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Prevalence and acceptability of psychological and/or economic intimate partner violence, and utilization of mental health services by its survivors in Lithuania

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ABSTRACT

Background Lithuania has one of the highest averages in the European Union when it comes to psychological and/or economic intimate partner violence (PE-IPV). IPV survivors are several times more likely to have mental health conditions than those without IPV experiences. The aim of this article is to study the prevalence, characteristics and attitudes of PE-IPV survivors in Lithuania, and the predictors of them accessing mental health services.

Methods A cross-sectional study based on a national survey representative of the adult population. The survey was implemented by a third-party independent market research company employing an online survey panel. Logistic regression models were used in the analysis.

Results Almost 50% of women in Lithuania experience PE-IPV. Females are significantly more likely to experience it than males. The vast majority of women find PE-IPV unacceptable; however, only one-third of survivors seek any type of help. Only one-tenth approach mental health services, with divorcees being at higher odds of doing so.

Conclusions Further research is needed to explore predictors and contextual factors of why IPV survivors seek mental healthcare, or not. Policy implications include the need to eliminate IPV and mental health stigma; develop accessible mental health services and effective treatment approaches.

Keywords coercive control, Lithuania, mental health services, psychological and/or economic intimate partner violence

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Introduction

Intimate partner violence (IPV) is a global pandemic and major public health issue. [1–4] It is also recognized globally as a type of gender-based violence, which means that women suffer disproportionately from IPV compared with men.[5–7] The WHO estimates that at least one in three women worldwide experience physical or sexual violence by their intimate partner at some point in their life.[3] Moreover, by far, the most prevalent form of IPV is psychological violence.[8–10] Psychological IPV, including coercive control and economic IPV, often precedes physical or sexual manifestations of abuse.[11–13] Its prevalence is estimated to be from around 20% to as much as 90%, depending on the study's methods and setting.[9,10,14–17]

In the European Union (EU), the average prevalence of psychological IPV is around 43%. In Lithuania, at least one in two women (51%) go through this experience at some point in their life.[18,19] According to a local victims' support service, this number may be even higher at potentially over 60%, with at least 10% of victims experiencing economic IPV specifically.[20] Therefore, the country is among those with the highest average levels of psychological IPV against women in the EU.[17,18] However, official statistics may not reflect the magnitude of the issue, since psychological and/or economic IPV (PE-IPV) remains to be one of the most latent forms of crime. This is due to the practical difficulties of convicting perpetrators in court, as well as the fact that at least 30% of women conceal the experience and do not seek help at all.[21,22]

Any type of IPV, but PE-IPV in particular, has serious consequences for survivors' physical and mental health.[3,8,13,23–26] Women with a history of IPV are around three times more likely to have mental health conditions (such as depression, anxiety or post-traumatic stress disorder), than those without this life experience.[8,25,26] Some survivors do approach mental health services for support, though for many different reasons (including negative societal attitudes and stigma), many do not seek help at all.[8,27–31] This type of gender-based violence is a complex, global public (mental) health issue and all healthcare services, including mental healthcare providers, have an important role to play in screening for and documenting it, as well as providing information and appropriate complex support.[32–35]

In Lithuania, negative societal attitudes and socially constructed 'norms' greatly affect the way society deals with IPV, as well as how mental health services operate and respond to the needs of IPV survivors.[36] These same attitudes also affect the way survivors see themselves and recognize (or not) the violence and mental health conditions that they are experiencing.[21] For example, economic violence can go unrecognized, being perceived as acceptable behaviour, or as part of the 'natural' order of socially constructed gender roles between a husband and wife (where the husband might have and maintain full control of the family's finances).[37] On the other hand, when IPV is publicly recognized, the general public tends to express a deeply rooted 'victim-blaming' attitude, with up to 50% of Lithuanians believing it is the woman's own fault that she experienced IPV.[36] Moreover, mental health stigma is also prevalent and negative attitudes persist toward potentially seeking help and support from mental health services.[38–40] Thus far, no studies in Lithuania explored the acceptability of PE-IPV among its survivors, in the context of mental health outcomes or socially constructed societal 'norms' as described above, nor the utilization of mental health services by IPV survivors.

The main objectives of this article are to study the prevalence, characteristics and attitudes of survivors of PE-IPV in Lithuania, their utilization of mental health services as well as predictors of their likelihood to seek mental health care.

