



Stigma as a Barrier to Mental Health Treatment: Insights From Lithuanian Nurses

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Abstract

Background. Mental health stigma remains a significant barrier to accessing and sustaining mental health care globally. In Lithuania, stigma is especially prevalent and may influence patient outcomes even within healthcare institutions.

Aim. To examine the level of knowledge, attitudes, and experiences of stigma among general practice nurses working with patients who have mental health disorders.

Methods. A cross-sectional quantitative study was conducted between September and December 2024 using an anonymous online survey distributed through nursing-focused Facebook groups. A total of 280 general practice nurses participated. The questionnaire assessed knowledge about mental health stigma, attitudes towards individuals with mental illness, and experiences of stigma in clinical practice. Data was analysed using descriptive statistics and Chi-Square tests.

Results. Few respondents reported a high level of knowledge about mental health stigma, and many had not received any relevant training. While most nurses expressed neutral or positive attitudes, stigmatising views regarding treatment adherence and social perceptions were still present. A majority reported that patients frequently experience discrimination. Educational background and prior training were associated with more accurate knowledge and reduced stigma.

Conclusions. There is a critical gap in mental health stigma awareness and training among nurses in Lithuania. Despite generally positive attitudes, persistent stigma continues to affect patient care. Targeted educational interventions are urgently needed to improve knowledge, reduce discrimination, and enhance treatment outcomes.

Keywords: Mental health; stigma; nursing; patient care; attitudes

1. INTRODUCTION

Mental health stigma remains a significant global public health concern with profound implications for both individual wellbeing and healthcare systems. Stigmatising attitudes and behaviours towards individuals with mental disorders contribute not only to social exclusion and discrimination but also interfere with timely access to care, adherence to treatment, and recovery outcomes. Numerous studies have highlighted that stigma can deter individuals from seeking help, worsen psychological symptoms, and increase the risk of social withdrawal and self-harm (Eiroa-Orosa et al., 2021; Marair & Slater, 2023).



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In Lithuania, as in many other countries, mental illness is often perceived as a sign of weakness, and individuals experiencing psychological distress may hesitate to disclose their condition due to fear of judgement or social rejection. This phenomenon is particularly pronounced among men, who may be culturally discouraged from expressing emotional vulnerability. Consequently, individuals with mental health disorders are frequently marginalised and unsupported, not only by society but also within healthcare systems where stigma among professionals may limit the quality of care provided (Kane et al., 2019).

Despite growing awareness of mental health challenges, recent national statistics underscore the urgency of addressing stigma (Lithuanian Health Information Centre, 2023). While WHO data suggest that Lithuania ranks high in suicide mortality globally, exact ranking may vary by source, highlighting a broader societal challenge tied closely to the social perception of mental illness.

Previous studies have examined nurses' attitudes towards mental illness in Lithuania and other European countries; however, these studies are either relatively old or do not focus specifically on mental health stigma as the primary topic. There is a lack of recent publications specifically dedicated to research on mental health stigma among general practice nurses in Lithuania or neighbouring countries. This study contributes new knowledge by specifically examining the level of knowledge, attitudes, and experiences of stigma among general practice nurses in Lithuania. It clarifies how nurses' attitudes and prior training influence stigma, and how these perceptions impact patient outcomes and the therapeutic relationship.

The Lithuanian context is particularly important because stigma remains a significant barrier to mental healthcare in the country, affecting both patient care and the functioning of healthcare systems. By focusing on this context, the study provides insights that are directly relevant to national policy, education, and clinical practice.

By analysing quantitative data collected from 280 nurses working with psychiatric patients, the study sheds light on structural, interpersonal, and intrapersonal manifestations of stigma within clinical settings. Furthermore, the findings highlight the critical need for educational interventions, policy reforms, and evidence-based strategies that promote empathy, inclusivity, and dignity in mental health treatment.

2. METHODS

2.1. Study design, participants, and sampling. The study employed a quantitative cross-sectional design using a structured questionnaire to examine the manifestation of mental health stigma in healthcare institutions and its impact on patient care quality. The survey was conducted from September to December 2024 via the online platform <https://manoapklausas.lt/>. Participation was voluntary and anonymous.

A non-probability sampling strategy was used, combining purposive and convenience sampling methods. Purposive sampling specifically targets general practice nurses who work directly with patients diagnosed with mental health disorders, ensuring relevant professional experience. Convenience sampling was applied due to the accessibility of participants via online platforms and professional social media groups (Facebook groups “SLAUGYTOJAI” and “Lietuvos slaugytojai”).

