

## The effect of self-awareness-based counseling on anger control in emergency medical personnel

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### Abstract

**Aim:** This study aimed to address the effect of self-awareness-based counseling on anger control among emergency medical personnel in Rafsanjan in 2021.

**Methods:** We used convenience sampling to conduct this quasi-experimental study on 80 emergency medical personnel in Rafsanjan in 2021, with a pretest-posttest control group design. We randomly divided eligible participants into intervention (N=40) and control groups (N=40). The intervention group received group discussion, lecture, and question-and-answer strategy to learn self-awareness skills. We used Skyroom to hold two 4.5-hour sessions. Participants completed demographic and background information questionnaire and Spielberger's State-

Trait Anger Expression Inventory 2 (STAXI-2) before and after the intervention. We used SPSS22 to analyze data.

**Results:** The study results suggested a significant difference in the mean total score of anger between the intervention and control groups after the intervention ( $P < 0.001$ ). The results also indicated a statistically significant difference in the mean scores of the state anger, the trait anger, and anger control and expression between the intervention and control groups after the intervention ( $P < 0.001$ ). Emergency medical personnel in the intervention group reduced anger and its subscales more than the control group.

**Conclusions:** According to the results of this study, it had a positive effect. Health managers and planners should hold self-awareness workshops to help healthcare workers, especially emergency personnel, manage and control their anger.

**Keywords:** counseling, self-awareness, anger, medical emergency

## Introduction

The term “self” allows individuals to realize their potential and facilitates life by providing a suitable situation and whole experience in everyday life [1]. Individuals’ knowledge and perception of themselves indicate they have a clear picture of their characteristics, values, attitudes, interests, and needs. They should use them to make better choices for themselves and others [2].

Golman presents five domains of self-awareness: emotional awareness, emotional control, self-arousal, recognition of emotions in others, and control of relationships [3]. Physicians and researchers consider self-awareness as a means to reduce psychological distress and develop

psychologically healthy people [4]. Individuals with self-awareness can become aware of and manage their feelings and emotions in aggressive situations [5].

Anger is a powerful and effective emotion in everyone's life [6]. It is a complex feeling that manifests physically and emotionally [7]. Anger often manifests when a person reacts to the inappropriate behavior of others, internal factors, such as irrational thoughts and opinions, misplaced expectations, and failure, or external factors, such as betrayal, lack of attention, negligence, insult, and violation [6].

Individuals with anger management skills have a different perspective on themselves before engaging in a behavior, allowing them to self-evaluate and make realistic choices [8]. Social support systems, problem-solving skills, self-relaxation skills, self-control skills, humor, compelling conversation, listening skills, and expression of feeling are all examples of anger coping skills. Anger management aims to reduce anger and physiological arousal [6,9]. Anger of a high level, intensity, frequency, or duration can be harmful to one's physical health, leading to depression, low quality of life, other emotional problems, interpersonal problems, and infringement. Uncontrollable anger also leads to physical and mental health problems, such as stomach ulcers, migraines, and depression [10,11].

The profession of emergency medical personnel is very stressful. They must make the fastest decisions about transferring patients to medical facilities [12]. Emergency medical personnel exhibit many unusual behaviors, including anger due to limited time in dealing with critically ill patients, expectations of the companions, the openness of the work environment, sense of inadequacy in saving the life of a dying patient, and factors related to human resources. These factors may affect their health and work quality, thereby threatening the community health and people's lives in the emergency department [13]. Violent acts have destructive physical and



psychological effects on personnel, including discomfort, despair, fear, burnout, a sense of insecurity, a refusal to continue working, and even physical injuries [14].

According to Iranian studies, the prevalence of violence among emergency medical personnel is greater than 70% [15,16]. One study in Turkey found that 78.4 percent of the emergency medical personnel were aggressive and unable to control their anger [17]. Mohammadi et al., in 2021, a study titled The effect of psycho-education on resilience and anger control among pre-hospital emergency staff: A quasi-experimental study was conducted in Zahedan, the results of independent t-test showed no significant difference in the mean and standard deviation of anger control score among pre-hospital emergency staff between the intervention and control groups before the intervention ( $P=0.672$ ), but after the intervention, mean and standard deviation of anger control score in the intervention group were significantly higher than those in the control group ( $P<0.001$ ) [18]. A study by Kalbali et al, in 2017 to determine the effect of anger management training Aggressiveness of emergency department nurses It was done, it showed, it took place Training workshops and follow-up training It can reduce the aggressiveness of nurses to give [19].