The research questions are as follows:

(1) What is the current prevalence of persons exposed to PE-IPV in Lithuania and what are the associated factors, compared with those who have not experienced this type of IPV?
(2) What are the levels of acceptability toward PE-IPV among persons who have experienced such violence, compared with those who have not?
(3) How regularly do survivors of PE-IPV seek help and use available healthcare services, and what are the predictors of them accessing mental health services?

Methods

Study design and instruments

This is a cross-sectional study, which is based on a nationally representative survey conducted in Lithuania in 2021 ($n = 1001$). This article is also a part of the broader observational, cross-sectional, mixed-methods study titled, 'Responses to Mental Health Care Needs of Survivors of Intimate Partner Violence by Mental Health Services in Lithuania and Portugal'.

The 2021 survey was conducted in the framework of the #ItsNotOk Initiative and its design was based on references from both the field of IPV and behavioural science.[41,42] It was designed and coordinated by a group of scientists from Behavioural Lab LT, Human Rights Monitoring Institute, Lisbon Institute of Global Mental Health, Center for Social Norms and Behavioral Dynamics at the University of

Pennsylvania, Department of Psychological and Behavioural Science at the London School of Economics and Political Science, and the University of Oxford.

The survey was implemented by a third-party independent market research company employing an online survey panel. The panel stores detailed and regularly updated profiles of its panellists, allowing for a targeted selection of study participants, to achieve the national demographic representation. To ensure that the survey sample was representative of the Lithuanian adult population by gender, age and region of living, the newest publicly available demographic statistics provided by the Lithuanian government were used to set the respective quotas. Participants were recruited accordingly by these quotas to reflect the national demographic composition. Within the targeted groups, participants were selected at random. Participants of the study were those who had given their informed consent to participate, were 18 years or older, living in Lithuania and Lithuanian speaking. The panel used a multisource recruitment strategy (via the web, telephone and face-to-face) to eliminate sample bias and conducted a quality check by removing responses filled-in too quickly and straight-lined responses.

The study was approved as an integral part of the broader mixed-methods study by the Research Ethics Committee of NOVA Medical School, NOVA University of Lisbon (Ref. No. 171/2021/CEFCM).

Study sample and assessment of variables

Exposure to psychological IPV was assessed by first describing this type of violence as 'behaviour by your intimate partner that includes calling names, humiliating, isolating, hurting your pets, destroying things dear to you, threatening, frightening, turning your children against you, etc.' and then asking the question 'Have you ever experienced psychological IPV?' ('yes' or 'no' answer).

Exposure to economic IPV was assessed by first describing this type of violence as 'behaviour by your intimate partner that includes controlling your finances, not allowing you to study or work, not allowing access to your/family bank accounts, demanding detailed reports for all your spendings, etc.' and then asking the question 'Have you ever experienced economic IPV?' ('yes' or 'no' answer).

Only data on experiences of PE-IPV (and not other types of IPV) was analysed in this study because only this data had been included in the survey. Excluding experiences of physical IPV from this study was motivated by the fact that, globally, it has been studied extensively, but PE-IPV has had much less scientific attention.

The sociodemographic characteristics assessed in this study included: gender, age (18–24; 25–34; 35–44; 45–54; 55–64; 65–75); education (never attended school; unfinished school; primary school; secondary school; vocational school; college; university); monthly household income after tax in euros (less than 450; 451–750; 751–1100; 1101–1700; more than 1700; cannot/do not want to say); residence (large city; large town; other town; small town/village (up to 2000 inhabitants)); relationship status (married, have a partner–unmarried; single; divorced; widow) and number of people living together in the household (1; 2; 3; 4; more than 4; no one else).

The research participants' own levels of acceptability toward PE-IPV were assessed, by presenting them with the following statements and questions, first about psychological IPV, then about economic IPV: 'Some people in Lithuania use this type of behaviour against their intimate partners. Society may either think that it is acceptable or unacceptable. In your personal opinion, to use such behaviour against intimate partners is . . . ' (answer options: 'acceptable; more acceptable than not; more unacceptable than acceptable; unacceptable').