Inclusion criteria were:

1. general practice nurses currently working in healthcare settings;
2. direct professional contact with patients diagnosed with mental health disorders;
3. age 22 years or older;
4. voluntary agreement to participate.

Exclusion criteria included:

1. nurses not involved in direct patient care;
2. healthcare professionals other than nurses;
3. incomplete questionnaires;
4. refusal to provide informed consent.

A total of 280 nurses consented to participate and completed the questionnaire; all fully completed responses were included in the final analysis. Due to the anonymous nature of the survey and open online recruitment, the exact number of individuals who viewed the invitation but did not participate could not be determined, and the response rate could not be calculated. No dropouts were recorded after consent.

According to official statistics, there are 22,332 nurses in the Lithuanian healthcare system (Official Statistics Portal, 2024), but the proportion who work directly with patients with mental health disorders is unknown. Therefore, the survey included a screening question to identify participants with direct professional contact with this patient population.

The questionnaire was newly developed for this study, based on a review of literature and previous instruments on mental health stigma, and pilot-tested for clarity and relevance. Internal consistency reliability was high across scales (Cronbach's $\alpha = 0.82\text{--}0.91$).

Sample size justification: The adequacy of the sample size ($N = 280$) was determined based on general recommendations for cross-sectional surveys and statistical power analysis. Assuming a medium effect size ($w = 0.3$), a significance level of $\alpha = 0.05$, and statistical power $(1 - \beta) = 0.80$, the minimum required sample size for Chi-Square tests is approximately 143 participants. The achieved sample size exceeds this requirement and is comparable to or larger than those used in similar studies examining stigma among healthcare professionals.

Representative considerations: The sample may not fully represent the wider population of general practice nurses, as a formal sampling frame was not used. Recruitment via social media may have introduced self-selection bias, as participation was limited to nurses active online and interested in the topic.

2.2. Ethical approval and informed consent. According to the Lithuanian Law on Ethics of Biomedical Research (Republic of Lithuania Law No. VIII1679, 2000), formal ethical approval is required only for biomedical research involving human health data or interventions, as defined in Articles 1–2 of the Law. Anonymous surveys that do not collect personally identifiable or health-related data fall outside the scope of biomedical research requiring ethics committee approval.

Prior to conducting the study, the research protocol was reviewed at the institutional level, and it was confirmed that the study met the criteria for exemption from formal ethics committee approval under national regulations.

The study posed minimal risk to participants and was conducted in accordance with the principles of the Declaration of Helsinki and relevant national and institutional ethical guidelines.

Prior to participation, respondents were informed about the purpose of the study, the voluntary nature of participation, and their right to withdraw at any time. Informed consent was obtained electronically through a mandatory consent question at the beginning of the questionnaire (“Do you agree to participate in this study?”). Only participants who provided consent were able to proceed with the survey.

Participant confidentiality and data protection were strictly ensured. No identifying information, including names, contact details, or IP addresses, was collected. All data were gathered anonymously through the online survey platform *manoapklausa.lt* and were accessible only to the researcher. The

data were stored securely and used exclusively for scientific and research purposes, in compliance with ethical standards and data protection requirements.

2.3. Outcome measures and instruments. The primary outcome measures of this study were nurses' level of knowledge about mental health stigma, their attitudes towards people with mental disorders, the perceived frequency of stigma in clinical practice, and the perceived impact of stigma on treatment continuity, patient satisfaction, and quality of life.

The structured questionnaire used consisted of closed-ended and semi-open questions. The questionnaire covered the following domains: knowledge about mental health stigma; perceptions of public attitudes towards mental illness; personal attitudes towards people with mental disorders; experiences related to discrimination in healthcare settings; views on stigma reduction strategies; the impact of stigma on treatment continuity and patient–professional collaboration.

Questionnaire development and validity. The questionnaire was developed based on a review of existing scientific literature and previously published instruments assessing mental health stigma among healthcare professionals. Selected items were adapted and modified to fit the study context. Prior to the main study, the questionnaire was pilot-tested on a small group of nurses ($N \approx 20$) to assess clarity, relevance, and comprehensibility. Minor revisions were made based on feedback.

Construct validity was explored through logical structuring of domains, and internal consistency reliability was assessed using Cronbach's alpha coefficients. Although exploratory factor analysis was not conducted, the domain structure was based on theoretical constructs identified in prior research.