According to foreign studies, a study on emergency personnel in the United States, more than 6 percent of the personnel were depressed, and 6% were nervous, and the longer their work experience, the higher these symptom [20]. According to Yildiz et al. (2014), a large number of participants were subjected to violence over time; the older the age and the greater the work experience, the better the communication skills and anger management. Individuals controlled their anger better when they had a higher level of education and were trained in anger management and communication skills [17].

Many experts have focused on the anger management skills training and various studies suggested that health institutions should train anger management and effective communication techniques. Therefore, personnel can control their anger and use a suitable method to combat violence and aggression. We have witnessed that emergency medical personnel are under a lot of stress that makes them express anger more. We conducted this study to determine the effect of self-awareness counseling on the anger management of emergency medical personnel of Rafsanjan University of Medical Sciences in 2021.

### Materials and Methods

This is a quasi-experimental study with a pretest-posttest control group design. The research setting was emergency medical center of Rafsanjan from November 19, 2021 to January 18, 2022. After receiving the code of ethics (IR.KMU.REC.1400.386) and permission from Rafsanjan University of Medical Sciences, written consent was obtained from the participants. In this method, according to the sample size, the available sampling method was used, then emergency medical personnel, including nursing and emergency medicine, were randomly assigned to intervention and control groups by lottery. Inclusion criteria included the personnel with an associate's and bachelor's degree in medical emergency and nursing, at least six months of work experience, and a willingness to participate in the research. Exclusion criteria included absence from training sessions and incomplete questionnaires (more than 15% of the questions). To estimate the sample size in the present study, we used Pocock's formula for sample size and the study of Yahyazadeh (2018) [21]. Therefore, 80 participants were selected, were divided into intervention (logo-therapy group, N=40) and control groups (N=40).

The data collection tools in this research were the demographic and background information questionnaire and Spielberger's STAXI-2 (This questionnaire was calculated by Spielberger and



colleagues for STAXI-2 scales and subscales and reported in its practical guide. The information summarized in the practical guide of the test shows that the alpha coefficients for the scales and subscales regarding the state of anger and the trait of anger are equal to 0.84 or higher, and for the scales regarding anger expression, anger control, and the overall index of anger expression, it is equal to 0.73 or higher. has been higher Therefore, Cronbach's alpha coefficients as measures of internal consistency are generally satisfactory for various components of STAXI-2, and gender and disease of the subjects do not have a significant effect on alpha coefficients[22]).

Demographic questionnaire included questions about age, marital status, field of study, most recent degree, workplace, employment status, personal studies and meditation, spirituality and religiosity, history of participation in anger management workshops, history of violent actions against the family, the history of violence against the patient, and the history of violence against healthcare members. The 57-item STAXI-2 (Spielberger, 1999) consists of three main sections measuring state anger (15 items), trait anger (10 items), and the experience, expression, and control of anger (32 items). Each of the items is rated on a four-point Likert scale. The items of the first section are graded ranging from not at all, somewhat, moderately, and very much, while the items of the second and third sections are graded from rarely, sometimes, often, and always. The minimum score is 32, while the maximum score is 128. The reliability of this questionnaire was 0.84 or higher for state anger and trait anger, and 0.73 or higher for anger control and expression. Asghari Moghadam et al. (2011) indicated good reliability (retest and internal consistency) and criterion validity of the Persian version of the STAXI-2 in the studied clinical population [23]. Khodayari Fard et al. (2010) investigated the validity of this scale and found that the STAXI-2 had adequate validity and reliability for measuring anger in young Iranians. As a result, clinical studies can use this questionnaire to assess traits and state anger [24].