To assess the utilization of mental health services, study participants were asked about whether they sought any kind of help and support at all, and also whether they sought help at specialized mental health services. The questions were as follows: 'Have you ever sought help for your experiences of psychological IPV?'; 'Have you ever sought help for your experiences of economic IPV?'; 'Did you receive the services of a psychologist/psychotherapist in the public sector?'; 'Did you receive the services of a psychologist/psychotherapist in the private sector?'; 'Did you receive the services of a psychiatrist in the public sector?'; 'Did you receive the services of a psychiatrist in the private sector?'; 'Did you receive services within a psychiatric hospital?' ('yes' or 'no' answers).

Data analysis

For the descriptive statistical analysis, observed absolute frequencies (*n*) and relative frequencies (%) were used for all the categorical variables. For the bivariate statistical analysis, Chi-Square or Fisher exact tests were employed to assess the association between categorical variables, as applicable. Univariate logistic regression models were performed with the dependent variables indicating whether various mental health services were sought by female survivors of IPV. The various potential factors that might influence the outcome were considered as explanatory variables. These factors included sociodemographic characteristics and the different types of violence that were experienced.

Estimated odds-ratios (OR) and corresponding 95% confidence intervals (95% CI) were obtained for each explanatory variable of the logistic regression models; their statistical significance was assessed by likelihood ratio tests.

The significance level $\alpha = 5\%$ was considered throughout the statistical analysis.

The data were analysed using the R software.[43] The R *car* package was used to obtain the likelihood ratio tests.[44]

Results

In total, 1001 people participated in the survey: 534 females (53%), 459 males (46%) and 8 people who identified as being of other gender or did not want to reveal their gender at all (1%). A statistically significant association between gender and experience of PE-IPV was found ($P = 0.020$) with women being significantly more likely to have experienced PE-IPV than men. For this reason, the main sample included in this study was of the participants who identified as women ($n = 534$), of whom almost half experienced PE-IPV ($n = 233$). The sociodemographic characteristics of the study participants, together with the associated acceptability rates of both types of IPV, are presented in Table 1.

The vast majority of women, regardless of whether they had experienced PE-IPV or not, found both types of IPV either unacceptable or more unacceptable than acceptable. Among survivors of PE-IPV, there were 3% of women who found PE-IPV either acceptable or more acceptable than not. Among women who did not experience IPV, this number was 2%.

As demonstrated in Table 2, less than one-third (27.5%) of the PE-IPV survivors sought any type of help, and around 13% received mental health services. The most frequently used service was that of a psychologist/psychotherapist.

No significant difference could be observed in the utilization of mental health services between women who experienced both types of IPV compared with those who experienced only one.

Out of all the sociodemographic predictors included in this study, as to whether or not survivors of PE-IPV seek help or access mental health services, only one ('relationship status') had a significant overall effect (see Table 3). Divorced women were most likely to seek any type of help ($P = 0.002$) as well as mental health services ($P = 0.006$). The only other predictor that was significant for accessing mental health services was living with more than 4 persons in the household ($P = 0.01$).

Discussion

Main finding of this study

This is the first ever representative study of the Lithuanian population on the prevalence and acceptability of PE-IPV. It is also the first of its kind on the utilization of mental health services by women exposed to this type of IPV. The study confirms that almost one in every two women in Lithuania experience PE-IPV, with females being significantly more likely to experience this form of domestic violence than males. This is in line with global tendencies concerning the prevalence of psychological IPV.[8–10,14–17] Almost all independent variables included in the current analysis were significantly associated with experiencing PE-IPV, i.e. age, place of residence, relationship status, education and income level. The results also show that the vast majority of survivors of PE-IPV found this type of behaviour by intimate partners unacceptable; yet, only a minority of them sought any type of help to deal with it or approached mental health services.

What is already known on this topic

Research has previously highlighted that generally survivors of IPV tend to conceal the fact that they were abused. This may be due to a number of possible reasons, among which are fear, shame, self-blaming, societal and internalized stigma, victim-blaming attitudes, the context of minority stress such as discrimination, financial and/or emotional dependency on the abuser, or the fact that they might not even consciously recognize the behaviour of their intimate partner as abuse at all.[21,37,45–47]

Previous studies mainly investigated the link between survivors of IPV and their physical healthcare, especially in primary care settings.[32–35,48,49] It is important to note that most of these studies have been primarily focused on physical IPV and were conducted in the USA, Canada, Sweden and Australia. The current study emphasizes and draws attention to the specificities of Lithuanian women experiencing specifically PE-IPV and the crucial role that mental health care services may play for this population.

