32%). While 15 of patients' families had breast cancer (30%), 35 of patients' families had no family history (70%). Simple mastectomy was applied to 22 of the participants (44%) and radical mastectomy to 28 of them (56%). The sociodemographic characteristics of the patients are shown in (Table 1).

		n	**%**
Education	Primary school High school College	23 18 9	46.0% 36,.0% 18.0%
Occupation	Yes No	24 26	48.0% 52.0%
Marital status	Married single	34 16	68.0% 32.0%
children	Yes no	35 15	70.0% 30.0%
Family support	Yes no	38 12	76.0% 24.0%
Cigarette	Yes No	30 20	60.0% 40.0%
Alcohol	Yes No	16 34	32.0% 68.0%

Family history of breast cancer	Yes No	15 35	30.0% 70.0%
Application period to the doctor	1 week 2 weeks 3 weeks 4 weeks	20 21 8 1	40.0% 42.0% 16.0% 2.0%
Hastaliginizin Ogrenilmesini	Yes No	36 14	72.0% 28.0%
What Are You Connecting To Your IIIness	Genetic Destiny	17 33	34.0% 66.0%
Do You Have Any Information About Your Disease	Yes No	28 22	56.0% 44.0%
Change in Behaviour After lllness	no change Distance	10 40	20.0% 80.0%
Disease Stage	I II III	17 25 8	34.0% 50.0% 16.0%
Type of surgery	Simple Mastecto My radical Mastecto my	22 28	44.0% 56.0%
Additional Treatment	Yes	50	100.00%
Arm Edema	Yes No	34 16	68.0% 32.0%
What did you feel when you	Deny	22	44,0%

Table 1: The Sociodemographic Characteristics of the Patients

In the sociodemographic form, questioning the psychosocial attitudes of the patients were also asked. While 36 people said yes (72%) to the question of "Do you want your disease to be known?", while 24 people did not want it to be known (28%). To the question of "What do you attribute your illness to?" 33 people said "destiny" (66%), while 17 people answered "heredity" (34%). While 28 of the participants (56%) had information about their diseases, 22 of them (44%) had no information about their diseases. In the next question "the attitude of other people after the diagnosis of the disease" asked to the patients and 40 of them (80%) said

"distant". To the question "What did you feel when you first learned about your illness?", 22 people answered "denial" (44%), 20 people responded "acceptance" (40%) and 8 people answered "worry" (16%).

The ages of the patients in the case and control groups did not differ significantly (p>0.05). In the case group, pre-treatment Beck Anxiety Score, Beck Depression Score and Beck Hopelessness Score were significantly higher than the control group (p>0.05). The 6th month Beck Anxiety Score, Beck Depression Score, and Beck Hopelessness Score were significantly higher in the case group than the control group (p>0.05). The Beck Anxiety Score, Beck Depression Score and Beck Hopelessness Score at the 6th month after the treatment in the case group showed a substantial decline (p>0.05) compared to pre-treatment (Table 2) (Figure 1).

Figure 1. The Beck Anxiety Score, Beck Depression Score and Beck Hopelessness Score at the 6th month after the treatment in the case group showed a substantial decline

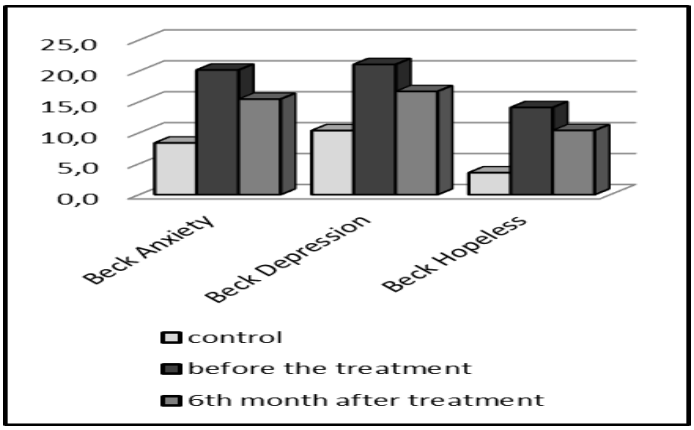

Table 2: In the case group, the Whool Brief physical area, mental area, social area and environment area score was considerably lower (p>0.05) than the control group at pre-treatment stage.