The samples were randomly divided into intervention and control groups. Both groups completed the STAXI-2 before the intervention. The intervention group received self-awareness-based counseling training, while the control group received no intervention. Following after completing the training, we conducted a posttest and then analyzed the collected data. We used a lecture, group discussion, and question-and-answer strategy and held two 2hour sessions on sky room due to the COVID-19 outbreak. The following were the topics covered in self-awareness-based counseling sessions:

Session	Topics
One	Getting to know the group members, explaining the purpose and rules, defining self-awareness and its types, anger, anger control, and self-awareness skills, presenting, recognizing, and managing emotions (sense of awareness), paying attention to consciousness content, showing the similarities and differences of each member, making correct decisions and solving problems when emotions and emergencies arise (with emotional awareness), recognizing physical characteristics and abilities in different activities
Two	Reviewing the previous session, self-concept, recognizing positive characteristics and their impacts on life, recognizing negative characteristics and how to correct them, improving personal and professional motivations, recognizing the factors that cause anger, identifying values and beliefs, realistic and unrealistic goals, familiarizing group members with their strengths and weaknesses and providing factors affecting and inhibiting the development of self-awareness, summarizing topics related to self-awareness, support system and communication skills, taking

into account the viewpoints of others and promoting empathy, self-esteem, and expressing its obstacles, personal and professional goals, values and beliefs, how to increase individual and professional productivity, summarizing the presented content, and appreciating the personnel

SPSS22 and frequency distribution tables, mean and correlation coefficients were used for data analysis. To measure the effect of the intervention, independent-t, paired-t, and ANOVA tests or Mann-Whitney U and Wilcoxon tests were used. A significance level of 0.05 was considered in this study.

## Results

The study results suggested that most of the subjects were male (34 in the intervention group and 34 in the control group), married (29 in the intervention group and 28 in the control group) and had bachelor's degree (32 in the intervention group and 30 in the control group). The majority of the participants were religious (38 in the intervention group and 37 in the control group), without a history of violence against the family, the patient, and the healthcare team (38 in the intervention group and 38 in the control group). Most participants had no history of participating in anger management workshops. The groups were identical regarding demographic variables ( $P>0.05$ )(Table 1).

Table 1: Comparison of demographic characteristics of two intervention and control groups.

Demographic profile	Interventin		Control	
	N	%	N	%
Sex				
Male	34	85	34	85
Female	6	15	6	15

1P= 0/00 ،= $\chi^2(1)$





Level of Education					0/738P= 1/265 ، = $\chi^2(3)$
Associate Degree	6	15	7	17/5	
Bachelor's degree	32	80	30	75	
Master's degree	2	5	3	7/5	
marital status					0/805P= 0/061 ، = $\chi^2(1)$
Single	11	27/5	12	30	
married	29	72/5	28	70	
being religious and spiritual					1p=
Yes	38	95	37	92/5	
No	2	5	3	7/5	
History of participation in anger management classes					1P= 0/00 ،= $\chi^2(1)$
Yes	17	42/5	17	42/5	
No	23	75/5	23	75/5	
A history of violence against the family					1P= 0/00 ،= $\chi^2(1)$
Yes	2	5	2	5	
No	38	95	38	95	
History of violence against the patient					1P= 0/00 ،= $\chi^2(1)$
Yes	2	5	2	5	
No	38	95	38	95	
History of violence against treatment team members					1P= 0/00 ،= $\chi^2(1)$
Yes	2	5	2	5	
No	38	95	38	95	
Age (years), (standard deviation) mean	33/85(6/24)	31/80(7/48)	0/187P= 1/330 ،=(78)t		
Employment history (years), (standard deviation) average	11(8/36)	7/85(6/62)	0/066P= 1/867 ،=(78)t		

According to the results, the total mean anger scores in the intervention and control groups were  $114.77 \pm 11.44$  and  $114.40 \pm 11.27$ , respectively, before the intervention. Independent-t test indicated no statistically significant difference in the total mean anger scores between the intervention and control groups before the intervention ( $P=0.883$ ). After the intervention, the total mean anger scores in the intervention and control groups were  $93.60 \pm 8.76$  and  $113.70 \pm 12.15$ , respectively. ANCOVA test indicated a significant difference in the total mean scores of anger between the intervention and control groups ( $P<0.001$ ), so the level of anger among the emergency medical personnel was lower than that in the control group (Table 2).

Table 2. Total mean score of anger in intervention and control groups.