What this study adds

The current study highlights that only around 1 in 10 women exposed to PE-IPV in Lithuania access mental health services. The study showed no significant difference in accessing mental health services between survivors of just one type of IPV or both psychological and economic IPV. This might be due to the fact that economic IPV is in fact a dimension of psychological IPV and a type of coercive control; thus, the impact of the abuse among women with these experiences may be similar.[13,25]

Nevertheless, this finding is unexpected and alarming because studies across the world show that women with experiences of IPV, especially psychological IPV and coercive control, including economic IPV, are more likely than those with no experience of IPV to have mental health

Table 1 The sociodemographic characteristics of women with and without the experience of psychological and/or economic IPV, and their associated levels of IPV acceptability ($n = 534$)

	Women in Lithuania who experienced psychological and/or economic IPV (n = 233)		*Women in Lithuania who did not experience psychological and/or economic IPV (n = 301)*		*P-value (Chi-Square Test) (*) statistical significance*
Age category	*n*	*%*	*n*	*%*	*0.008**
18–24	27	11.6	60	19.9	
25–34	26	11.2	48	15.9	
35–44	39	16.7	49	16.3	
45–54	55	23.6	42	14.0	
55–64	44	18.9	58	19.3	
65–75	42	18.0	44	14.6	
Education level	***n***	**%**	***n***	**%**	0.001*
Primary School	6	2.6	1	0.3	
Secondary School	37	15.9	37	12.3	
Vocational School	28	12.0	31	10.3	
College	72	30.9	67	22.3	
University	90	38.6	165	54.8	
Household income (per month)	***n***	**%**	***n***	**%**	<0.001*
Less than 450 EUR	33	14.2	28	9.3	
451–750 EUR	61	26.2	47	15.6	
751–1100 EUR	48	20.6	50	16.6	
1101–1700 EUR	35	15.0	58	19.3	
More than 1700 EUR	19	8.2	49	16.3	
I cannot/do not want to say	37	15.9	69	22.9	
Residence	***n***	**%**	***n***	**%**	0.004*
Large city	75	32.2	135	44.9	
Large town	63	27.0	52	17.3	
Other Town	59	25.3	60	19.9	
Small Town/Village (up to 2000 inhabitants)	36	15.5	54	17.9	
Relationship status	***n***	**%**	***n***	**%**	<0.001*
Married	97	41.6	133	44.2	
Have a partner—unmarried	40	17.2	63	20.9	
Single	22	9.4	56	18.6	
Divorced	61	26.2	23	7.6	
Widow	13	5.6	26	8.6	
No. of persons the woman lives with (including children)	***n***	**%**	***n***	**%**	0.4
1	28	12.0	42	14.0	
2	78	33.5	88	29.2	
3	40	17.2	61	20.3	
4	24	10.3	43	14.3	
More than 4	14	6.0	11	3.7	
No one else (no children or they are older than 18 years)	49	21.0	56	18.6	

(continued)

Table 1 Continued

	Women in Lithuania who experienced psychological and/or economic IPV (n = 233)		*Women in Lithuania who did not experience psychological and/or economic IPV (n = 301)*		*P-value (Chi-Square Test) (*) statistical significance*
Age category	*n*	*%*	*n*	*%*	*0.008**
Acceptability level of psychological IPV	***n***	**%**	***n***	**%**	0.8
Acceptable	4	1.7	3	1.0	
More acceptable than not	0	0.0	1	0.3	
More unacceptable than acceptable	22	9.4	26	8.6	
Unacceptable	207	88.8	271	90.0	
Acceptability level of economic IPV	***n***	**%**	***n***	**%**	0.06
Acceptable	2	0.9	1	0.3	
More acceptable than not	5	2.1	1	0.3	
More unacceptable than acceptable	26	11.2	23	7.6	
Unacceptable	200	85.8	276	91.7	

Table 2 Help-seeking and types of mental health services accessed by survivors of PE-IPV (*n* = 233)