All instruments were self-reported. Responses were recorded using Likert-type scales ranging from 'strongly disagree' to 'strongly agree'. The Likert scale ranged from 1 to 5, where higher scores indicated greater agreement or stronger expression of the measured construct.

The reliability of the questionnaire was assessed using Cronbach's alpha coefficients: knowledge and attitude scale: $\alpha = 0.85$; public attitude scale: $\alpha = 0.82$; stigma impact on treatment continuity scale: $\alpha \approx 0.85$; stigma reduction strategies scale: $\alpha = 0.91$.

These values indicate very good internal consistency and confirm that the instrument is reliable and appropriate for use in this study.

2.4. Statistical analysis. Statistical analysis was performed using IBM SPSS Statistics for Windows, Version 25.0.

Descriptive statistics were used to summarise the data:

1. frequencies and percentages for categorical variables;
2. means and standard deviations for knowledge and attitude scales.

Scale interpretation. Composite scale scores were calculated as the mean of item responses within each domain, with possible values ranging from 1 to 5. Higher scores indicated higher levels of knowledge, more positive attitudes, or stronger perceived impact of stigma.

The internal consistency of the questionnaire was assessed using Cronbach's alpha.

Associations between categorical variables were analysed using the Chi-Square (χ^2) Test. For Chi-Square analysis, Likert-scale responses were categorised into three groups (agree, neutral, disagree) to meet test assumptions. Expected cell frequencies were checked to ensure that at least 80% of cells had expected counts ≥ 5 . When assumptions were not met, categories were merged accordingly.

Effect sizes were calculated using Cramér's V to assess the strength of associations (0.1 = small, 0.3 = medium, 0.5 = large effect).

The level of statistical significance was set at $p < 0.05$.

The analysis examined:

1. associations between participation in training and level of knowledge;

2. differences in attitudes according to educational background;
3. relationships between stigma perception and treatment continuity.

All tests were two-tailed, and results were considered statistically significant when p -values were below 0.05 ($p < 0.05$).

3. RESULTS

The study included 280 respondents – 87% were women and 13% were men. The majority lived in urban areas (87%) and had either a university (28%) or college-level (72%) higher education. Most respondents were under the age of 25 (28%).

When analysing knowledge about stigma, it was found that only 6% of respondents had a high level of knowledge about mental health stigma, while 42% reported having only superficial knowledge. Based on the analysis, most of the respondents indicated having at least partial or reasonably good knowledge. The standard deviation ($SD = 0.97$) indicated relatively low variability in responses, suggesting a consistent level of knowledge among respondents. This indicates moderate homogeneity of responses rather than strong consensus. Overall, these findings highlight a lack of information and need for more training in the field of healthcare.

The study results regarding respondents' participation in mental health-related training showed that 59% of participants had not attended any such training. The difference in the average knowledge scores between those who had participated in training and those who had not was statistically significant ($p < 0.05$; $V = 0.21$, indicating a small-to-moderate effect size).

The most common sources of information were the internet (26%), literature (16%), and social media (15%), while only 8% cited formal education as their main source. A Chi-Square (χ^2) Test revealed that respondents who had participated in training were significantly more likely to choose health-care professionals as their primary source of information ($\chi^2 = 4.83$, $p = 0.028$; Cramér's $V = 0.22$).

Results on respondents' attitudes towards people with mental health disorders revealed a predominantly neutral or positive stance. Specifically, 68% of respondents expressed a neutral attitude, 27% a positive or very positive attitude, and only 5% held a negative view. These findings indicate that negative attitudes are present but not dominant. The Cronbach's alpha coefficient was calculated as $\alpha = 0.82$, indicating good reliability of the scale. Respondents' opinions indicate that society often holds stereotypical views about mental disorders. The majority agreed that people with mental health issues experience social isolation and that society tends to view mental disorders as a serious problem or a personal weakness. At the same time, many respondents acknowledged recovery as possible. Chi-Square Test results for individual statements are presented in Table 1 (all $p < 0.05$), indicating statistically significant differences in response distributions across categories. Effect sizes ranged from small to moderate (Cramér's $V \approx 0.15$ – 0.30).