	Control		**Case**		
	Median. ± s.s./	**Median**	**Median. ± s.s/n-**	**Median**	**p**
Age	53.2 ± 6.6	53	54.7 6.6	55	0.353[m]
Back Anxiety					
Before treatment 6th month after treatment change in groups p	8.4 ± 3.2	8	20.0 ± 4.1	20	**0.000[m]**
	8.4 ± 3.2	8	15.4 ± 3.5	15	**0.000[m]**
	0.000[w]				
Back Depression					
Before treatment 6th month after treatment change in groups p	10.4 ± 2.6	10	21.1 ± 4.3	20	**0.000[m]**
	10.4 ± 2.6	10	16.7 ± 5.0	15	**0.000[m]**
	0.000[w]				
Back Hopeless					
Before treatment 6th month after treatment change in groups p	3.6 ± 1.9	4	14.1 ± 2.6	14	**0.000[m]**
	3.6 ± 1.9	4	10.4 ± 2.9	10	**0.000[m]**

	0.000[w]				
Whool Brief physical	9.4 ± 1.7	10	15.4 ± 2.5	15	**0.000[m]**
Before treatment 6th month after treatment change in groups p	9.4 ± 1.7	10	13.0 ± 2.6	14	**0.002[m]**
	0.000[w]				
Whool Brief psychologic	9.9 ± 1.6	10	14.3 ± 2.5	14	**0.000[m]**
Before treatment 6th month after treatment change in groups p	9.9 ± 1.6	10	11.0 ± 2.8	11	**0.002[m]**
	0.000[w]				
Whool Brief Social	8.7 ± 1.8	9	18.0 ± 28.4	14	**0.000[m]**
Before treatment 6th month after treatment change in groups p	8.7 ± 1.8	9	18.0 ± 28.4	14	**0.000[m]**
	0.000[w]				
Whool Brief environment	8.0 ± 2.6	9	13.8 ± 1.7	14	**0.000[m]**
Before treatment 6th month after treatment change in	8.0 ± 2.6	9	10.2 ± 2.4	10	**0.000[m]**
	0.000[w]				
[m]Mann-whitney u test / [w]Wilcoxon test					

In the case group, at the 6th month after the treatment, Whool Brief physical area, mental area, social area and environment area score was noticeably higher ($p>0.05$) than the control group. In the case group, at the 6th month after the treatment, Whool Brief physical area, mental area and environmental area score presented a noteworthy increase ($p<0.05$) compared to the pre-treatment. In the case group, 6th month after the treatment, Whool Brief social area score did not differ significantly ($p>0.05$) compared to pre-treatment. (Figure 2). In the case group, the rate of being anxious at the 6th month after treatment declined significantly ($p<0.05$) compared to the pre-treatment. In the case group, the rate of dissatisfaction with the body, at the 6th month after the treatment, showed a substantial decrease ($p<0.05$) compared to the pre-treatment (Table 3) (Figure 3).

Figure 2: The control before treatment 6th month after treatment

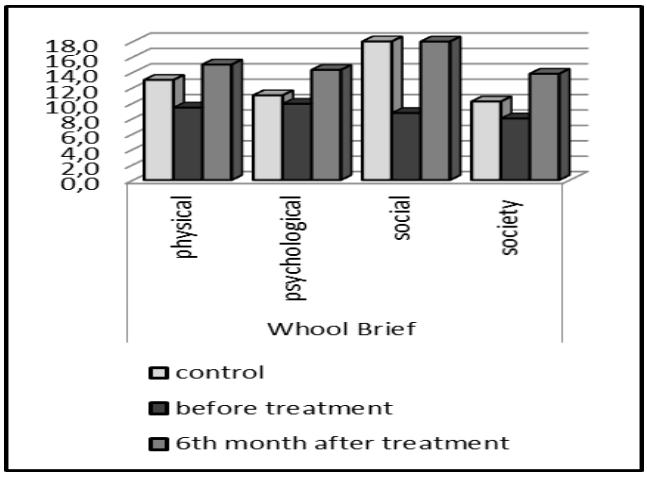

Figure 3: In the case group, the rate of dissatisfaction with the body, at the 6th month after the treatment, showed a substantial decrease (p<0.05) compared to the pre-treatment.

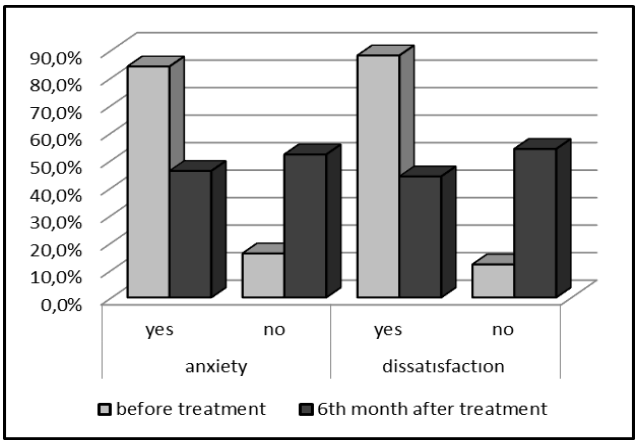

Table 3: In the case group, the rate of being anxious at the 6th month after treatment declined significantly (p<0.05) compared to the pre-treatment.