		Women who experienced both psychological and economic IPV (n = 95) n (%)	*Women who experienced either only psychological IPV (n = 112) or only economic IPV (n = 26) n (%)*	*P-value (Chi-Square Test)*
Public sector	Psychiatrist	1 (1.05)	2 (1.45)	0.792
	Psychologist/psychotherapist	6 (6.32)	7 (5.07)	0.684
	Psychiatric hospital	2 (2.11)	1 (0.725)	0.358
	Any mental health services	8 (8.42)	9 (6.52)	0.584
Private sector	Psychiatrist	4 (4.21)	1 (0.725)	0.071
	Psychologist/psychotherapist	4 (4.21)	7 (5.07)	0.760
	Any mental health services	8 (8.42)	8 (5.80)	0.436
Any type of mental health services at any sector		16 (16.8)	15 (10.9)	0.187
Any type of help		31 (32.6)	33 (23.9)	0.143

conditions.[8,25,26] Hence, the current study highlights that even though the prevalence of experiencing PE-IPV is high and so is the expected rate of mental health conditions among these women, only a small fraction of them seek help at all or receive mental health services in Lithuania. There may be several possible reasons for this phenomenon.

Firstly, psychological and/or economic abuse are still much less recognized as types of domestic violence, compared with physical and/or sexual IPV.[50] Additionally, physical abuse is significantly more often investigated by the police.[22]

When considering mental health services specifically, the reasons for a general lack of interaction with them may be rooted in predominant negative attitudes toward mental health conditions and services in Lithuanian society.[38,39] As it was recently emphasized in the OECD Health Working Paper (2022): 'Despite legislative reform in recent years, there remains legislation prohibiting those with a diagnosed mental health disorder from taking up specified professions, and performing certain activities. Formal and informal modes of stigmatisation continue to act as a barrier to help-seeking and treatment'.[39]

In the current study, divorcees had higher odds of accessing mental health services compared with other relationship statuses, which might be related to the fact that it is very

Table 3 Association between the sociodemographic factors and whether or not PE-IPV survivors sought help or accessed mental health services ($n = 233$)

		Seeking any type of help for experiencing PE-IPV OR (95%CI), P-value	*Seeking any mental health services for experiencing PE-IPV OR (95%CI), P-value (*) statistical significance*
Age category	18–24	Reference category	Reference category
	25–34	1.354 (0.5157, 3.604) 0.536	1.1857 (0.2715, 5.180) 0.814
	35–44	1.368 (0.5478, 3.531) 0.504	1.5183 (0.4184, 6.123) 0.529
	45–54	1.585 (0.6660, 3.971) 0.306	1.6139 (0.4699, 6.346) 0.458
	55–64	0.839 (0.3128, 2.248) 0.723	1.7660 (0.5358, 6.812) 0.367
	65–75	1.543 (0.6281, 3.945) 0.349	0.7500 (0.1440, 3.502) 0.712
	Overall Test of Effect	0.675	0.791
Education level	Primary School	0.167 (0.00784, 1.43) 0.1355	2.6667 (0.1366 17.061) 0.378
	Secondary School	0.500 (0.14317, 1.73) 0.2688	1.4118 (0.4880, 3.619) 0.492
	Vocational School	0.688 (0.22498, 2.13) 0.5097	1.4815 (0.4658, 4.011) 0.465
	College	1.312 (0.47150, 3.82) 0.6072	0.5970 (0.1908, 1.579) 0.328
	University	Reference category	Reference category
	Overall Test of Effect	0.427	0.496
Household income (per month)	Less than 450 EUR	Reference	
	451–750 EUR	0.659 (0.286, 1.540) 0.326	0.733 (0.2427, 2.329) 0.583
	751–1100 EUR	0.625 (0.263, 1.491) 0.283	0.493 (0.1363, 1.709) 0.261
	1101–1700 EUR	0.605 (0.250, 1.463) 0.260	0.521 (0.1439, 1.808) 0.300
	More than 1700 EUR	0.255 (0.068, 0.783) 0.246	0.278 (0.0396, 1.261) 0.126
	I cannot/do not want to say	0.521 (0.216, 1.256) 0.143	0.550 (0.1647, 1.836) 0.320
	Overall Test of Effect	0.290	0.652
Residence	Large city	Reference	Reference
	Large town	1.228 (0.6259, 2.355) 0.542	0.7706 (0.2665, 1.981) 0.604
	Other Town	1.021 (0.5070, 1.992) 0.953	1.0090 (0.3923, 2.432) 0.984
	Small Town/Village (up to 2000 inhabitants)	0.885 (0.3904, 1.869) 0.757	0.6512 (0.1806, 1.876) 0.461
	Overall Test of Effect	0.882	0.845
Relationship status	Married	Reference	Reference
	Have a partner – unmarried	1.081 (0.5047, 2.206) 0.834	1.2315 (0.4141 3.3339) 0.690
	Single	0.808 (0.3115, 1.859) 0.636	0.5239 (0.0799 2.0078) 0.407
	Divorced	2.733 (1.4255, 5.213) 0.002*	3.3182 (1.3967 7.9627) 0.0063*
	Widow	0.683 (0.1570, 2.081) 0.550	0.5239 (0.0283 2.8127) 0.542
	Overall Test of Effect	0.016*	0.0237*
No. of persons the woman lives with (including children)	1	Reference	Reference
	2	1.9810 (0.8248, 5.530) 0.152	2.4129 (0.62621 15.8646) 0.260
	3	1.1722 (0.4138, 3.596) 0.769	1.7708 (0.36974 12.6179) 0.502
	4	1.2444 (0.3919, 4.067) 0.708	1.0462 (0.12259, 8.9275) 0.965
	More than 4	3.3684 (0.9534, 11.987) 0.055	8.5000 (1.69416 62.5870) 0.014*
	No one else (no children or they are older than 18 years)	1.5072 (0.5639,4.481) 0.430	2.4286 (0.56654 16.6348) 0.278
	Overall Test of Effect	0.316	0.117