Group		Before intervention	After intervention	Mean difference	Within-group comparison
		SD±M	SD±M		
Anger	Intervention	114.77±11.44	93.60±8.76	21.175	T= 11.960*, P< 0.001
	Control	114.40±11.27	113.70±12.15	0.700	T=1.512*, P=0.139
	Between-group comparison	T= 0.148*, P=0.883	F= 153.107***, P< 0.001, Partial Eta Squared= 0.665	T=11.189**, P< 0.001	

The study results revealed that before the intervention, the mean anger scores in the intervention and control groups were  $17.65 \pm 4.59$  and  $17.62 \pm 4.19$ , respectively. The independent-t test found no statistically significant difference in the mean anger scores between the intervention and control groups before the intervention ( $P=0.980$ ). After the intervention, the mean scores of anger in the intervention and control groups were  $15.02 \pm 1.04$  and  $17.67 \pm 4.44$ , respectively. The ANCOVA test indicated a significant difference in the mean scores of anger between the

intervention and control groups ( $P < 0.001$ ). The level of anger in the intervention group was lower than in the control group (Table 3).

Table 3. Mean scores of state anger and its subscales in intervention and control groups.

Group		Before intervention	After intervention	Mean difference	Within-group comparison
		SD $\pm$ M	SD $\pm$ M		
State anger	Intervention	17.65 $\pm$ 4.59	15.02 $\pm$ 1.04	2.625	T= 3.635*, P= 0.001
	Control	17.62 $\pm$ 4.19	17.67 $\pm$ 4.44	- 0.050	T= - 0.530*, P= 0.599
	Between-group comparison	T= 0.025**, P= 0.980	F= 24.621***, P< 0.001, Partial Eta Squared= 0.242	T=3.673**, P< 0.001	
Feeling of anger	Intervention	6.50 $\pm$ 2.19	5.40 $\pm$ 0.84	1.10	T= 3.122*, P=0.003
	Control	6.55 $\pm$ 2.18	6.65 $\pm$ 2.14	- 0.1	T=-1.669*, P= 0.103
	Between-group comparison	T=- 0.102**, P= 0.919	F= 21.097***, P<0.001, Partial Eta Squared= 0.215	T= 3.358**, P<0.001	
Expressing anger verbally	Intervention	5.72 $\pm$ 1.63	4.87 $\pm$ 0.64	0.850	T= 3.275*, P=0.002
	Control	5.62 $\pm$ 1.12	5.67 $\pm$ 1.42	- 0.050	T= - 0.530*, P=0.599
	Between-group comparison	T= 0.319**, P= 0.751	F= 16.088***, P<0.001, Partial Eta Squared= 0.173	T= 3.259**, P= 0.002	
Expressing anger physically	Intervention	5.42 $\pm$ 1.46	4.75 $\pm$ 0.43	0.675	T= 2.896*, P=0.006
	Control	5.45 $\pm$ 1.46	5.52 $\pm$ 1.48	- 0.07	T= - 1.778*, P= 0.083
	Between-group comparison	T= - 0.076**, P= 0.939	F= 18.423***, P<0.001,	T= 3.166** P= 0.002	



			Partial Eta Squared= 0.193		
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Table 4 showed that, before the intervention, the mean scores of the trait anger in the intervention and control groups were  $14.40 \pm 4.72$  and  $14.17 \pm 4.66$ , respectively. The independent t-test indicated no statistically significant difference in the mean scores of the trait anger between the intervention and control groups before the intervention ( $P=0.831$ ). After the intervention, the mean scores of the trait anger in the intervention and control groups were  $10.92 \pm 2.04$  and  $14.07 \pm 4.51$ , respectively. ANCOVA test found a significant difference in the mean scores of trait anger between the intervention and control groups ( $P<0.001$ ). The level of anger in the intervention group was lower than in the control group (Table 4).

Table 4. The mean scores of the trait anger and its subscales in intervention and control groups.

Group		Before intervention	After intervention	Mean difference	Within-group comparison
		SD $\pm$ M	SD $\pm$ M		
Trait anger	Intervention	14.40 $\pm$ 4.72	10.92 $\pm$ 2.04	3.475	T= 4.142*, P<0.001
	Control	14.17 $\pm$ 4.66	14.07 $\pm$ 4.51	0.10	T= 1*, P=0.323
	Between-group comparison	T= 0.214*, P=0.831	F= 27.034***, P<0.001, Partial Eta Squared= 0.260	T= 3.995**, P< 0.001	
Angry temperament	Intervention	5.82 $\pm$ 2.21	4.72 $\pm$ 1.06	1.10	T= 2.697*, P=0.010
	Control	5.70 $\pm$ 2.15	5.60 $\pm$ 2.08	0.10	T= 1*, P=0.323
	Between-group comparison	T= 0.256**, P= 0.799	F= 8.889***, P= 0.004, Partial Eta Squared= 0.103	T= 2.381**, P= 0.020	