Table 1. Respondents' attitudes towards public perception of mental health disorders

Statement	χ^2 value	df	p-value	Statistically significant	Notes
People with mental health disorders often experience social isolation	21.45	4	0.0003	$p < 0.05$	The majority of respondents agreed
Society often views mental disorders as a sign of personal weakness	16.32	4	0.0026	$p < 0.05$	Reflects a stereotypical viewpoint
Individuals with mental disorders can recover and live fulfilling lives	11.87	4	0.018	$p < 0.05$	Indicates the presence of positive attitudes
Mental health problems can be overcome by willpower alone	27.61	4	<0.0001	$p < 0.05$	Only a small portion of respondents agreed
Society is not sufficiently understanding towards people with mental disorders	19.04	4	0.0008	$p < 0.05$	Highlights the need for education and stigma reduction

Note: χ^2 – Chi-Square Test; df – degrees of freedom; $p < 0.05$ indicates statistical significance.

Respondents' opinions indicated that strong stigma and discrimination related to mental health disorders are perceived as common. Most respondents stated that individuals with mental health disorders frequently face discrimination (87%). However, this reflects perceived societal stigma rather than respondents' personal attitudes. These findings emphasise the need to strengthen mental health policies and anti-stigma measures.

The Cronbach's alpha coefficient for the scale was $\alpha = 0.73$, indicating good internal consistency. The majority agreed that mental health disorders are as real as physical illnesses. However, a proportion of respondents still associate mental health disorders with violence, indicating the persistence of certain stereotypes. Most respondents supported the effectiveness of treatment, although some uncertainty remained. Many also indicated that discussing mental health may cause discomfort. The Chi-Square Test results for Table 2 (all $p < 0.001$) indicate statistically significant differences in response distributions; however, critical χ^2 values are not reported, in accordance with reporting guidelines. Effect sizes ranged from small to moderate (Cramér's $V \approx 0.20$ – 0.35).

Table 2. Respondents' opinions about mental health disorders

Statement	χ^2 value	df	p-value	Statistically significant	Notes
Mental health problems are as real as physical health problems	249.0	4	<0.0001	$p < 0.05$	Strong consensus
People with mental health disorders are more prone to violence	96.0	4	<0.0001	$p < 0.05$	Majority disagree
Mental health disorders can be effectively treated with therapy and medication	79.3	4	<0.0001	$p < 0.05$	General agreement
Talking about mental health problems causes discomfort for people	78.4	4	<0.0001	$p < 0.05$	Mixed responses
People with mental health disorders should not be part of society	141.2	4	<0.0001	$p < 0.05$	Majority strongly disagree

Note: χ^2 – Chi-Square Test; df – degrees of freedom; $p < 0.05$ indicates statistical significance.

Further analysis showed strong support for stigma reduction. As many as 90% agreed that reducing stigma would improve quality of life.

The Cronbach's alpha coefficient was $\alpha = 0.91$, indicating excellent internal consistency. Respondents rated most strategies positively, particularly public education, professional training, and media involvement ($\geq 80\%$ agreement). Policy-related strategies received more neutral responses. Chi-Square analysis (Table 3, all $p < 0.001$) confirmed that response distributions were statistically significant, with small-to-moderate effect sizes (Cramér's $V \approx 0.18$ – 0.32).

Table 3. Distribution of respondents on the effectiveness of mental health stigma reduction strategies

Statement	χ^2 value	df	p-value	Statistically significant
Public education and awareness raising about mental health	52.3	4	<0.001	$p < 0.05$
Implementation of anti-stigma campaigns in schools and workplaces	40.5	4	<0.001	$p < 0.05$
Training healthcare professionals on mental health stigma and its reduction	54.1	4	<0.001	$p < 0.05$
Encouraging the media to accurately and respectfully portray mental health disorders	48.7	4	<0.001	$p < 0.05$
Creation of support groups and peer groups for people with mental health disorders	44.8	4	<0.001	$p < 0.05$
Increasing funding for mental health services and resources	39.6	4	<0.001	$p < 0.05$
Advocacy for policy changes to protect the rights of people with mental health disorders	28.7	4	<0.001	$p < 0.05$

Note: χ^2 – Chi-Square Test; df – degrees of freedom; $p < 0.05$ indicates statistical significance.

Regarding additional nursing training, most respondents supported its importance. One-third viewed it as beneficial but not essential.