		Before Treatment		6th month after Treament		p
	Yes no	n	%	n	%	
Anxiety		42 8	84.00% 16.0%	23 26	46.00% 52.0%	0.000^{N}
Dissatisfaction from body	Yes no	44 6	88.00% 12.0%	22 27	44.00% 54.0%	0.000^{N}
^{N}Mc Nemar Test						

Discussion

Cancer, which is one of the most important and current problems of today's medicine and human beings' world, is a physical disease with mental and psychosocial components**.** Breast cancer is a cancer type that requires intensive and long treatment and is foremost seen in women. 20-35% of female breast cancer patients experience depression and anxiety at a certain point of their disease, regardless of the stage and treatment status of the disease. The depression (average 21.1 ± 4.3) and anxiety levels (average 20.2 ± 4.1) of the patients participating in our study, before psychiatric treatment, were significantly higher than the healthy control group ($p<0.05$). Clinical depression and anxiety observed at different stages of cancer depend on the nature of difficulties and intensity frequency. At the stage of diagnosis, patients experience complex emotions due to difficulties in accepting and coping with cancer. In our study, after the diagnosis phase, 22 people replied as "denial" (44%) 20 people answered as "acceptance" (40%) and 8 people responded as "worry" (16%). These results show the anxiety felt after diagnosis and difficulties in accepting the diagnosis. In the last measurements, made after psychiatric interview and psychosocial support, anxiety and depression levels decreased significantly compared to the first measurements ($p < 0.05$). This result shows the importance of psychiatric treatment in reducing anxiety and regression of depressive complaints. In addition, depression is among the most common mood disorders in cancer patients and make cancer treatment difficult. Psychiatric treatments will also positively affect the oncological treatments.

Hope expresses one's positive expectations for the future. Coping with breast cancer is a difficult situation for both women and their families. Throughout the diagnosis and treatment of breast cancer, women may experience actual or potential loss of independence, reduced or lost mobility and working capacity, pain, and deformity. Women with advanced breast cancer reported uncertainty about the future, difficulty in coping with physical symptoms, and concerns about maintaining hope. This study showed that with increased psychosocial support decreased patients' level of hopelessness. The decrease in anxiety at the end of the 6th month may have decreased the level of hopelessness.

Quality of life is an expression of individual well-being and a subjective expression of satisfaction in different areas of life. Although quality of life includes family, work life and socioeconomic conditions, it also includes the difference between hopes and dreams of the individual and the difference between realities, the goals, expectations that is the individual's perception of satisfaction and well-being from his daily life. Quality of life in the medical field is an expression of the patient's physical, emotional and social well-being. Breast loss after mastectomy has significant effects on mental and sexual life. In the study conducted by Sertöz on 125 women living with breast cancer for an average of 1.5 years, it was reported that total mastectomy disrupted body perception and caused sexual problems. The meaning of the breast in women and the removal of the breast due to cancer causes a significant decrease in quality of life as well as physical problems. In our study, although lower results were obtained in the physical field, in the psychological field and environment in the pre-psychiatric period compared to the control group, the significant increase after psychiatric treatment showed that patients with breast cancer benefited from psychiatric treatment and had a significant improvement in their quality of life. The absence of significant changes in the social field may be related to the distant behaviour of the relatives of the patients. Most of the previous studies related to psychological approaches in breast cancer are generally retrospective studies, whereas our study is planned prospectively. The importance of psychiatric consultation, evaluation and treatment is increasing day by day. Although developments in oncology progress at a dizzying speed, the psychological destruction caused by the disease cannot be avoided. Bio-

psycho-social approach is important in evaluating patients. Our study showed the close association and severity of anxiety and depression in cancer patients compared to the control group. This result reveals the importance of psychiatric diagnosis and treatment along with medical treatment in cancer patients.

Conclusion

As a result, the only goal in cancer treatment is not to eliminate the disease, but to increase the quality of life by reducing post-treatment morbidity. Adding psychiatric consultation and treatment to oncological treatment in breast cancer has a positive effect in reducing the degree of depression, anxiety and hopelessness and provides a significant increase in quality of life. The effects of psychiatric treatment on long-term survival will also be investigated in the future.

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Corresponding Author: Seva Bag, Istanbul Training and Research Hospital-Psychiatry Department-Org Abdurrahman Nafiz Gurman Cad. Etyemez, Samatya, 34098 İstanbul, Turkey.
E-mail: sevdabag@yahoo.com

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