Angry reaction	Intervention	8.57±2.84	6.20±1.63	2.375	T= 4.548*, P<0.001
	Control	8.47±2.91	8.52±2.89	- 0.050	T= - 1.433*, P= 0.16
	Between-group comparison	T= 0.155**, P= 0.877	F= 32.428***, P<0.001, Partial Eta Squared= 0.296	T= 4.634**, P<0.001	

Table 5 showed that, before the intervention, the mean scores of anger control and expression in the intervention and control groups were  $82.72 \pm 7.44$  and  $82.60 \pm 7.54$ , respectively. The independent t-test indicated no statistically significant difference in the mean scores of anger control and expression between the intervention and control groups before the intervention ( $P=0.941$ ). After the intervention, the mean scores of anger control and expression in the intervention and control groups were  $67.65 \pm 8.08$  and  $81.95 \pm 8.06$ , respectively. The ANCOVA test revealed a significant difference in the mean scores of anger control and expression between the intervention and control groups ( $P<0.001$ ). The rate of anger control and expression in the intervention group was lower than in the control group.(Table 5).

Table 5. Mean score of anger control and its subscales in intervention and control groups.

Group		Before intervention	After intervention	Mean difference	Within-group comparison
		SD ± M	SD ± M		
Anger control and expression	Intervention	82.72±7.44	67.65±8.08	15.075	T=11.836*, P<0.001
	Control	82.60±7.54	81.95±8.06	0.650	T= 1.460*, P=0.152
	Between-group comparison	T= 0.075**, P=0.941	F= 123.697***, P<0.001, Partial Eta Squared=0.616	T= 10.691**, P<0.001	
Anger	Intervention	12.60±3.01	9.95±2.39	2.650	T= 4.694*,

expression-out					P<0.001
	Control	12.47±3.17	12.55±3.12	- 0.075	T= - 1.356*, P= 0.183
	Between-group comparison	T= 0.181**, P= 0.857	F= 30.190***, P<0.001, Partial Eta Squared= 0.282	T= 4.804**, P<0.001	
Anger expression-in	Intervention	16.35±3.89	12.52±3.14	3.825	T= 5.873*, P<0.001
	Control	16.32±3.87	16.30±3.91	0.025	T= 1.001*, P=0.323
	Between-group comparison	T= 0.029**, P=0.977	F= 43.662***, P<0.001, Partial Eta Squared= 0.362	T= 5.830**, P<0.001	
Anger control-out	Intervention	26.65±4.57	23.20±4.38	3.450	T= 3.812*, P<0.001
	Control	26.60±4.63	26.22±4.44	0.375	T= 1.955*, P= 0.058
	Between-group comparison	T= 0.049**, P= 0.961	F= 14.218***, P<0.001, Partial Eta Squared= 0.156	T= 3.324**, P= 0.001	
Anger control-in	Intervention	27.12±4.32	21.97±3.48	5.150	T= 8.696*, P<0.001
	Control	27.20±4.26	26.85±4.01	0.350	T= 1.465*, P=0.151
	Between-group comparison	T= - 0.078**, P= 0.938	F= 76.007***, P< 0.001, Partial Eta Squared= 0.497	T= 7.516**, P< 0.001	

## Discussion

This study aimed to investigate the effect of self-awareness-based counseling on anger in emergency medical personnel of Rafsanjan in 2021. Based on the analysis of covariance after the



intervention, there was a significant difference between the mean score of total anger in the two intervention and control groups. Hence, the level of staff anger in medical emergencies was less than the control group, and a significant difference between the mean score of the state of anger in the two intervention and control groups, the level of anger in the intervention group was lower than the control group, therefore we can improve managerial capability under challenging situations by reducing maladaptive and aggressive behaviors and replacing them with more adaptive and efficient strategies. A training program instructs nurses on how to manage anger and recognize their own physical reactions before they become aggressive. Therefore, they will be better prepared to control their physical symptoms and reactions in aggressive situations. Yun et al. (2021) demonstrated that an anger management program for nurses effectively reduced anger and job stress, improved psychological well-being; and regulated heart rate changes; the results of this study are in line with our research [25]. Farahani et al. (2018) emphasized the effect of anger management training on aggression and job satisfaction [26]. Guay et al. (2016) found that the positive impact of training lasted for more than 14 months after the training. In addition, the reduction of violent acts affected staff's perceptions of their work, improved communication between healthcare providers and patients, and reduced job abandonment through commitment and motivation. The results of this study align with our research [27]. Islamian et al. (2010) revealed a positive effect of training on people's attitudes and management of violent behaviors when dealing with violent situations; the results of this study are in line with our research [28]. Yildiz et al. (2015) reported that health institutions should train staff in anger management and effective communication techniques to help them control their anger against violence and aggression [29]. The results of these studies were consistent with our findings.