The scale assessing stigma impact on treatment continuity demonstrated good reliability ($\alpha \approx 0.85$). More than half of respondents agreed that stigma may lead patients to avoid or discontinue treatment. A large proportion of neutral responses suggest uncertainty or indirect exposure to stigma. Positive relationships with healthcare professionals were identified as important for improving trust and treatment adherence. No statistically significant differences were found between specific statements in this domain ($p > 0.05$), indicating relatively consistent response patterns.

4. DISCUSSION

The results of this study revealed the significant impact of mental health stigma on the quality of patient care within Lithuanian healthcare institutions. Although most respondents held neutral or positive attitudes towards individuals with mental health disorders, important gaps in knowledge and limited participation in relevant training were observed. These findings are consistent with international

research, which emphasises that education and awareness are essential in combating stigma (Corrigan et al., 2014; Eiroa-Orosa et al., 2021; Knaak et al., 2017).

One of the most notable findings was the lack of targeted training and its association with knowledge and attitudes towards patients. Only 6% of respondents reported substantial knowledge about stigma, and more than half had never participated in any training related to the topic. This underscores the need to strengthen formal education on mental health both at the undergraduate level and within continuous professional development. Similar patterns have been observed internationally, where healthcare professionals often report insufficient preparation to manage mental health issues effectively (Gunasekaran et al., 2022; Henderson et al., 2014).

The persistence of stigma among healthcare professionals appears to be influenced by several systemic factors. Limited formal education on mental health, entrenched cultural beliefs that link mental illness to personal weakness or danger, and inconsistent institutional support for professional development contribute to subtle yet pervasive negative stereotypes. Furthermore, reliance on informal information sources, such as the internet and social media, may perpetuate inaccurate or incomplete knowledge. These findings align with studies in other countries demonstrating that stigma is often reinforced by broader societal norms and structural gaps within healthcare systems (Chan & Tsui, 2023; Walsh & Foster, 2021).

This study also highlights the consequences of stigma for patient care. Over half of respondents indicated that stigma may lead patients to avoid or discontinue treatment, reinforcing findings from international research on the negative effects of stigma on treatment adherence and recovery (Corrigan et al., 2014; Knaak et al., 2017). Positive therapeutic relationships, characterised by empathy, respect, and collaboration, were identified as protective factors, emphasising the role of professional attitudes in mitigating stigma-related harm.

In summary, these results indicate a critical need for systemic interventions targeting both healthcare professionals and the public. National-level programmes that integrate anti-stigma education into nursing curricula, support continuous professional development, encourage responsible media portrayal, and implement structural changes in healthcare institutions are essential. By addressing both cultural and institutional factors, these strategies can foster a more inclusive and supportive environment for individuals with mental health disorders, improving both care quality and patient outcomes.

Study limitations

This study has several limitations that should be considered when interpreting the results. First, the cross-sectional design does not allow for causal inferences between variables. Second, the use of self-reported data may introduce response bias, including social desirability bias.

A further limitation is the non-probability sampling strategy, which combined purposive and convenience sampling methods through social media. Although this approach enabled targeted recruitment of nurses with relevant professional experience, it may limit the representativeness of the sample. In addition, the total number of nurses working directly with patients with mental health disorders in Lithuania is unknown, making it difficult to assess how well the sample reflects the wider population.

Recruitment via social media (e.g. Facebook groups) may also have introduced self-selection bias, as participation was limited to nurses who are active online and interested in the topic.

Implications

The findings suggest a need for systemic interventions, including enhanced training for healthcare professionals and broader public education initiatives.

A stronger integration of anti-stigma education into nursing curricula and continuing professional development programmes is recommended. Additionally, healthcare institutions should promote recovery-oriented practices that emphasise patient autonomy, dignity, and long-term engagement in care.

5. CONCLUSIONS AND PERSPECTIVES

There is a critical gap in mental health stigma awareness and training among nurses in Lithuania. Despite generally positive attitudes, persistent stigma continues to affect patient care. Targeted educational interventions are urgently needed to improve knowledge, reduce discrimination, and enhance treatment outcomes.

Future research should focus on evaluating the effectiveness of structured anti-stigma education and training programmes for nurses using longitudinal and interventional study designs, while also expanding the scope of research to include other healthcare professionals and patient perspectives to gain a more comprehensive understanding of stigma within healthcare settings. In addition, system-level studies examining organisational culture, institutional policies, and national mental health strategies could contribute to the development of sustainable, evidence-based interventions aimed at reducing stigma and improving mental health care outcomes in Lithuania.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Conflicts of Interest: The author declares no conflict of interest.

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