difficult to seek help while still in an abusive relationship. This is especially relevant in the case of economic IPV, where the woman may become financially dependent on the abuser, with a highly threatened personal independence and economic security.[12,13,26] Also, psychological IPV and coercive control especially may leave the victim-survivor not only entrapped in the power and control wheel of manipulative strategies systematically used by the abuser but also isolated, with a diminished self-esteem, and in a state of terror, none of which can easily contribute to seeking help.[11,25,51]

Finally, practical reasons for not using mental health services may also be related to inaccessibility and potentially a lack of services based in the community and in rural areas of the country.[39] The inaccessibility of public mental health services may result in vast economic and social exclusion-related problems, since only those who can financially afford to use services in the private sector end up receiving the services, while the poorest and most vulnerable may be left behind.

This situation is alarming because in light of global evidence, not only physical but also mental healthcare services are vital for the path to healing of IPV survivors.[32,52] In most IPV cases, a complex support is needed, taking into account all aspects of the human rights-based and bio-psycho-social model, as well as a trauma-informed approach.[24,53,54] Studies have shown that mental health interventions for female IPV survivors have the greatest impact when they employ a holistic approach and provide individualized and trauma-informed support.[55,56]

To encourage IPV survivors to seek help, societal stigma related to both IPV and mental health conditions needs to be eliminated. Broader implications for public health and policy in Lithuania include: the urgent need to develop more accessible mental health services in the community, a fostering of effective evidence-based interventions to better address the needs of IPV survivors, and to develop new therapeutic approaches, including trauma-informed support. Further quantitative and qualitative research with larger sample sizes is needed in order to better understand the predictors and contextual factors of why IPV survivors utilize mental health care services, or not; especially among survivors of PE-IPV.

Limitations

The study is cross-sectional which limits causal inferences, namely the direction of the associations. Due to the relatively small sample size in some parts of the analysis, more uncertainty was obtained in the estimates, due to larger CIs. There is room for further research and deeper analysis with larger samples of this population and with validated instruments. Additionally, only experiences of psychological and/or economic IPV were analysed and included in the survey, due to the limited data availability on this subject. Thus, the study leaves space for further exploration of relevant associations related to physical and/or sexual IPV.

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Authors' contributions

The study was conceptualized by the first author U.G. and most of the co-authors contributed to the study design. The survey for data collection was designed, coordinated and implemented by P.Y.S., M.H., U.G. and E.Ž. The main statistical analysis of the collected data was conducted by S.A.-L. and U.G., with support from E.Ž. The first draft of the manuscript was written by U.G. and all co-authors reviewed, commented on it and provided their contributions. All co-authors reviewed and approved the final version of the manuscript.

Conflict of Interest

The co-authors declare that there is no conflict of interest.

Data availability

The data underlying this article will be shared on reasonable request to the corresponding author.

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