Our results revealed a statistically significant difference in the mean scores of anger and its subscales between the intervention and control groups after the intervention. Therefore, the level of anger in the intervention group was lower than that in the control group, but we observed no noticeable change in the control group. Üzar-Özçetin et al. (2017) demonstrated that nursing students in the counseling group had higher anger control scores and lower trait anger scores after the intervention compared with the control group. Therefore, authorities should integrate such training into the education program of nursing students; the results of this study are in line with our research [30]. Although their study differed from our study in the type and structure of counseling, as well as the target population, it was in line with our study because it emphasized the role of counseling and training in anger control. Hojjat et al. (2017) discovered that training emotional self-awareness skills improved anger and anxiety control among men in an inpatient rehab facility for drug addiction, implying that training could be used to treat people with an addiction[31]. Their results and our results are the same due to the effect of self-awareness training on anger control. However, the two studies also had differences in the training program, its implementation, and the target population.

Khanzade et al. (2018), Mohammadiarya et al. (2012) and Ashrafi et al. (2014) reported that self-awareness skills training reduced aggression and improved anger management in students and adolescents who participated in these studies; although the research community of these studies is different from our study, it is consistent with our research because of the anger management training [32-34]. Their results supported our results regarding the effect of self-awareness training on anger control. However, their studies differed from ours, including the intervention, data collection tool, and target population.



The first step toward controlling anger, sadness, and fear is to recognize them. As a result, it is necessary to understand emotions in the face of unpleasant situations, thoughts and beliefs, how to interpret events, and one's wishes and expectations. Self-awareness allows a person to learn more about themselves, identify their weaknesses and strengths, correct their weaknesses, and strengthen their strengths. People can learn how to access the resources they require and how to express their emotions more effectively. Group training can help reduce aggression by making people feel that others are not the source of their problems, which reduces psychological stress and anger. Our results suggest that self-awareness-based counseling and anger management may be beneficial in reducing the aggression of emergency medical personnel in life-threatening situations.

This study had limitations, including personnel's insufficient cooperation and carelessness in completing questionnaires. To address this limitation, we gave study participants enough time to complete the questionnaires and gave them a certificate of participation in the workshop and 10-hour in-service training. We explained the study objectives and the importance of the participants' responses in obtaining reliable results, and then asked them to fill in the questionnaire more patiently. We also informed them that our results might be helpful to others.

## Conclusions

Our results revealed that self-awareness-based counseling improved anger control and its subscales in emergency medical personnel. As emergency medical personnel work in difficult and stressful environments, they may exhibit more aggressive behaviors than other healthcare providers may. Therefore, we recommend health managers and planners hold self-awareness training workshops for healthcare workers, particularly emergency personnel, to help them



manage and control their anger. We found no similar study in this regard, so more research with a larger sample size is required before we can speak confidently about the effectiveness of this intervention.

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### Declaration

#### Ethics approval and consent to participate

We conducted this study after receiving the code of ethics (IR.Kmu.REC.1400.386) from the ethics committee of Kerman University of Medical Sciences as well as permission from the university and the emergency medical center officials and participants' consent. The research units were assured that their participation was voluntary, they could withdraw from the study at any time, and their information would remain confidential. The study results were provided to the control group after the study.

#### Consent for publication

Not applicable

#### Availability of data and materials

All data generated or analysed during this study are included in this published article.

#### Competing interests

The authors declare that they have no competing interests.

#### Funding

Not applicable

#### Authors' contributions

MHR collected the study data. MHR, ZKH, A.A, AM and ZA wrote the article. All the authors read the article and made the necessary checks for its correction. Then all of them approved the article.

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